Certificate of Need Application

Essent Healthcare of Connecticut, Inc.
Vassar Health Connecticut, Inc.

Transfer of Ownership of
Sharon Hospital

November 3, 2016

MERITAS LAW FIRMS WORLDWIDE

Jennifer Groves Fusco
(t) 203.786.8316
(f) 203.772.2037
jfusco@uks.com

November 3, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Transfer of Ownership of Regional Healthcare Associates & Tri State Women's Services to a Connecticut Medical Foundation

Dear Deputy Commissioner Addo:

This office represents Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, Vassar Health Connecticut, Inc., Health Quest Systems, Inc., Regional Healthcare Associates, LLC, and Tri State Women's Services, LLC. Enclosed please find one (1) bound original each of the Certificate of Need Applications for the following proposals:

- Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc.; and
- Transfer of Ownership of Regional Healthcare Associates, LLC and Tri State Women's Services, LLC to a Connecticut Medical Foundation affiliated with Vassar Health Connecticut, Inc.

Also enclosed are the following:

- Two (2) $500 filing fee checks; and
- A USB flash drive that contains the pdfs of each submission, Word versions of the application forms, and a single Excel workbook that contains the financial worksheets for both submissions.

Please feel free to contact me with any questions. We look forward to working with you on these matters.

Very Truly Yours,

Jennifer Groves Fusco

/jgf

cc: David Ping

Checklist

Instructions:

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

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

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

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

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

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original hardcopy in a 3-ring binder and a USB flash drive containing:

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

For OHCA Use Only:

Docket No.: 16-32132 **Check No.:** 10285
OHCA Verified by: [signature] **Date:** 11/4/16

TABLE OF CONTENTS

ATTACHMENT I

TREASURER, STATE OF CONNECTICUT 06/13/2016 10285297

INVOICE DATE	INVOICE NUMBER	PURCHASE ORDER #	DESCRIPTION	GROSS AMOUNT	DISCOUNT AMOUNT	NET AMOUNT
06/08/2016	CR06082016	CON /SHARON HOS		500.00	0.00	500.0
TOTALS						

VERIFY THE AUTHENTICITY OF THIS MULTI-TONE SECURITY DOCUMENT. CHECK BACKGROUND AREA CHANGES COLOR GRADUALLY FROM TOP TO BOTTOM.

COPYBAN CAPTURE ANTI-FRAUD PROTECTION

10285297

HEALTH QUEST SYSTEMS, INC.
1351 Route 55
Lagrangeville, NY 12540

JPMorgan Chase Bank, N.A.
1166 Avenue of the Americas / 20
New York, NY 10036

1-2/210

CHECK DATE
06/13/2016

FIVE HUNDRED DOLLARS AND ZERO CENTS **********

$*$500.00

PAY TO THE ORDER OF

TREASURER, STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS
410 CAPITOL AVE. MS#13HCA
PO BOX 340308
HARTFORD CT, 06134

[redacted]

[redacted]

ATTACHMENT II

Ad #: RA0736206

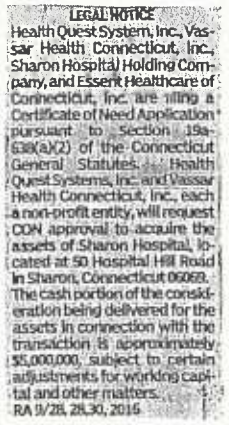
AFFIDAVIT OF PUBLICATION

STATE OF CONNECTICUT
County of New Haven Waterbury September 30th 20 16

The subcriber, being duly sworn, deposes and says that he (she) is the bookkeeper of the **Republican-American** and that the foregoing notice for

SEIDEN ADVERTISING

was published in said **Republican-American** in **3** editions of said newspaper issued between **09/28/16** and **09/30/16**



LEGAL NOTICE
Health Quest System, Inc., Vassar Health Connecticut, Inc., Sharon Hospital Holding Company, and Essent Healthcare of Connecticut, Inc. are filing a Certificate of Need Application pursuant to Section 19a-638(a)(2) of the Connecticut General Statutes. Health Quest Systems, Inc. and Vassar Health Connecticut, Inc., each a non-profit entity, will request CON approval to acquire the assets of Sharon Hospital, located at 50 Hospital Hill Road in Sharon, Connecticut 06069. The cash portion of the consideration being delivered for the assets in connection with the transaction is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28, 28,30, 2016

SUBSCRIBED AND SWORN BEFORE ME THIS THE 30th

day of September 2016

Notary Public

My Commission Expires: 8/31/17

SH000007
11/03/2016

Commercial for sale, lease, rent

THOMASTON LEASE
7000SF comm'l/mfg. $5/SF NNN.
860-283-6261

WATERBURY DOWNTOWN LEASE
600-5,000 sq. ft. Call for details,
203-841-2500 x121

WATERBURY small church, 40-60 people, $800 utils incl'd. Call 203-695-7417, 203-910-6935

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

GUTHY-RENKER Fitness Flyer
203-729-9661

TV Heavy black TV & stereo console for 32" TV. Need truck for pickup. 203-879-2211

Lost & found

FOUND Mini collie/sheltie mix, female, approx. 3-5- years old. Contact Colebrook Animal Control Officer 860-201-3217 to claim

IMPOUNDED BETHLEHEM blk & white cat Kasson Grove area redeem 203-910-3228

IMPOUNDED WTBY Chih mix, m, brindle, pit mix f, white &tan redeem 203-574-6909

Legals/ Public Notices

NOTICE TO CREDITORS
ESTATE OF R.W. Lance, AKA Richard W. Lance, (16-00674)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated September 21, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge

The fiduciary is:
Romeo Josef
c/o Atty Thomas E. Porzio
625 Wolcott Street, Suite 21
Waterbury, CT 06705

R-A September 28, 2016

TOWN OF HARWINTON
PUBLIC INFORMATION MEETING
Proposed Town of Harwinton Blight Ordinance discussion will be held on TUESDAY, October 4, 2016 at 7:00 P.M. , Main Assembly Hall, Harwinton Town Hall, 100 Bentley Drive, Harwinton, CT. Residents, business owners and other interested individuals are encouraged to take advantage of this opportunity to learn about and discuss the proposed Ordinance before a Town Meeting vote. Location is ADA accessible. If language assis-

Legals/ Public Notices

NOTICE OF HEARING
TOWN OF THOMASTON
PLANNING AND ZONING COMMISSION
ZONING MAP CORRECTIONS

The Planning and Zoning Commission, Thomaston, CT will hold a public hearing on Wednesday, October 5, 2016, 7:00 pm, Meeting Room #1, 4th Level, Thomaston Town Hall, 158 Main St., Thomaston, CT on the following corrections to errors in the 2008 and 2012 Thomaston Zoning Map:

1. Assessor's Map 17 Block 04 Lot 01 Hill Road (adjacent and east of 580 North Main Street) from RA-80A residential to M2 heavy manufacturing to correct a 2008 zoning map error
2. Assessor's Map 24 Block 03 Lot 03 Hill Road (adjacent and west of 341 Railroad Street) from RA-80A residential to M2 heavy manufacturing to correct a 2008 zoning map error
3. An 11.4 Acre portion of Assessor's Map 30 Block 06 Lot 01, Northfield Road (State Rte 254, West of 510 Northfield Road) from RA-80A residential to General Commercial to correct a 2008 zoning map error

At this hearing interested persons may appear and be heard and written communications will be received. A copy of documents related these corrections are on file in the Land Use Office and Town Clerks' Office, Thomaston Town Hall.

Dated at Thomaston, CT this 23rd and 28th Day of September, 2016

Ralph Celone, Chairman
Thomaston Planning and Zoning Commission
RA 9/23, 28, 2016

NOTICE TO CREDITORS
ESTATE OF Patricia L. Lasky
(16-00542)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated August 17, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge

The fiduciary is:
Jodi Ann Lasky
80 Idlewood Road
Wolcott, CT 06716

R-A August 26, 2016

NOTICE TO CREDITORS
ESTATE OF Sophie A. Cantamessa, AKA Sophie Cantamessa, (16-00748)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated September 20, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge

The fiduciary is:
Carol A. Olsen
c/o Atty Mark Iannone
Tynan & Iannone

Legals/ Public Notices

LEGAL NOTICE
TOWN OF SHARON
ZONING BOARD OF APPEALS

At a Special Meeting of the Sharon Zoning Board of Appeals held on September 26, 2016 Appeal #176 of James A. Quella, for Q Farms LLC was approved by a vote of four to one for a sign up to the maximum of 8 (eight) square feet. A copy of this decision will be on file at the Town Clerk's Office.

Dated at Sharon, Connecticut this 27th day of September 2016.

William Trowbridge, Chairman
Sharon Zoning
Board of Appeals
R-A September 28, 2016

LEGAL NOTICE
Health Quest System, Inc., Vassar Health Connecticut, Inc., Sharon Hospital Holding Company, and Essent Healthcare of Connecticut, Inc. are filing a Certificate of Need Application pursuant to Section 19a-638(a)(2) of the Connecticut General Statutes. Health Quest Systems, Inc. and Vassar Health Connecticut, Inc., each a non-profit entity, will request CON approval to acquire the assets of Sharon Hospital, located at 50 Hospital Hill Road in Sharon, Connecticut 06069. The cash portion of the consideration being delivered for the assets in connection with the transaction is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28, 28,30, 2016

Request for Qualifications
#04-1613

The Judicial Branch Purchasing Services Office, on behalf of The Connecticut Bar Examining Committee and the Judicial Branch Human Resources Management Unit, is seeking quotations from qualified Contractors for performing Independent Medical Evaluations (IME).

The deadline to submit written questions is Thursday, October 6, 2016 by 4:00 p.m.

Sealed proposals must be received before 2:30 p.m. on Wednesday, October 19, 2016. Immediately thereafter, all proposals will be publicly opened and prices read aloud. Late proposals will NOT be accepted.

VENDORS CURRENTLY REGISTERED UNDER THE STATE'S SMALL BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO APPLY.

Proposal package may be obtained at Judicial Materials Management Unit, Purchasing Services at: 90 Washington Street, 4th Floor, Hartford, CT or call (860) 706-5200 to request by mail, or access the web site below.

PLEASE CHECK THE JUDICIAL WEB SITE AT:
www.jud.ct.gov/external/news/busopp/Default.htm

JUDICIAL BRANCH
MATERIALS MANAGEMENT UNIT
PURCHASING SERVICES
90 WASHINGTON STREET

Legals/ Public Notices

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
ORDER OF NOTICE

NOTICE TO: Elvis Castro; Father of a female child born on 10-15-13 to Vanessa G. of parts unknown. A petition has been filed seeking:
Commitment of minor child(ren) of the above named or vesting of custody and care of said Child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person.

The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 10-5-16 at 10:00 a.m. at 7 Kendrick Avenue, 3RD Floor, Waterbury, CT 06702.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Waterbury Republican American, a newspaper having a circulation in the town/city of Waterbury, CT

Honorable John Turner
Judge

Brenda Petitti, Admin Clerk 1
Date signed: 9-8-16

RIGHT TO COUNSEL: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your Hearing is to be held.
RA 9/28/2016

REQUEST FOR PROPOSALS:
The Northwest Hills Council of Governments (NHCOG) is seeking proposals for a qualified consultant to conduct a critical habitat study of specific areas in Kent and Cornwall, CT. The full request for proposals is available from the NHCOG, 59 Torrington Road, Suite A-1, Goshen CT 06756 Tel 860-491-9884 or email dkrukar@northwesthillscog.org. Responses must be sentvia emailby noon on October 11, 2016. EOE
RA 9/28/16

Notice of Decision
Town of Warren
Inland Wetlands & Conservation Commission
At the regular meeting of the Inland Wetlands and Conservation Commission on Thurs, Sept 22, 2016 at 7:00 pm at the Warren Town Hall, 50 Cemetery Rd, the following applications were approved: (1) A. H. Howland & Associates, PC for The Cove, LLC – North Shore Road (Assessor's Map 45 Lot 12-1) – Drainage Improvements Associated with Construction of Single Family Dwelling and Improvements to Existing Pier and Stairway at Shoreline; (2) A. H. Howland & Associates, PC for The Cove, LLC – North Shore Road (Assessor's Map 45 Lot 12) – Improvements to Existing Pier and Stairway at Shoreline; and (3) A. H. Howland & Associates, PC for Catherine Deckelbaum, 33 Arrow Point Road – Drainage Improvements Associated with Reconstruction of Single Family Dwelling. The files for these applications are available for inspection in the Land Use Office, Town Hall, 50 Cemetery Rd., Warren, CT.
Dated this 27th day of Sept

Legals/ Public Notices

LEGAL NOTICE
Health Quest System, Inc., Vassar Health Connecticut, Inc., Regional Healthcare Associates, LLC, and Tri State Women's Services, LLC are filing a Certificate of Need Application pursuant to Section 19a-638(a)(3) of the Connecticut General Statutes. Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Regional Healthcare Associates, LLC, a private physician practice with locations at 50 Hospital Hill Road in Sharon, Connecticut 06069, 29 Hospital Hill Road, Sharon, Connecticut 06069, 2 Old Park Lane, New Milford, Connecticut 06776, and 64 Maple Street, Kent, Connecticut 06757. In addition, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Tri State Women's Services, LLC, a private physician practice with locations at 50 Amenia Road, Sharon, Connecticut 06069, 115 Spencer Street, Winsted, Connecticut 06098, and 76 Church Street, Canaan, Connecticut 06018. These acquisitions are taking place in conjunction with the acquisition by Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. of the assets of Sharon Hospital. The cash portion of the consideration being delivered for the assets in connection with the transaction involving the acquisition of Sharon Hospital and the physician practices is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28,29,30, 2016

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
ORDER OF NOTICE

NOTICE TO:John Doe; Father of a male child born to Christina M. on 9-4-13 in Waterbury, CT

of parts unknown

A petition has been filed seeking:

Termination of parental rights of the above named in minor child(ren)

The petition whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 10-12-16 at 2:00p.m. at SCJM, 7 Kendrick Ave, 3RD Floor, Waterbury, CT 06702.

Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the: Waterbury Republican American, a newspaper having a circulation in the town/city of Waterbury, CT

Honorable John Turner
Judge

Brenda Petitti, Admin Clerk 1
Date signed 9-20-16

RIGHT TO COUNSEL: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your Hearing is to be held.
RA 9/28/16

Apartments for rent

OAKVILLE 1st flr., 2BR 2 bth, c/air, garage, no pets cr. ck $1150+sec Call 860-274-4586 after 6pm

OAKVILLE Riverside St. Nice 1BR $600. No pets. Off st. prkg. Sec 8 ok. 203-335-2567, 203-895-9121

WATERBURY 1, 2, 3 & 4 BR apts. available. Property Management Center (203) 755-6649.

WATERBURY 1, 2, 3, 4 BR Apts & Houses available NEWLY RENOVATED Agent 203-565-9639

WATERBURY 1, 2 & 3 rm apts clean, appl, util secure bldg lndry $465/up. Sect 8 OK. 203-753-3239

WATERBURY 1, 2 & 3 rms, nice, heat & appl, secure building, prkg, $450 & up (203) 206-4051

WATERBURY 1 & 2 BR HT/HW, appl Sect. 8 OK. $925. 203-745-8626

WATERBURY DOWNTOWN Beautiful renov. apts. in modern 10 story fireproof Elev. Bldg. w/great views; 1 BR $630; Low rentals incl: 1 Parking Space, Carpet/HW Flr., Security / Lndry Rm. No Pets. Habla Espanol. Mgmt: 203-756-1999; 203-837-7428

WATERBURY
EAST END 1 BR apts. Some newly remodeled, on-site laundry, on busline, $675-$700. Credit check. 203-725-6121

WATERBURY East End 1 BR, Heat & HW incl, off-st. prkg., laundry facil, $800/mo. 203-592-7944.

WATERBURY EAST END
SCOTT GARDENS
SPACIOUS TOWNHOUSE APTS.
Now Paying $200 Referral Bonus
1-2-3 BEDROOM
FROM $775 TO $1040
INCLUDES heat, hot water, range, refrig, new on-site laundry, assigned prkg. Beautifully landscaped, quiet & safe, 24 hr. maint, very close to Rt. 84, for qualified persons reduced sec. deposit-credit report fee $50. 203-757-7311
Open Monday-Friday 9-5
Open Saturday 10-3
windsormy.com

WATERBURY Exc. East End area. 1st fl, 2br, off st pkg, nice yard, fresh paint, new carp., WD, appl, no utils, no pets 1 yr. lease Sec $825. 203-217-8817

WATERBURY large 2BR modern, off street prkg, quiet Watervile section, porch overlooking woods $750. 203-915-4310

Apartments for rent

WATERBURY RIDGEGATE APTS 2 story T/H 2-3 BR H/HW included, appl. prkg, W/D hookup HW Flr start $875 Sect. 8 OK 203-575-1680 ext. 106

WATERBURY SPACIOUS 1BR & 2BR immaculate, No pets, on-site laundry. 860-810-2941

WATERBURY tired of viewing dirty, neglected apts, ours are clean and updated. 1 & 2 Br. 293-729-2269, 203-805-1680

WATERBURY Town Plot, 2 BR, off st. prkg w/laundry & storage in bsmt. No pets. $850 mo., Heat & HW included. Mandatory background/credit chk required. Tony, 203-518-0602, 9-6.

WATERBURY Town Plot, very clean, 5rm, 2br, 3rd flr. WD hkup, off st prkg. Gas heat. 603 Washington Av. 203-232 6861

HW flr & tile, AC, gas ht, gar EZ Rt 8/184 start@ $1200. 203-756-7068

Garages for rent

WATERBURY Perkins Ave. 2 bay garage 10x30, secure, $150/mo. Text 203-558-0868 or 203-704-0691

Houses for rent

NAUGATUCK cape near Middlebury line, quiet, 6 rm, 3 BR, $1500, 1st mo. & sec. 203-627-9909

WATERBURY EAST MOUNTAIN 3 BR, 1 bath $1375/month Call Rosie 203-560-9702 Call Cristina 203-509-2025

WATERBURY single family E.End, Overlook, Bunker Hill, South End Starting @ $1200 203-510-6177

Roommates

WATERBURY furnished West End house to share w/adult male 2BR 2 ba $500/mo. or $400 if handy. All incl 203-756-0013 lv msg

Rooms

Waterbury East End starting at $125 wk. Shared kit & bath, $400 sec. Velezis Realty 203-574-7777

WATERBURY room, bed, micro, refrig., all utilities, cable, clean safe nghb. $140/wk. 203-668-3005

WATERBURY roommate female to share w/same 3BR home nice area sec/ref $350. 203-681-7035

Real Estate For Sale

Lots for sale

BANTAM LAKE bldg lot priv community tennis boat water sewer incl $169,000 860-868-1256

NORFOLK, CT 1.28 acres, $70,000 or best offer. 508-943-5797 or cell 508-353-9722.

Mobile home

MOBILE HOME FIX IT
Sales, supplies & service
203-754-5962; 203-755-0739

NAUGATUCK 4 units to choose from starting at $29,900 incl. pool & clubhouse 203-729-8277

WATERBURY DOWNTOWN LEASE 600-5,000 sq. ft. Call for details, 203-841-2500 x121

WATERBURY small church, 40-60 people, $800 utils incl'd. Call 203-695-7417, 203-910-6935

Announcements

Absolutely free
Lost & found
Special notices

Absolutely free

COUCH GREY with reclining heated seats on both ends. HEAVY!!! FREE
Call 203-527-9434

GUTHY-RENKER Fitness Flyer 203-729-9661

KITTENS free to good homes. Call 203-757-5971

SCRAP METAL FREE
203-527-8482

TV Heavy black TV & stereo console for 32" TV. Need truck for pickup. 203-879-2211

Lost & found

FOUND POMERIAN mix. Oronoke Road area. Found last weekend.
Call 860-274-1322

IMPOUNDED NAUGATUCK #38, f, Chih. brown, High St., 9/24. 203-729-4324

Legals/ Public Notices

NOTICE TO CREDITORS
ESTATE OF Edward E. Badoreck, of Naugatuck,
AKA Edward Badorek, (16-00107)

The Hon. Peter E. Mariano, Judge of the Court of Probate, District of Naugatuck Probate Court, by decree dated March 22, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Patricia Alegi, Chief Clerk

The fiduciary is:
Jolanta Badorek
c/o Attorney Charles S. Silver
2505 Main Street, Suite 209A
Stratford, CT 06615
R-A September 29, 2016

PUBLIC NOTICE

Legals/ Public Notices

LEGAL NOTICE
Health Quest System, Inc., Vassar Health Connecticut, Inc., Sharon Hospital Holding Company, and Essent Healthcare of Connecticut, Inc. are filing a Certificate of Need Application pursuant to Section 19a-638(a)(2) of the Connecticut General Statutes. Health Quest Systems, Inc. and Vassar Health Connecticut, Inc., each a non-profit entity, will request CON approval to acquire the assets of Sharon Hospital, located at 50 Hospital Hill Road in Sharon, Connecticut 06069. The cash portion of the consideration being delivered for the assets in connection with the transaction is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28, 28,30, 2016

Valerie B. Denyer
c/o Atty Joseph A. Geremia, Jr.
27 Homes Avenue
P.O. Box 2507
Waterbury, CT 06710

R-A September 29, 2016

LEGAL NOTICE
Health Quest System, Inc., Vassar Health Connecticut, Inc., Regional Healthcare Associates, LLC, and Tri State Women's Services, LLC are filing a Certificate of Need Application pursuant to Section 19a-638(a)(3) of the Connecticut General Statutes. Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Regional Healthcare Associates, LLC, a private physician practice with locations at 50 Hospital Hill Road in Sharon, Connecticut 06069, 29 Hospital Hill Road, Sharon, Connecticut 06069, 2 Old Park Lane, New Milford, Connecticut 06776, and 64 Maple Street, Kent, Connecticut 06757. In addition, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Tri State Women's Services, LLC, a private physician practice with locations at 50 Amenia Road, Sharon, Connecticut 06069, 115 Spencer Street, Winsted, Connecticut 06098, and 76 Church Street, Canaan, Connecticut 06018. These acquisitions are taking place in conjunction with the acquisition by Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. of the assets of Sharon Hospital. The cash portion of the consideration being delivered for the assets in connection with the transaction involving the acquisition of Sharon Hospital and the physician practices is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28,29,30, 2016

Legals/ Public Notices

NOTICE TO CREDITORS
ESTATE OF Jean A. Maurice, AKA Jean P. Maurice, AKA Jean Maurice, (16-00702)

The Hon. Thomas P. Brunnock, Judge of the Court of Probate, District of Waterbury Probate Court, by decree dated September 27, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Thomas P. Brunnock, Judge

The fiduciary is:
Julie Palionis
c/o Atty William J. Tracy, Jr.
Furey, Donovan, Tracy & Daly, PC
43 Bellevue Avenue
PO Box 670
Bristol, CT 06011

Package.

Sealed quotations must be received by 11:30 A.M. on October 21, 2016. Immediately thereafter all quotations will be publicly opened and prices read aloud.

VENDORS CURRENTLY REGISTERED UNDER THE STATE'S SMALL BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO BID.

Bid package may be obtained at Judicial Purchasing Services at: 90 Washington St., Hartford or call (860) 706-5200 to request by mail, or access the web site below.

PLEASE CHECK THE JUDICIAL WEB SITE AT:

www.jud.ct.gov/external/news/busopp/

JUDICIAL BRANCH
PURCHASING SERVICES OFFICE
90 WASHINGTON STREET
HARTFORD, CT 06106

An Equal Opportunity/Affirmative Action Employer

R-A September 29, 2016

PUBLIC NOTICE

YOUR RECORDS WILL BE DESTROYED NOTIC
NECTICUT STATE REGULATION 19A-14-44

TO THE PATIENTS/CLIENTS OF MARGARET

PLEASE BE INFORMED THAT MARGARET G
LATE OF NAUGATUCK, CONNECTICUT, DIE

AN ESTATE HAS BEEN OPENED AT THE N
COURT (PD21) UNDER DOCKET NUMBER 1

IF YOU DESIRE TO OBTAIN YOUR FILE, YOU M
OF THE PUBLISHING OF THIS PUBLIC NOTI

SCOTT F. LEWIS, ESQ.
LEWIS, LEWIS & FERRARO, LLC
SUITE 202
28 NORTH MAIN STREET
WEST HARTFORD, CT 06107
R-A September 29 & October 6, 2016

Legal Publi

TO
INLAND WE
NOTICE

At its regul
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Approved:
16, Town o
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Dated this
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Lynn Werr

R-A Septe

WATERBU

SPECI

Notice is h
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Notice is
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Town of
Zoning C
Martin W

R-A Sept

s/ Notices

ATION TO BID

'Thomaston Board
invites interested
ubmit bids to pro-
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Thomaston Center
Thomas Avenue,
. Bids will be ac-
or before October
1:00 AM. All work
in early SPRING
will be a MANDA-
id meeting at the
tober 13, 2016 at
Contractors must
by the State of
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oposals can be ob-
First Selectman's
naston Town Hall,
treet, Thomaston,
n-refundable pay-
made payable to
Thomaston.
er 30, 2016

Legals/ Public Notices

INVITATION TO BID

The Town of Thomaston Board of Education invites interested parties to submit bids to provide security man-trap walls at Thomaston High School, 185 Branch Road, Thomaston. Bids will be accepted on or before October 21, 2016 at 10:00 AM. All work to be done in early SPRING 2017. There will be a MANDATORY pre-bid meeting at the site on October 11, 2016 at 10:00 A.M. Contractors must be licensed by the State of Connecticut. The complete request for proposals can be obtained in the First Selectman's Office, Thomaston Town Hall, 158 Main Street, Thomaston, CT with a non-refundable payment of $25 made payable to the Town of Thomaston.
R-A September 30, 2016

Legals/ Public Notices

LEGAL NOTICE

Health Quest System, Inc., Vassar Health Connecticut, Inc., Sharon Hospital Holding Company, and Essent Healthcare of Connecticut, Inc. are filing a Certificate of Need Application pursuant to Section 19a-638(a)(2) of the Connecticut General Statutes. Health Quest Systems, Inc. and Vassar Health Connecticut, Inc., each a non-profit entity, will request CON approval to acquire the assets of Sharon Hospital, located at 50 Hospital Hill Road in Sharon, Connecticut 06069. The cash portion of the consideration being delivered for the assets in connection with the transaction is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28, 28,30, 2016

PUBLIC NOTICE

Statute Reference: 19a-638 et seq. of the Connecticut General Statutes
Applicants: Saint Mary's Hospital, Inc. and Trinity Health-New England, Inc.
Project Address: 1075 Chase Parkway, Waterbury, CT 06708
Proposal: Saint Mary's Hospital Inc.'s joint venture interest in the Harold Leever Regional Cancer Center, Inc. and a change in ultimate control of Saint Mary's Hospital, Inc. to Trinity Health – New England, Inc., a subsidiary of Trinity Health Corporation as approved under OHCA Docket Number 15-32045-CON.
Capital Expenditure: $0
RA 9/29,30,10/1, 2016

Legals/ Public Notices

LEGAL NOTICE

The Conservation Commission of the Town of Salisbury will hold a Public Hearing at 6:30 PM on Tuesday the 4th of October 2016 at the Town Hall at 27 Main Street, Salisbury, CT

Application of Dean Haubrich, 144 Millerton Road, Lakeville, CT to replace the existing culvert for a stream in a new location.

This application is on file with the Town Clerk and may be reviewed Monday thru Friday between the hours of 9:00AM and 3:30PM. At this hearing interested persons may be heard and written communications received.

Conservation Commission of Town of Salisbury, Connecticut

Larry Burcroff
Chairman
R-A September 23 & 30, 2016

Legal Notice
Town of Goshen

The financial statements of the Town of Goshen for the fiscal year ending June 30, 2016, have been recorded and are on file in the Town Clerk's Office and are available for public inspection.

Dated at Goshen, Connecticut this 28th day of September, 2016.
Attest: Barbara L. Breor, Town Clerk
RA 9/30/16

Legals/ Public Notices

LEGAL NOTICE
TOWN OF KENT
NOTICE OF WETLANDS AGENT APPROVAL

Pursuant to Section 12.2 of the Regulations, the Town of Kent Inland Wetlands Commission gives notice that its agent has approved Application #1140-16A, Christopher and Karren Garrity, 92 North Main Street, construction of 3' x 5' wooden landing, Map 19 Block 42 Lot 2. Any persons may appeal this decision to the Kent Inland Wetlands Commission within 14 days of this notice by submitting such appeal in writing to the Land Use Office, 41 Kent Green Boulevard, P.O. Box 678, Kent, CT 06757.

Dated this 30th day of September, 2016

Donna M. Hayes
Land Use Administrator
RA 9/30/2016

LEGAL NOTICE
TOWN OF SALISBURY CT
FINAL ACTION OF THE PLANNING & ZONING COMMISSION ON A PROPOSED SUBDIVISION PLAN

at a meeting of the Town of Salisbury Planning & Zoning Commission held on September 26, 2016 entitled "Don Breslauer & Noreen Driscoll" was approved. Map dated June 3, 2016 showing the above subdivision is on file in the office of the Planning & Zoning Commission. Planning and Zoning Commission Of Salisbury
Martin Whalen, Secretary
RA 9/30/2016

Legals/ Public Notices

LEGAL NOTICE
Winchester Inland Wetlands and Watercourses Commission
Notification of Decision

Notice is hereby given that the Winchester Inland Wetlands and Watercourses Agent approved the following activity on September 28, 2016:

1. Remove Existing Concrete Deck and Build New Deck Using Pressure Treated Lumber.
Nieves Home
Improvements, LLC
534 West Wakefield Boulevard
Winsted, CT 06098
Map 032, Block 119, Lots 004

For additional information on this approval, please contact the Planning and Community Development Department at Town Hall, 338 Main Street Winsted, CT

Dated at Winchester, CT
this 29th day
of September, 2016
Steven Sadlowski,
Wetlands Agent
R-A September 30, 2016

PUBLIC TENDER NOTICE

The Town of Salisbury, CT is seeking an experienced Construction/Project Management Firm to oversee an extensive renovation of its Elementary School. Interested/Qualified parties should respond to salisburyctcm@gmail.com for further details. The Town of Salisbury is an Equal Opportunity Employer.
R-A September 23 & 30, 2016

Legals/ Public Notices

Request for Quotation #03-1613

The State of Connecticut Judicial Branch invites qualified contractors to submit quotations to furnish and install vehicle security caging systems in juvenile transportation vans and cars as well as perform repairs to existing caging systems statewide.

Sealed quotations must be received by 11:30 A.M. on Wednesday, October 19, 2016. Immediately thereafter all quotations will be publicly opened and prices read aloud.

VENDORS CURRENTLY REGISTERED UNDER THE STATE'S SMALL BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO BID.

Bid package may be picked-up at Judicial Purchasing Services, 90 Washington Street, 4th Floor, Hartford, CT or call 860-706-5200 to request by mail, or access the web site below.

PLEASE CHECK
THE JUDICIAL WEB SITE AT:

www.jud.ct.gov/external/news/busopp/

JUDICIAL BRANCH
PURCHASING SERVICES
90 WASHINGTON STREET
HARTFORD, CT 06106

An Equal Opportunity/ Affirmative Action Employer
R-A September 30, 2016

Legals/ Public Notices

LEGAL NOTICE

Health Quest System, Inc., Vassar Health Connecticut, Inc., Regional Healthcare Associates, LLC, and Tri State Women's Services, LLC are filing a Certificate of Need Application pursuant to Section 19a-638(a)(3) of the Connecticut General Statutes. Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Regional Healthcare Associates, LLC, a private physician practice with locations at 50 Hospital Hill Road in Sharon, Connecticut 06069, 29 Hospital Hill Road, Sharon, Connecticut 06069, 2 Old Park Lane, New Milford, Connecticut 06776, and 64 Maple Street, Kent, Connecticut 06757. In addition, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. or one of their affiliates will request CON approval to acquire the assets of Tri State Women's Services, LLC, a private physician practice with locations at 50 Amenia Road, Sharon, Connecticut 06069, 115 Spencer Street, Winsted, Connecticut 06098, and 76 Church Street, Canaan, Connecticut 06018. These acquisitions are taking place in conjunction with the acquisition by Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. of the assets of Sharon Hospital. The cash portion of the consideration being delivered for the assets in connection with the transaction involving the acquisition of Sharon Hospital and the physician practices is approximately $5,000,000, subject to certain adjustments for working capital and other matters.
RA 9/28,29,30, 2016

NOTICE TO CREDITORS
ESTATE OF John R. Draves,
of Naugatuck, (16-00337)

The Hon. Peter E. Mariano, Judge of the Court of Probate,

Legals/ Public Notices

Legal Notice
Litchfield Zoning Board of Appeals

The Litchfield Zoning Board of Appeals will hold public hearings on October 4, 2016 at the Town Hall Annex, 80 Doyle Road, Bantam, CT at 7:30 p.m., for the following variance requests:

Case 16-10-1 To discuss and possibly act upon a request from Debra Bennett for Side yard variance of 7 ' from RR Section 2 for a proposed bathroom addition for property at 96 Milton Road

Case 16-10-2 To discuss and possibly act upon a request from David M. Battistoni for Front yard variance of 8' and side yard variance of 12' from RR Section 2 for a proposed attached one car garage for property at 72 Clark Road

Case 16-10-3 To discuss and possibly act upon a request from Tony & Beth Cecchinato for Side yard variance of 3' from HR20 Section 2 for a proposed deck extension for property at 159 West Street.

Case 16-10-3 To discuss and possibly act upon a request from Douglas White for Front yard variance of 46' from RR Section 2 for a proposed barn for property at 20 Osborn Road.

At this hearing interested persons may appear and be heard and written communication will be received. Copies of the applications are on file in the Litchfield Land Use Office located at the Town Hall Annex, 80 Doyle Road, Bantam, Connecticut. Brian Donohue, Chairman
RA 9/20/16, 9/30/16

LIQUOR PERMIT

NOTICE OF REMOVAL
This is to give notice that I,

ATTACHMENT III

Affidavit

Applicant: **Essent Healthcare of Connecticut, Inc.**

Project Title: **Transfer of Ownership of Sharon Hospital**

I, MICHAEL BROWDER, EVP & CFO
(Name) (Position – CEO or CFO)

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

Signature

10/17/16
Date

Subscribed and sworn to before me on 10/17/16

Roma L. Daniel

Notary Public/Commissioner of Superior Court

My commission expires: 8/4/2020

ROMA L. DANIEL
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Affidavit

Applicant: **Vassar Health Connecticut, Inc.**

Project Title: **Transfer of Ownership of Sharon Hospital**

I, Robert Friedberg, President, of Vassar Health Connecticut, Inc. being duly sworn, depose and state that the Sharon Hospital facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

10/14/16
Date

Subscribed and sworn to before me on October 14, 2016

Notary Public/Commissioner of Superior Court

Virginia Marie DeLillo
Notary Public, State of New York
No. 01DE6136957
Qualified in Ulster County
Term Expires November 14, 2017

My commission expires: 11/14/2017

ATTACHMENT IV

General Information

Name of Applicant:	Name of Co-Applicant:
Essent Healthcare of Connecticut, Inc.	**Vassar Health Connecticut, Inc.**

Connecticut Statute Reference:
19a-638(a)(2)

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Sharon Hospital	**004221800**	**Acute Care General Hospital**	**Sharon Hospital**

STREET & NUMBER	
50 Hospital Hill Road	
TOWN	**ZIP CODE**
Sharon	**06069**

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
Sharon Hospital	**004221800**	**Acute Care General Hospital**	**Sharon Hospital**

STREET & NUMBER	
50 Hospital Hill Road	
TOWN	**ZIP CODE**
Sharon	**06069**

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
To Be Determined	**Acute Care General Hospital**	**Vassar Health Connecticut, Inc.**

STREET & NUMBER	
50 Hospital Hill Road	
TOWN	**STATE**
Sharon	**CT**

Chief Executive	NAME		TITLE		
	Robert Friedberg		**President, Health Quest Systems, Inc.**		
	STREET & NUMBER				
	1351 Route 55, Suite 200				
	TOWN			STATE	ZIP CODE
	LaGrangeville			**NY**	**12540**
	TELEPHONE	FAX	E-MAIL ADDRESS		
	(845) 475-9501	**(845) 475-9511**	**rfriedberg@health-quest.org**		

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	**See Exhibit A.**
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☒ NO ☐	**Attached as Exhibit B is evidence of tax-exempt status for Health Quest Systems, Inc.; Vassar Health Connecticut, Inc. will apply separately for tax exemption.**
Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☒	Other: _____
Applicant's Fiscal Year (mm/dd)	Start: **01/01**	End: **12/31**[1]

[1] Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital has a fiscal year that runs from January 1 through December 31, which corresponds with the fiscal years of its parent companies and affiliated hospitals operating in other states. The State of Connecticut requires that acute care general hospitals, including Sharon Hospital, file Audited Financial Statements with the Office of Health Care Access for a fiscal year that runs from October 1 through September 30. For purposes of this CON filing, and as requested in Question 18.b. below, the Applicants have prepared Financial Worksheets that correspond with the fiscal year in Essent Connecticut's Audited Financial Statements submitted to OHCA. Certain other historic data (i.e. volume, payer mix) is reported based on the same fiscal year. Vassar Health Connecticut, Inc.'s fiscal year will be January 1 through December 31. However, Vassar Connecticut will audit its financials to meet the OHCA filing requirements, and therefore financial and other projections in this CON are based on an October 1 through September 30 fiscal year.

Contact:

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

Contact Information			
NAME		TITLE	
David Ping		**Senior Vice President of Strategic Planning & Business Development**	
STREET & NUMBER			
1351 Route 55, Suite 200			
TOWN	STATE	ZIP CODE	
LaGrangeville	**NY**	**12540**	
TELEPHONE	FAX	E-MAIL ADDRESS	
(845) 475-9734	**(845) 475-9740**	**dping@health-quest.org**	
RELATIONSHIP TO APPLICANT	**Senior VP of Strategic Planning & Business Development for Health Quest Systems, Inc., parent of Vassar Health Connecticut, Inc.**		

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

Prepared by			
NAME		TITLE	
Jennifer G. Fusco		**Attorney**	
STREET & NUMBER			
Updike, Kelly & Spellacy, P.C., 265 Church Street			
TOWN	STATE	ZIP CODE	
New Haven	**CT**	**06510**	
TELEPHONE	FAX	E-MAIL ADDRESS	
(203) 786-8316	**(203) 772-2037**	**jfusco@uks.com**	
RELATIONSHIP TO APPLICANT	**Legal Counsel for Applicants**		

Executive Summary

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

This proposal involves the transfer of ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc. The proposed transaction is a "reverse conversion" that will reestablish Sharon as a not-for-profit hospital after nearly 15 years of for-profit ownership. The transaction also includes the acquisition of two private physician practices, Regional Healthcare Associates, LLC and Tri State Women's Services, LLC, by a Connecticut medical foundation to be established by Vassar Connecticut.

In recent years a series of market factors, including ongoing cuts in reimbursement from state funding programs, have threatened the financial viability of the Hospital. Sharon and the Physician Practices have had consistent difficulties recruiting physicians to practice in the area. As a result, the Hospital has seen a decline in inpatient discharges, ED visits, and outpatient visits generally. At the same time the Physician Practices have seen numerous physician retirements, relocations and practice divestitures, resulting in similar volume declines.

Sharon's parent company, RCCH HealthCare Partners, determined that affiliation of the Hospital with a larger regional health system with the ability to recruit specialty physicians would be most beneficial for the Sharon community. After considering several potential purchasers, RCCH determined that Health Quest was the best option for Sharon in terms of proximity, resources and overall fit.

Being a member of the Health Quest system will mean financial assistance and the infusion of capital in infrastructure and technology upgrades that will benefit both Sharon and the Physician Practices; enhanced local governance to include appointees of the Foundation for Community Health; coordinated access to tertiary services at Health Quest system hospitals; additional physician recruitment resources; and the relocation of Health Quest physicians from New York to bridge coverage gaps in Sharon.

With the availability of Health Quest system resources, Sharon Hospital and the Physician Practices will remain viable community health providers in a remote part of the state where healthcare options are limited.

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

Project Description

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

RESPONSE:

This proposal involves the transfer of ownership of Sharon Hospital ("Sharon" or the "Hospital") from Essent Healthcare of Connecticut, Inc. ("Essent Connecticut"), a subsidiary of RegioinalCare Hospital Partners, Inc. ("RCHP"), to Vassar Health Connecticut, Inc. ("Vassar Connecticut") (collectively with Essent Connecticut the "Applicants"), a newly-formed Connecticut non-stock corporation and a subsidiary of Health Quest Systems, Inc. ("Health Quest"). Sharon became the first for-profit acute care general hospital in the State of Connecticut when it was acquired by Essent Connecticut in 2002. The proposed transaction is a "reverse conversion" that will reestablish Sharon as a not-for-profit hospital and a member of the Health Quest system operating out of Eastern New York state. This will be accomplished through an Asset Purchase Agreement that also includes the acquisition of two private physician practices currently managed by an Essent Connecticut affiliate (see Exhibit C). These practices, Regional Healthcare Associates, LLC ("RHA") and Tri State Women's Services, LLC ("TWS") (collectively the "Physician Practices"), will be owned and operated by a Connecticut medical foundation affiliated with Health Quest and Vassar Connecticut (the "Medical Foundation"). This component of the transaction is subject to a separate Certificate of Need ("CON") filing for transfer of ownership of a large group practice under Section 19a-638(a)(3) of the Connecticut General Statutes. The Applicants intend to complete the sale of Sharon and the Physician Practices immediately upon receipt of regulatory approval.

Background on Sharon Hospital, RCCH Hospital Partners & Health Quest

The Applicants propose to bring Sharon under the ownership of a regional hospital system, restoring local, non-profit ownership after nearly 15 years of ownership by a for-profit system based out of Tennessee.

Sharon Hospital, Regional Healthcare Associates & Tri State Women's Services

Sharon Hospital is a duly licensed, 78-bed acute care general hospital located at 50 Hospital Hill Road in Sharon, Connecticut. Although it is one of the smallest hospitals in Connecticut by licensed bed count, Sharon provides a full complement of hospital services to the local community. These include a 24/7 emergency department and certified stroke center; a 9-bed

intensive care/step-down unit; a 32-bed medical/surgical unit; a 6-bed maternity unit; a 12-bed senior (55 and older) behavioral health unit (only 1 of 3 such units located in Connecticut); radiology services (CT, MRI, ultrasound, nuclear medicine, mammography, bone density, x-ray, interventional radiology, and a vein clinic (EVLT)); 24/7 hospitalist services; same-day surgery/same-day medicine (outpatient surgery, gastroenterology, ophthalmology, and infusion); surgical services (OB/GYN, orthopedic, general, ophthalmology, podiatry); wound center; full-service inpatient and outpatient laboratory; rehabilitation services (PT, OT, ST); and inpatient and outpatient cardiology (cardiac rehabilitation, stress, echo, nuclear).

In addition, the Hospital's direct parent Sharon Hospital Holding Company ("SHHC") is a party to Services Agreements with RHA and TWS whereby SHHC provides management, billing, contracting, and other administrative services to the Physician Practices. The Physician Practices are multi-specialty group practices that include internal medicine, hospitalist, OB/GYN, pediatrics, general surgery, and orthopedic physician services.

Sharon is located in the Northwest corner of the state approximately 30 miles from the next closest acute care general hospital. It has a primary service area that includes the Connecticut towns/cities of Sharon, North Canaan, Salisbury, New Milford, Torrington, Cornwall, Canaan, Kent, and Winchester and the New York towns of Clinton, Copake, Amenia, Pine Plains, and Washington. The Hospital's secondary service area includes the towns/cities of Norfolk and Litchfield, Connecticut and Pawling, Stanford, Poughkeepsie, Ancram, and Rhinebeck, New York. The total service area population is 137,450. Approximately 57% of Sharon's inpatient discharges in FY 2016 were of Connecticut residents and approximately 42% of inpatient discharges were of New York residents, with the remainder of inpatients originating from other states. While the service area population is in a slight decline, a significant percentage of the population (36.1%) is over the age of 55, with this number projected to reach 40.1% by FY 2021 (see Exhibit D).

RCCH HealthCare Partners

Sharon is part of the RCCH HealthCare Partners ("RCCH") system based out of Brentwood, Tennessee. RCCH has 17 regional health systems located in 12 states including Alabama, Arizona, Arkansas, California, Connecticut, Iowa, Montana, Ohio, Oklahoma, Oregon, Texas, and Washington. The system's focus is on the development of regionally-focused delivery systems in non-urban communities. Sharon is the only RCCH hospital located in Connecticut or the Northeastern United States. This makes it more difficult for RCCH to leverage operating synergies and recruitment opportunities in favor of the Sharon community.

Health Quest Systems & Vassar Connecticut

Health Quest, headquartered in LaGrangeville, New York, is a leading non-profit healthcare system in the Mid-Hudson Valley. The network includes three medical centers: Vassar Brothers Medical Center in Poughkeepsie, Northern Dutchess Hospital in Rhinebeck, and Putnam Hospital Center in Carmel. It also includes Health Quest Medical Practice, Health Quest Urgent Care, and several affiliates, including Hudson Valley Home Care (a home health care agency),

The Thompson House (a skilled nursing facility), and The Heart Center. Health Quest comprises 597 licensed beds and has more than 5,000 employees.[2]

Below is a description of core services provided at each of the existing Health Quest hospitals in New York, as well as the Health Quest Medical Practice and other system providers:

- Vassar Brothers Medical Center ("VBMC") –VBMC is a 365-bed acute care hospital located in Poughkeepsie, New York. It is the tertiary referral center for the mid-Hudson Valley. The key service lines include cardiovascular (open heart surgery, transcatheter aortic valve replacement (TAVR), cardiac catheterization, electrophysiology, PTCI) neurosciences (neurosurgery, neuro-interventional, stroke center designation), oncology (Dyson Center for Cancer Care, radiation oncology, medical oncology, surgical oncology, thoracic oncology, breast oncology, GYN oncology, infusion and chemotherapy, clinical trials), orthopedics (joint replacement, makoplasty, spine program) and women's and children's (LDR, perinatology and Level 3 NICU). In addition, VBMC is a Level 2 Trauma Center. VBMC is also a center for minimally invasive surgery, equipped with two daVinci robots and a Navio robotics system for some orthopedic procedures. VBMC broke ground in September 2016 on a $510 million construction project that will replace all of its medical surgical beds with private rooms, replace its emergency department and develop an interventional floor for surgery, TAVR, cardiac catheterization and other interventional procedures.

- Northern Dutchess Hospital ("NDH") – NDH is a 68-bed acute care hospital located in Rhinebeck, New York. NDH completed and opened a nearly $50 million construction project in February of 2016. This project replaced medical surgical beds with all private rooms, replaced all of the hospital's surgical operating suites and added nearly 25,000 square feet of medical office space. NDH provides a wide range of services to its community, but is best known for its orthopedics and women's services. Included in its bed complement is an 11 bed CARF accredited rehabilitation unit. NDH also has a daVinci robot for minimally invasive surgery and uses a Navio robotics system for some of its joint replacement procedures.

- Putnam Hospital Center ("PHC") – PHC is a 164-bed acute care facility located in Carmel, New York. In 2010, PHC opened a new wing that replaced the majority of its medical surgical beds with private rooms, added a cancer center, medical office space and a conference center. PHC has a specialty in orthopedics and also has an inpatient adult behavioral health unit.

- Health Quest Medical Practice ("HQMP") – HQMP is the employed physician group of Health Quest. HQMP has more than 300 providers located throughout Columbia, Dutchess, Orange, Putnam, and Ulster Counties. It offers physician services in 27 specialties, including primary care and OB/GYN.

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[2] The FY 2013 net patient revenue for the Health Quest system did not exceed $1.5 billion for purposes of the cost and market impact review required by Section 19a-639f of the Connecticut General Statutes.

- The Heart Center ("THC") – THC is a practice unit for Health Quest's 28 cardiologists. THC has offices in Rhinebeck, Poughkeepsie, Kingston, and Orange County. It provides comprehensive cardiology services to the patients in Health Quest's service area and beyond.

- The Thompson House a/k/a Northern Dutchess Rehabilitation Facility ("TTH") – TTH is a 100-bed skilled nursing facility located on the campus of Northern Dutchess Hospital. It is three-star rated for quality by CMS. Included in its 100 beds is a 20 bed sub-acute unit.

Vassar Connecticut and the Health Quest system, as tax-exempt organizations, care for all patients, regardless of their insurance coverage or ability to pay for services. The company's mission is to deliver exceptional healthcare to the communities it serves. Health Quest's vision is to be the region's leading healthcare organization recognized nationally for its quality, safety, service and compassion. This region will now include Northwest Connecticut, in particular the greater Sharon community. Health Quest's dedication to and investment in people, technology and facilities, distinguishes it as the provider of choice for patients, families and employees. Its mission and vision are attained through the commitment and motivation of the company's leaders, employees, physicians, and volunteers.

Health Quest's core set of values inform its decisions and behaviors and reflect the company's primary objective of putting patients and their families first. These include:

- Respect – *We treat everyone with dignity.*
- Excellence –*We strive to achieve increasingly higher standards in quality, safety, service and compassion.*
- Accountability – *We recognize that each employee plays a significant role in meeting the needs of our patients, and take ownership for our actions and our commitments.*
- Compassion – *We believe that the nature of our roles requires us to extend empathy to our patients, their families, and each other.*
- Honor – *We support each other and work as a team. We celebrate and acknowledge individual and collective success, and demonstrate integrity in everything we do.*

Decision to Sell Sharon Hospital; Clear Public Need for Sale

As previously mentioned, Sharon became the first for-profit acute care hospital in Connecticut in 2002, when it was acquired by Essent Connecticut. Essent Connecticut is a subsidiary of Essent Healthcare, Inc. ("Essent"), which at the time was a for-profit hospital system that focused on the acquisition and operation of "essential" community hospitals. Sharon was struggling to survive as a non-profit and the Essent acquisition brought about much needed management expertise and capital investments in infrastructure and technology. This included, notably, a complete overhaul and modernization of the Hospital's Labor and Delivery Unit and Emergency Department and the acquisition and fit-out of a new MRI scanner to serve Sharon area patients.

The for-profit conversion of Sharon was the subject of joint proceedings under Section 19a 486 of the Connecticut General Statutes and was approved by both the Attorney General and the

Commissioner of Public Health (Docket No. 01-486-01). Since the Sharon acquisition, Essent has undergone several parent-level restructurings. This included a merger with RCHP in 2011, as well as the 2016 merger of RCHP and Cappella Health to form RCCH HealthCare Partners. Throughout these transitions, the governance and control of Essent Connecticut and Sharon Hospital has remained unchanged.

Since acquiring the Hospital RCCH and its predecessor companies have been dedicated to and enjoyed providing a full range of acute care services to meet the needs of the citizens of Sharon and Northwest Connecticut. In recent years a series of market factors, including ongoing cuts in reimbursement from state funding programs, have threatened the financial viability of the Hospital, as reflected in its audited financial statements filed with the Office of Health Care Access ("OHCA"). Net losses have increased from ($1.41) million in FY 2014 to an estimated ($3.18) million in FY 2016. Some of the primary drivers of the incremental net loss in recent years have been increases in self-pay activity driving up bad debt provisions; provider tax increases; and physician coverage-based costs for specialty call services.

In addition, Sharon saw a 16% decrease in inpatient discharges between FY 2013 and FY 2016. This decrease was largely due to declining ED visits (5% decline in both total ED visits and ED visits resulting in admission since FY 2014), insurance plan design, increasing consumerism, and closure of the Hospital's oncology service in FY 2015. Sharon has also seen a 22% decline in inpatient surgical cases since FY 2014. These decreases in volume tie to Essent Connecticut's inability to recruit and retain physicians to this rural part of the state. Recruitment of physicians has become more of a challenge as larger competing systems make inroads into the community. The difficulties that Sharon faces with recruitment were evident with the loss of its sleep center, which was forced to close in 2015 after the Medical Director relocated out of state and the Hospital was unable, despite its best efforts, to recruit a replacement (see Docket No. 15-32014-CON). Similar circumstances led to the aforementioned closure of the Yale-New Haven Hospital oncology service at Sharon in 2015 (see Docket No. 14-31969-CON).

In response to these pressures RCCH conducted an ongoing review of a wide range of strategic options to further community needs, and concluded that the best result for the families in Sharon and surrounding communities was to affiliate with a larger regional health system.[3] Such an affiliation would help identify a number of specialty physicians that RCCH has not been able to offer the community as a standalone facility. Through a careful process of evaluation RCCH identified several systems with the financial wherewithal to grow the Hospital in the future. These included both not-for-profit and investor-owned entities. They included in-state systems, as well as out-of-state companies pursing expansion opportunities in-state. At the end of the day, RCCH determined that Health Quest was the best option for Sharon in terms of proximity, resources and overall fit.

[3] Sale of Sharon was considered only after the Hospital had achieved all of the cost-savings it could by maximizing operational efficiencies, lowering supply costs through group purchasing, and curtailing underutilized services, to name a few measures undertaken by RCCH and Essent Connecticut.

Benefits to the Community of Health Quest Ownership of Sharon Hospital

The sale of Sharon to Vassar Connecticut, and the integration of the Hospital into the Health Quest system, will help address the fiscal and operational issues that formed the basis of RCCH's decision to sell. As discussed in greater detail below, this transaction contemplates the immediate and strategic infusion of capital by Health Quest in Sharon. This is made possible, in part, by grant funds from the Foundation for Community Health, Inc. ("FCH"). In addition, Health Quest expects to see efficiencies resulting from shared corporate and administrative services. Sharon area patients will have enhanced access to higher quality care, including tertiary services, within the Health Quest system. Moreover, becoming a member of Health Quest is expected to result in increased referrals to Sharon and the Physician Practices for hospital and physician services. At the same time, Health Quest has the resources necessary to assist in recruiting high-quality physicians to practice in and around Sharon, including existing members of HQMP.

Financial Assistance, Resource Sharing & Other Cost-Saving Measures

FCH will be issuing two separate grants to fund a portion of the purchase price for Sharon and the Physician Practices (the "Asset Purchase Grant") and to cover direct cost outlays associated with Health Quest's strategic investment in the Hospital (the "Working Capital Grant"). FCH is the non-profit community foundation formed with the charitable assets of the original Sharon Hospital when it was converted to for-profit in 2002. As a "conversion" foundation, FCH received the net proceeds of the sale of the non-profit Sharon Hospital and was designated as the recipient of all non-restricted income from legacies left in wills and from trusts that were originally designated to go to the former Hospital. FCH's mission is to maintain and improve the physical and mental health of the residents of the area historically serviced by the non-profit Sharon Hospital. FCH is a leader and catalyst for the development of innovative and effective rural health delivery systems that focus on prevention, access and well-developed community-level collaborations. FCH accomplishes its mission through collaboration and advocacy, providing grant funds, convening stakeholders, evaluating existing healthcare services, making program-related investments, and conducting research, to name a few thing.[4]

The total amount of the grant being awarded by FCH to Health Quest in connection with this transaction is $9 million. The Asset Purchase Grant will supply $3 million of the $5 million cash portion of the purchase price being paid by Vassar Connecticut for the Hospital and Physician Practices. The remaining $6 million comprises the Working Capital Grant. This money will be disbursed in annual installments over a period of three (3) to four (4) years after the closing. It can be used for strategic investments including, but not limited to, direct physician and provider costs, strategic equipment, facility upgrades, ambulatory networks, information technology infrastructure, and other programmatic investments. Expenditures made with the grant funds must be of specific and direct benefit to Sharon and cannot be used for Health Quest system-wide improvements that also benefit the Hospital. Health Quest will evaluate its capital investment annually however it expects to invest on average $5 million (inclusive of the Working Capital Grant funds) in capital improvements for the Hospital and Physician Practices during each of the first five (5) years of operation.

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[4] Source: www.fch.org

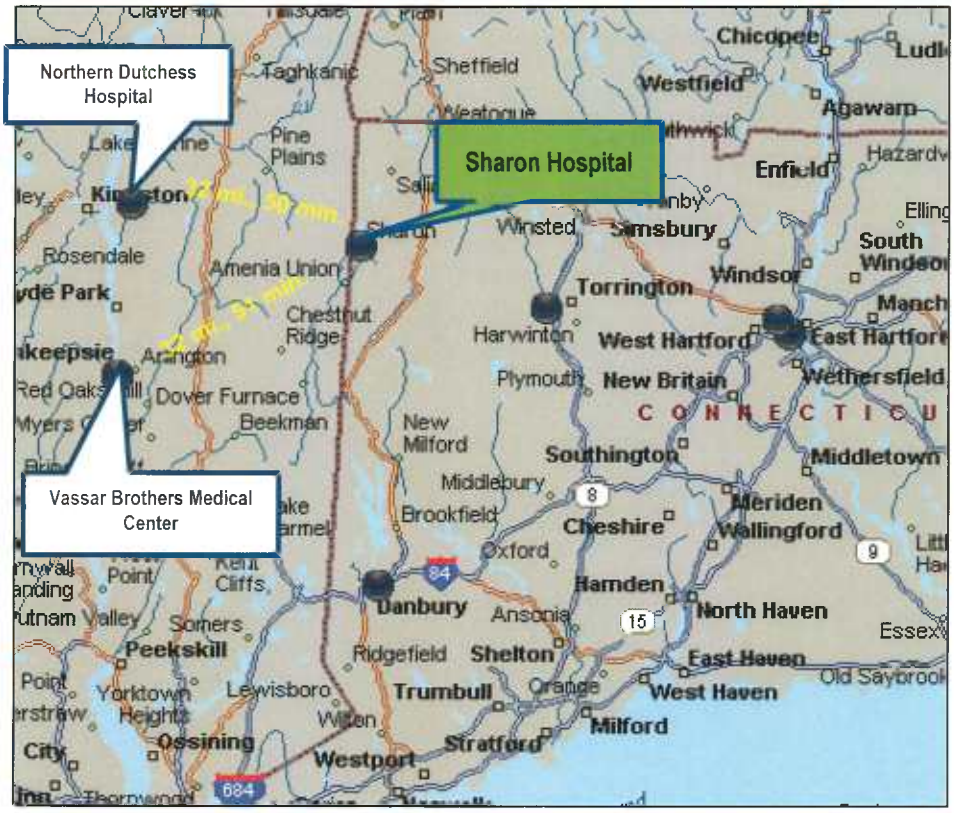
In addition, Vassar Connecticut will be able to avail itself of Health Quest's corporate services, which should allow for greater operating efficiencies and reduce costs. The centralized services available to Sharon will include compliance, quality, finance, purchasing, patient and employee experience, and planning. Vassar Connecticut expects Sharon to achieve top decile performance in each of these areas with the resources that Health Quest will provide. This process will begin while Health Quest is managing the day-to-day operations of the Hospital pursuant to the Management Agreement signed contemporaneous with the Asset Purchase Agreement, which was effective October 1, 2016. Health Quest will introduce Sharon to its internal processes and offer the Hospital its corporate resources to ensure a smooth transition and begin standardizing operations. Health Quest and Vassar Connecticut will also develop a strategic plan for Sharon, the implementation of which will begin once the sale has been completed.

As discussed above, Sharon's net income losses grew from ($1.41) million in FY 2014 to ($3.18) million in FY 2016. Losses by the Hospital and Physician Practices combined without this proposal are projected to continue in subsequent years. With the Health Quest proposal to purchase Sharon and the Physician Practices and convert them to non-profit entities, the Hospital will show significant gains in income beginning in FY 2017. These gains will off-set Physician Practice losses by FY 2018. This financial turnaround is possible because of:

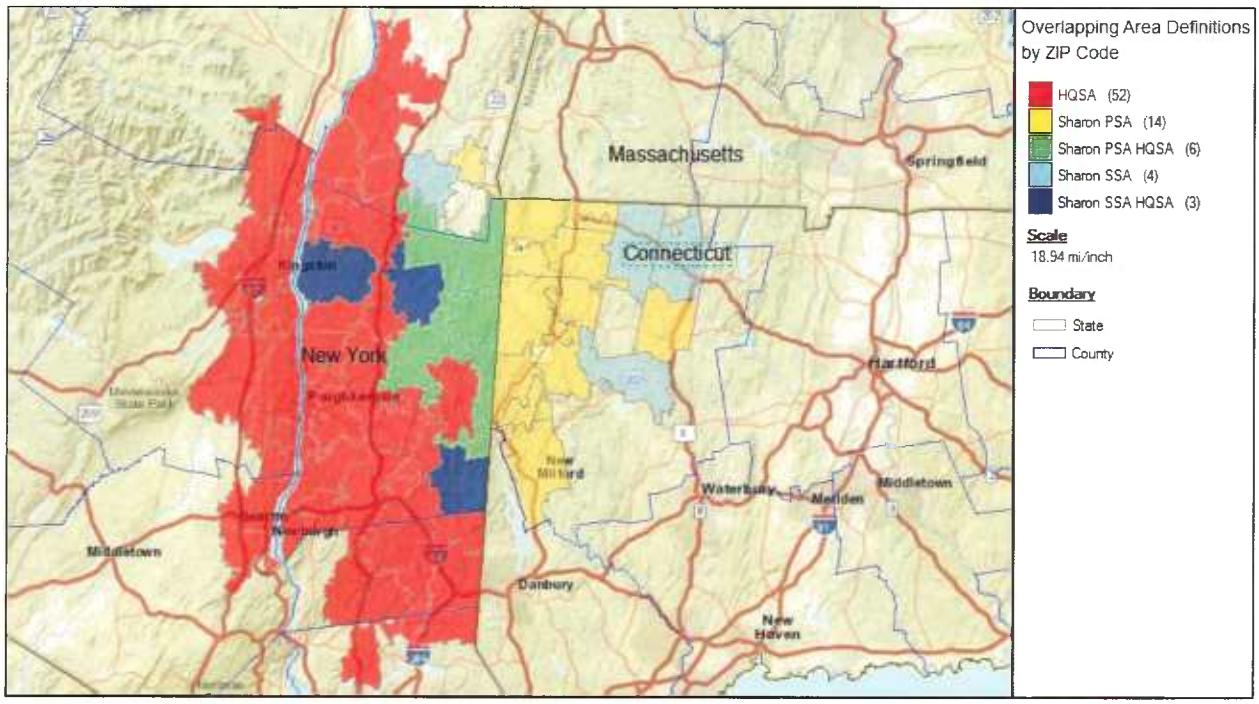
- The increase in both inpatient discharge and outpatient visit volume at the Hospital. This is possible because of the successful recruitment and shared resourcing of additional physicians to the Sharon area by Health Quest. In addition, in order to alleviate capacity issues at VBMC and NDH, Health Quest is going to shift volume from these hospitals to Sharon when medically appropriate to do so. This will involve patients residing east of the Taconic in areas that are closer to Sharon than VBMC or NDH. VBMC also anticipates sending geropsychiatric patients to Sharon because this service is not available elsewhere within the Health Quest system. This will result in more patients being treated locally and increased patient revenue;
- Scalable administrative opportunities to improve operating efficiency through synergistic alignment within the Health Quest operating structure. This includes, but is not limited to: (a) technological enhancements (i.e. EHR); (b) improved supply chain management and buying power; and (c) regional system alignment.

Enhanced Access To and Quality of Healthcare in Sharon Region

Bringing the Hospital into the Health Quest system will improve the quality of healthcare for Sharon area residents. It will enhance access to the tertiary service offerings available at VBMC in particular. Health Quest is a natural fit for Sharon given its geographic footprint. Patients from the Sharon area can access VBMC and NDH in just over 50 minutes by car, as the map below indicates.



The proximity of Health Quest system providers to Sharon results in an overlap in service areas among the various Health Quest hospitals and physician practices and their counterparts in Sharon. As the map below shows, there is substantial PSA overlap along the New York border (green shaded area), with SSA overlap extending as far as Rhinebeck (dark blue shaded area).



When appropriate, patients from the Sharon area will be sent or transferred to VBMC for a higher level of care. VBMC has the closest open heart surgery program (top 10 provider in New York State for each of the last 10 years), the closest interventional cardiac catheterization program (door-to-balloon times better than national standards at 59.9 minutes), the closest Level 3 neonatal intensive care unit, and the closest neuro-interventional program to treat stroke patients, to name a few. Numerous studies have shown that the shorter the time to treat heart attacks and strokes, the better the patient outcomes. Having programs in heart and stroke, which are also award winning for quality, available as part of the Health Quest system will be of benefit to those individuals residing in the Sharon area. Once the Hospital is part of the Health Quest system, patients who are seen at Sharon will receive tertiary services at VBMC in a carefully coordinated manner, with physicians and staff from each hospital working as part of an integrated team, following similar protocols, policies and procedures, and having access to common electronic health records ("EHR") once requisite IT upgrades have been accomplished at the Hospital and Physician Practices. The same holds true for services obtained by Sharon area residents at any Health Quest hospital or facility.

Vassar Connecticut will also tap the resources of the Health Quest Medical Practice, Heath Quest's employed physician medical group, to recruit additional providers to the Sharon service area. HQMP employs more than 300 providers. Primary care (general internal medicine, family practice); obstetricians and gynecologists, orthopedic surgeons, cardiologists, and oncologists will be high priority recruitments. A number of HQMP physicians will also be expanding their practices into the Sharon area. Recruiting additional physicians and relocating HQMP physicians to practice in the Sharon area will greatly improve the quality of care available to the community and generate additional patient volume at the Hospital, improving Sharon's overall financial condition. This process will be made easier by the service area overlap between Health Quest and the Sharon entities as shown in the map above.

Note also that other providers within the Health Quest system will benefit from the expanded relationship with Sharon and the Physician Practices, thus strengthening the healthcare delivery system in Eastern New York and Northwestern Connecticut. When the best interest of a patient dictates it, the patient may be referred from the Sharon area to one of the Health Quest hospitals, TTH, HQMP, or THC. THC intends to open an office in Sharon to treat cardiology patients locally. Patients that require cardiac catheterizations, PCIs, cardiac surgery or other advanced cardiac diagnostic and treatment services will be referred to VBMC when appropriate. HQMP intends to open an office locally and place primary care physicians, OB/GYNs, surgeons and medical oncologists (in addition to the recruitment of physicians to practice with the newly formed Medical Foundation). The goal of this will be to treat patients at Sharon. Again, if a patient needs advanced services, that patient will be transferred to VBMC, if appropriate and consistent with patient choice. NDH may benefit from the transfer of patients to its CARF accredited rehabilitation unit and TTH might see transfers of patients to either its sub-acute unit or the skilled nursing beds there. These patients might have gone elsewhere for their services but for the relationship between Sharon and other providers within the Health Quest system.

Moreover, conversion of the Hospital back to a tax-exempt entity will improve access to healthcare services for all area residents. As a non-profit entity, Vassar Connecticut will accept all patients, regardless of their insurance or ability to pay for their care. This includes Medicaid recipients and uninsured/underinsured patients. In addition, in order to maintain its tax-exempt status, Vassar Connecticut will be required to conduct a Community Health Needs Assessment ("CHNA"), which it will file with OHCA, to determine how best to meet the healthcare needs of the Sharon community. Health Quest expects to perform an initial community benefit analysis soon after its purchase of Sharon, after which the Hospital will be placed on the same review cycle as the other system hospitals.

The sale of Sharon to Vassar Connecticut, and the involvement of FCH, will also ensure continued, enhanced local input and control of the Hospital's governing body. The new Sharon board will be largely composed of local appointees. FCH will have the right to select 12 of the 15 trustees for appointment to the initial Sharon board under Vassar Connecticut's ownership. These FCH-appointed trustees will serve terms ranging from four (4) to six (6) years. Thereafter, the Board will self-perpetuate with Vassar Connecticut reappointing trustees in a manner consistent with the governance procedures and protocols in place at other Health Quest hospitals. This includes, as a goal, significant membership drawn from the local community. It is the intent of Vassar Connecticut to draw from the current local Governing Board members to populate the new non-profit hospital board. In Health Quest's experience, board members who live in the community served by a hospital understand the needs of the community and are motivated to do the right thing for their neighbors. They understand the local market dynamics and needs. While the existing Sharon Hospital local Governing Board has significant community representation, this board is ultimately answerable to the Essent Connecticut board in Tennessee. This will not be the case with Vassar Connecticut where all governance will remain local and regional.

Note that the Hospital currently seeks input from a local Advisory Board put into place in accordance with the Attorney General's Order in the original conversion proceeding. The

Advisory Board was created to provide for a level of community involvement in the operation of Sharon as a for-profit hospital. It is comprised of elected public officials from the Sharon area, members of the Sharon Medical Staff, community members appointed by elected public officials, and representatives of Essent Connecticut. The Office of Attorney General recently notified Health Quest that none of the remaining conditions of the original conversion Order will be extended to Vassar Connecticut as the subsequent purchaser of Sharon. This includes the local Advisory Board, which according to the Attorney General is unnecessary going forward because Health Quest's corporate board will properly represent the community's needs. A letter from Assistant Attorney General Gary Hawes confirming same is attached as Exhibit E. This letter also releases Health Quest from any other obligations that might have been extended to a subsequent purchaser, including those concerning charity care requirements, cross-collateralization of Sharon's assets and notifications to referred patients.

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

RESPONSE:

As previously mentioned, in response to ongoing financial pressures and issues with recruitment and retention of physicians to practice in rural Sharon, RCCH decided that it would be better for the community if the Hospital was affiliated with a larger regional health system. RCCH identified several systems with the financial wherewithal to grow the Hospital, including both not-for-profit and investor-owned entities. They included in-state systems, as well as out-of-state companies pursing expansion opportunities in-state.

RCCH and Health Quest began their discussion regarding purchase of the Hospital in June of 2014. The parties spent several months conducting preliminary due diligence, after which the transaction was placed on hold while other potential purchasers were considered by RCCH. Discussion between RCCH and Health Quest resumed in the spring of 2015, and over the course of the last 18 months the parties have completed due diligence and negotiated the terms of the sale. The definitive documents were signed on September 13, 2016, after which Essent Connecticut, Vassar Connecticut and related entities published notice of their intent to request CON approval for the transfer of ownership of Sharon and the Physician Practices on September 28, 29 and 30, 2016. Vassar Connecticut has also met with representatives of the Department of Public Health ("DPH") regarding licensure requirements and is in the process of arranging for the transfer or receipt of the additional regulatory approvals required to operate the Hospital.

3. Provide the following information:

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

      RESPONSE:

      See OHCA Table 1.

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

      RESPONSE:

      See OHCA Table 2. The PSA towns comprise the lowest number of contiguous zip codes that accounted for at least 75% of Sharon Hospital's inpatient volume in FY 2016. The PSA towns are those with one or more zip codes that generated at least .5% of inpatient discharges in FY 2016.

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

   RESPONSE:

   Vassar Connecticut will be applying for an Acute Care General Hospital license from DPH.

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

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

      RESPONSE:

      A copy of Essent Connecticut's current Acute Care General Hospital license is attached as Exhibit F.

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

RESPONSE:

Curriculum Vitae for the following individuals are attached as Exhibit G:

- Robert Friedberg, President, Health Quest Systems, Inc.
- Glenn Loomis, M.D., Chief Medical Operating Officer, Health Quest Systems, Inc. and President, Helath Quest Medical Practice
- Gary Zmrhal, Senior Vice President and Chief Financial Officer, Health Quest Systems, Inc.
- David Ping, Senior Vice President of Strategic Planning and Business Development, Health Quest Systems, Inc.
- Robert Diamond, Chief Information Officer, Health Quest Systems, Inc.
- Michael Holzhueter, Esq., Senior Vice President and General Counsel, Health Quest Systems, Inc.
- Peter Cordeau, President and Chief Executive Officer, Sharon Hospital
- Christian Bergeron, Chief Financial Officer, Sharon Hospital
- Lori Puff, Chief Nursing Officer, Sharon Hospital

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

RESPONSE:

Not applicable. The CON Application involves the transfer of ownership of Sharon Hospital and not the establishment of a new service.

d. letters of support for the proposal;

RESPONSE:

See Exhibit H. With respect to letters that are unsigned, signed versions are forthcoming and will be provided to OHCA as they are received.

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

RESPONSE:

Not applicable.

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

RESPONSE:

Copies of the following agreements related to the proposed transfer of ownership of Sharon Hospital are attached as Exhibit C:

- Asset Purchase Agreement, dated September 13, 2016;
- Management Agreement, dated September 13, 2016;

Public Need and Access to Care

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

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

RESPONSE:

The Department of Public Health, Office of Health Care Access Division has not yet established policies and standards in regulation concerning the transfer of ownership of hospitals. Notwithstanding, this proposal improves the quality, accessibility and cost-effectiveness of care, ensures the continued existence of hospital services in a rural community, brings these services back under the auspices of a not-for-profit entity that provides services to all individuals regardless of ability to pay consistent with its mission, and promises the enhancement of technology, equipment, services, and resources for the benefit of Sharon area residents. All of this is consistent with the statutes that guide OHCA's decision making process for CON requests, as well as the objectives of the Statewide Healthcare Facilities and Services Plan ("SHP") as discussed below.

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

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

RESPONSE:

The proposed sale of Sharon to Vassar Connecticut aligns with many of the goals, objectives and guiding principles of the 2012 Statewide Healthcare Facilities and Services Plan and the 2014

Supplement ("SHP Supplement"). One of the primary purposes of the SHP is to examine access to and utilization of facilities and services state-wide and determine how best to distribute healthcare resources in order to serve those in need and keep the system financially viable.

The SHP aims to provide "better access to services through planned geographic distribution" and ensure that "overall access to quality health care" is maintained (SHP, pp. 1, 2). Access to hospital services in the Sharon area exists only because the Hospital continues to exist. It is critical that Sharon remain a viable acute care general hospital so that area residents do not need to travel more than 30 miles if they require this level of service. This is particularly true of emergency and safety net services and services for vulnerable populations (SHP Supplement, p. 47). Vassar Connecticut and Health Quest can help to ensure the Hospital's long-term viability so that life-saving services can be sustained locally.

The SHP also seeks to "enhance primary care access and availability" and promote "equitable access to health services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary healthcare" (SHP, pp. 1, 2). In addition, the SHP supports the need for "a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty provider)" (SHP, p. 2). As previously mentioned, Vassar Connecticut intends to place HQMP physicians in the Sharon area and to recruit new physicians to practice locally and maintain Medical Staff privileges at the Hospital. Recruitment of physicians has been extremely difficult under Essent Connecticut ownership because of the Hospital's remote location and the absence of a regional network of RCCH hospitals in the Northeast. Physician recruitment will focus not just on specialty physicians, but on enhancing the primary care network in the Sharon area. This increased availability of physicians will promote equitable access to care in an appropriate and timely manner. Moreover, the Health Quest relationship will allow patients from the Sharon area to receive tertiary services in a more coordinated fashion at other system hospital such as VBMC. This will also support equitable access to appropriate care for resident of the service area.

The SHP also encourages "collaboration among health care providers to develop health care delivery networks," particularly on a regional level (SHP, p. 2). The inability to collaborate regionally under RCCH leadership was a significant issue for Sharon that impacted its ability to deliver services and remain financially strong. Bringing the Hospital into the Health Quest system will "promote and support the long term viability of the state's health care delivery system," including the long term viability of Sharon and its ability to continue to serve the needs of a community with no other hospital option (SHP, p. 2). Lastly, as discussed herein, Vassar Connecticut and the Health Quest system will bring quality improvements to the Hospital in terms of processes, infrastructure and technology, to name a few, consistent with the SHP objective of maintaining and improving the quality of healthcare services offered to Connecticut residents (SHP, p. 2).

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

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

   a. identify the target patient population to be served;

RESPONSE:

The target population to be served includes patients from the PSA and SSA of the Hospital as set forth in OHCA Table 2. According to the Truven Health Analytics data attached as Exhibit D, the combined service area has a population of 137,450. A majority of residents (62.7%) are over the age of 35, with roughly equal numbers of men and women. The population is largely white (85.3%) and 32.3% of residents are college educated. The average household income is nearly $90,000.

Note also that FCH conducted a Study of Community Health Needs in October of 2014 (the "Assessment") (see Exhibit I). The Assessment identifies certain specific health considerations among the population surveyed, which includes residents of Litchfield County in Connecticut and Columbia and Dutchess Counties in New York. These include rising substance abuse rates, including the abuse of prescription drugs and cheaper opiate substitutes, and obesity, especially among children and youth.

The Assessment also remarks on the unique health challenges faced by Hispanics, the region's largest non-white population, including transportation, cost and communication barriers, as well as lack of awareness of services. Moreover, the Assessment cites the higher proportion of seniors in the service area as compared with other counties in Connecticut and New York. Seniors face many of the same barriers to access as other vulnerable populations. In addition, they often face challenges such as social isolation, memory loss and unwillingness to accept services. Insufficient follow-up care for seniors after a hospital stay is another identified concern.

As previously mentioned, Health Quest will conduct its own CHNA after purchase of the Hospital and Physician Practices is complete. The assessment will further identify and clarify significant health issues in the Sharon area, vulnerable populations, and barriers to access faced by these individuals.

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

RESPONSE:

The target population for this proposal is currently receiving services at Sharon and/or the Physician Practices. Alternatively, patients may be traveling outside of the service area for healthcare that is not available in and around Sharon due to an inability to recruit

physicians to practice in a remote community.

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

RESPONSE:

Not applicable. This proposal does not involve the acquisition of new equipment or the establishment of a service. The clear public need for the sale of Sharon to Vassar Connecticut is detailed in Response to Question 1 (Project Description) above.

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

RESPONSE:

Not applicable. Applicants are not proposing a new facility or service location. A discussion of the needs of the greater Sharon service area, and how addition of the Hospital to the Health Quest system will help meet those needs, is included in Response to Question 1 (Project Description) above.

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

RESPONSE:

See Response to Question 8a above. See also FCH's CHNA attached as Exhibit I and Truven Health Analytics data attached as Exhibit D.

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

RESPONSE:

Health Quest has a history of providing services to all patients in a non-discriminatory fashion. The company does not discriminate against patients in the provision of healthcare services at its hospitals, skilled nursing facility or physician practices based upon race, color, national origin, sex, age, or disability. Health Quest is fully compliant in this regard with Section 1557 of the Patient Protection and Affordable Care Act. Health Quest will bring its commitment to serving these individuals to its ownership of Sharon as a non-profit hospital. As mentioned above, the FCH Assessment of health needs in the greater Sharon area identified Hispanics as the largest non-white population (8.4% of the service area population) and identified certain barriers to access faced by these individuals. Health Quest will work to ensure that these individuals have meaningful access to healthcare services despite any language issues and address any other barriers to access that they might encounter.

In addition, as a non-profit health system, Health Quest provides services to all individuals regardless of payer status or ability to pay. This includes participation with Medicare and Medicaid and the care and treatment of many uninsured and underinsured individuals. Medicare patients accounted for 55% of Sharon's inpatient discharges in FY 2016 and Medicaid and uninsured patients combined accounted for 20% of inpatient discharges that same year. Nearly 37% of the Sharon area population has an average household income of less than $50,000 per year (see Exhibit D). Sharon has historically treated governmentally insured and low income patients and will continue to do so under Vassar Connecticut ownership as part of the non-profit Health Quest system.

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

RESPONSE:

Vassar Connecticut is not proposing any changes to the clinical services offered by the Hospital. Vassar Connecticut and Health Quest intend to add cardiologists, OB/GYNs, surgeons, and medical oncologists to the staff at Sharon. This will enhance access to care, allowing more patients to remain in the Sharon area for treatment. In addition, as Health Quest assesses the needs of the Sharon community it is contemplating the addition of a daVinci robotics system for the Hospital's operating suite. Health Quest will also evaluate the licensed beds at Sharon to determine whether the number is appropriate based on historic and projected inpatient discharges and average daily census.

h. explain how access to care will be affected;

RESPONSE:

The proposed transfer of ownership of Sharon to Vassar Connecticut, part of the non-profit Health Quest system, will increase access to care for all residents of the Sharon area. As previously mentioned, the Hospital has had significant issues recruiting physicians to practice in remote Sharon. With the Hospital and Physician Practices becoming part of the Health Quest system, Vassar Connecticut anticipates being able to leverage the system's resources, placing more doctors in the Sharon area and increasing access to healthcare services. These would include cardiologists, OB/GYNs, primary care physicians, surgeons, and medical oncologists. Area residents would also have access to more than 300 providers employed by HQMP. In addition, patients from the Sharon area will have enhanced access to services offered at other Health Quest hospitals. For example, patients will be able to receive certain tertiary services at VBMC in Poughkeepsie in the coordinated manner typical of referrals between hospitals and providers within an integrated health system. These services would include open heart surgery, interventional cardiac catheterization, neonatal ICU and neuro-interventional stroke treatment.

Moreover, as a non-profit hospital the new Sharon will treat all patients regardless of ability to pay. Vassar Connecticut will participate with most commercial insurers, Medicare and New York and Connecticut Medicaid. It will also provide services to the uninsured, underinsured and those without means to pay consistent with its charitable mission. This will enhance access to services for low-income residents in particular in the Sharon area.

i. discuss any alternative proposals that were considered.

RESPONSE:

As previously mentioned, RCCH conducted an ongoing review of a wide range a strategic options to address the financial and recruitment issues that have threatened the viability of the Hospital. These included discussions with larger health systems, both not-for-profit and investor-owned. They included in-state systems, as well as out-of-state companies pursing expansion opportunities in-state. At the end of the day, RCCH determined that Health Quest was the best option for Sharon in terms of proximity, resources and overall fit.

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

9. Describe how the proposal will:

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

RESPONSE:

The acquisition of Sharon by Vassar Connecticut, a Health Quest subsidiary, will enhance the quality of healthcare services consistent with the system's practices and objectives. Health Quest has a goal of achieving top decile performance in quality and patient satisfaction. All of the initiatives and best practices from Health Quest's other hospitals will be utilized at Sharon to improve quality. Health Quest is currently focusing on the following areas:

- Average Length of Stay Reduction – Health Quest has a variety of programs in place to reduce length of stay. Health Quest hospitals have daily discharge huddles that work on patient discharges. These hospitals have also added services on weekends such as physical therapy and case management in order to ensure timely discharge.

- 30-Day Readmission Reduction – Health Quest has hired case managers who are assigned to patients to ensure that they are following their discharge instructions. The company has instituted patient call-backs, so that patients are contacted on discharge, also to make sure that they are following their discharge instructions. Health Quest staff are making follow-up appointments for patients with their physicians at discharge to improve compliance with follow-up visits. The company also provides patients with medications at discharge so that they do not need to stop at a pharmacy.

- Risk Based Mortality Ratio – Health Quest has developed a sepsis policy for all of its hospitals, including the use of a rapid response teams to deal with patients at the first sign of sepsis. The CMOs meet monthly to discuss their results and develop ways to improve.

- Catheter Associated UTI (CAUTI) Reduction – Health Quest removes catheters the same day as surgery to reduce Foley days. The company does weekly CAUTI rounds on its medical surgical units and intensive care units to reduce Foley days.

- Patient Satisfaction (HCAHPS) – Health Quest does a variety of rounding on patients, including leader rounding and hourly rounding. The company has instituted bedside handoffs for shift changes. It also has a variety of unit specific dashboards that are used to monitor patient satisfaction.

The quality of healthcare in the Sharon region will also be enhanced by increased access to physician services through the recruitment efforts of Health Quest. Residents will have coordinated access to physician and hospital services, including tertiary services, at other Health Quest system hospitals. In addition, Vassar Connecticut plans to evaluate capital investments in the Hospital. Preliminarily, these might include a daVinci robot for the Hospital's surgical suite and the upgrade of Sharon's IT systems to integrate the Hospital's EHR with other Health Quest providers. All of these quality improvement measures will be beneficial to area residents.

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

RESPONSE:

See Responses to Questions 8f and 8h (Public Need & Access to Care) above.

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

RESPONSE:

This proposal to bring Sharon into the non-profit Health Quest system improves the cost-effectiveness of healthcare delivery in several ways:

- Treatment of patients locally – Health Quest will recruit physicians to the Sharon area who will treat patients at the Hospital. Studies show that treating patients locally is the most cost-effective way to treat patients.

- Conversion to not-for-profit – The conversion of Sharon back to a not-for-profit entity means that the people in the service area are the "shareholders." Any profit will be reinvested to improve the facilities and the services at the Hospital, allowing even more patients to be treated locally. Not-for-profit status will also lead to greater access to care. In order to maintain its tax-exempt status, Vassar Connecticut will have to show that it is meeting the needs of the local community. An important part of this access is ensuring that care is available to all in the community and that Vassar Connecticut treats all of those patients that can safely be treated locally.

- Ownership by local entity – Having the Hospital owned by a local entity with local board representation by people who live and work in the service area will also ensure cost-effectiveness. Health Quest understands the local economy and the local market and its board will make sure that care is provided in as cost-effective manner as possible.

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

RESPONSE:

The acquisition of Sharon by Vassar Connecticut will help improve the coordination of care by integrating the Hospital into a regional health system. For the first time, Sharon area residents will have meaningful access to a local health system whereby they can receive tertiary hospital services, skilled nursing services and enhanced specialty physicians services within the system, depending upon their needs. With integrated EHR, providers throughout the Health Quest system can access a patient's records instantaneously and coordinate care with referring providers, allowing for more accurate and timely diagnosis and treatment.

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

RESPONSE:

This proposal will ensure access to care for Medicaid recipients and indigent persons. As a not-for-profit hospital, Sharon will be required to care for all patients regardless of payer source or ability to pay. Consistent with the Health Quest mission, Vassar Connecticut will participate with Medicare, and New York and Connecticut Medicaid and will provide services to uninsured and underinsured individuals residing in the Sharon area. In FY 2016, 55% of Sharon's inpatient discharges were Medicare patients and 20% of its discharges were Medicaid and uninsured patients. This represents a significant percentage of overall discharges. These patients deserve

access to the highest quality, comprehensive healthcare in their community and Health Quest will work to provide this.

12. Provide a copy of the Applicant's charity care policy and sliding fee scale applicable to the proposal.

RESPONSE:

With the release of Health Quest from any ongoing conditions of the original Conversion Order, Vassar Connecticut will adopt the Health Quest system's Financial Assistance Policy, which is attached as Exhibit J. As a non-profit entity, Health Quest is required to treat all patients regardless of ability to pay and its policy is broad and inclusive.

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

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

RESPONSE:

Not applicable. If anything, the conversion of Sharon to non-profit status will increase access to services for Medicaid recipients and indigent persons consistent with the mission of Health Quest and Vassar Connecticut as tax-exempt entities.

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

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

RESPONSE:

The sale of Sharon to Vassar Connecticut will not adversely impact patient healthcare costs in any way. Vassar Connecticut does not plan to adjust price structure as a result of the proposal or to impose any facility fees that are not already imposed by Essent Connecticut as the Hospital's current owner.

Financial Information

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

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

RESPONSE:

Health Quest was recently rated A3 with a negative outlook from Moody's and A- with a stable outlook from Standard and Poor's. The company will use its financial strength to grow and stabilize the Hospital. Health Quest's ability to bring physicians to the community and to serve more patients locally will cause volume at the Hospital to increase. This will lead to increased revenue and will help to improve its financial viability of the Hospital and the overall strength of the healthcare delivery system in Northwestern Connecticut. Moreover, as can be seen from Financial Worksheet B, the incremental revenue and expense savings associated with the Health Quest acquisition will result in a significant increase in the Hopsital's projected net income beginning as early as FY 2017, making the project financially feasible.

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

RESPONSE:

See OHCA Table 3.

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

RESPONSE:

As previously mentioned, $3 million of the $5 million purchase price for Sharon Hospital and the Physician Practices will be funded through the Asset Purchase Grant from FCH. Any remaining balance after consideration of working capital and other adjustments contemplated in the Asset Purchase Agreement will be paid with Health Quest operating funds.

18. Include as an attachment:

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

RESPONSE:

FY 2015 audited financial statements for Essent Connecticut and its parent company, SHHC, dated June 27, 2016, are on file with OHCA. FY 2015 Audited Financial Statements for Health Quest and its subsidiaries are attached as Exhibit K.

    b. completed **Financial Worksheet A (non-profit entity), B (for-profit entity) or C (§19a-486a sale)**, available on OHCA's website under OHCA Forms, providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." **Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.**

RESPONSE:

Financial Worksheet B for Sharon Hospital and Financial Worksheet A for Health Quest are attached as Exhibit L.

The Applicants used Financial Worksheet B, which applies to for-profit entities, for Sharon Hospital so that they could properly account for income taxes and retained earnings when disclosing "actual" and "without CON" figures. Financial Worksheets A and B are identical with the exception of these provisions. When projecting "incremental" and "with CON figures" for the new non-profit entity these sections were simply left blank.

Financial Worksheet B for Health Quest shows as incremental the combined impact to the system of the acquisition of both the Hospital and the Physician Practices.

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

RESPONSE:

See OHCA Table 4.

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

RESPONSE:

The following are assumptions used, and clarifications regarding, the Financial Worksheets attached as Exhibit L:

Projection Assumptions (w/out CON):

Sharon Hospital:

A. Projecting 1.5% net year over year growth (FY 2017 – FY 2020). The net impact considers historical trends, stable payer mix, payer contract changes, volume changes, and service mix (inpatient & outpatient) changes.
B. Operating expense projections assume cost of living / price index based increases:
    a. Salary & Benefits @ 2%
    b. Supplies (including Rx) @ 5%
    c. Other expenses @ 1%
C. Intercompany fees representing loss transfer from the Physician Practices have been accounted for in the Physician Practice transfer CON. These totaled approximately $3.1 million in FY 2015 and $3.4 million in FY 2016.

Health Quest:

A. Projecting 3.3% net year over year growth (2017 – 2020). The net impact considers historical trends, strategic growth initiatives, increased physician recruitment, opening of a new bed tower at VBMC, stable payer mix, payer contract changes, volume changes, and service mix (inpatient & outpatient) changes.
B. Operating expense projections assume cost of living / price index based increases:
    a. Salary & Benefits @ 3%
    b. Supplies (including Rx) @ 6.4%
    c. Other expenses @ 3%
C. Malpractice and Lease/Rental expenses are included in the "Other" Expense line.

Projection Assumptions (incremental):

A. Incremental projections are pro-rated for an acquisition date of 7/1/2017.
B. The net impact considers historical trends, stable payer mix, payer contract changes, volume changes and service line growth (inpatient and outpatient).
C. Projected volume growth is based upon the factors detailed in response to Question 1 (Project Description) above and Question 24 (Financial Information) below.

D. Administrative efficiencies that contribute to cost-savings are detailed in response to Question 1 (Project Description) above.

Contributing Factors related to Net Income change FY 2015 v. FY 2016:

A. Increases in self-pay activity are driving up bad debt provisions ($600K).
B. Provider Tax increase ($700K).
C. Physician coverage based services (Pediatrics and other specialty on-call coverage ($700K).

Non-Operating Adjustment FY 2015:

A. The significant net income loss for FY 2015 is the result of two material one-time accounting transactions: 1) impairment of fixed assets ($15.3M) and 2) impairment of deferred tax asset ($1.7M). **Fixed Assets**: A revaluation of hospital assets was conducted and measured at fair value as of September 30, 2015. In the end a write-down of fixed asset was required to account for the new fair market value that resulted in a ($15.3M) charge to FY2015 financial results. Notes regarding the valuation can be found on pages 17 & 18 of Sharon Hospital Holding Company, Inc.'s audited financial statements submitted to the State in July 2016. **Tax Asset:** As of September 30, 2015, Sharon Hospital Holding Company, Inc. established a valuation allowance to fully offset its net deferred tax assets. The valuation allowance was recorded due to the uncertainty of the recognition of any future benefit from this tax asset. Notes regarding the allowance can be found on page 19 of the audited financial statements.

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

RESPONSE:

Not applicable.

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

RESPONSE:

The table below shows the minimum number of inpatient discharges or outpatient visits required each year in order for the Hospital to cover financial incremental expenses.

	FY 2017	FY 2018	FY 2019	FY 2020
Minimum Inpatient Discharges	6	88	213	319
Minimum Outpatient Visits	208	2,917	7,083	10,625

Utilization

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

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

RESPONSE:

See OHCA Tables 5 and 6. Units reported are inpatients discharges and outpatient visits.

24. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Table 5 and 6.

RESPONSE:

The decline in inpatient visits as shown in OHCA Table 5 was largely a result of a decrease in ED visits requiring admission, as well as the FY 2015 closure of the oncology services operated by Yale-New Haven Hospital at Sharon. Outpatient visits declined during this time as well. This included a decline in treated and discharged ED patients, outpatient oncology visits, sleep center visits, and other outpatient visits related to physician services.

With regard to projected volume, Health Quest will begin to shift some admissions from VBMC and NDH, both of which are at or near capacity. These will be medically appropriate patients for the Hospital to accept and will be patients that live east of the Taconic and have shorter travel distances to Sharon than they have to either VBMC or NDH. Direct participation with New York insurance payers will also contribute to and support the shift. Health Quest anticipates that this shift will occur in FY 2017 and FY 2018 and be the equivalent of an average daily census ("ADC") of six (6) patients. This will also include geropsychiatric patients, for which Health Quest does not have a service currently. In addition, through the recruitment of cardiology, orthopedics, general surgery, OBGYN, oncology and primary care physicians, which Health Quest will do in FY 2017 and FY 2018, an additional four (4) patients per day can be kept in the community by the end of FY 2017, increasing the ADC by ten (10) patients. Beyond that time, Health Quest projects demand growing with the aging of the population and as the impact of the newly recruited physicians takes hold in the community. Health Quest has projected demand to increase by approximately 2% per annum between FY 2018 and FY 2020. This also accounts for the continued shift to ambulatory patients, which will depress the growth of the inpatient demand.

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

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

RESPONSE:

See OHCA Table 7. Projections are based on the current patient population mix for inpatient discharges. The Hospital accepts all patients regardless of payer source or ability to pay and treats a considerable amount of governmentally insured and uninsured individuals. It will continue to accept all patients regardless of payer source or ability to pay under Vassar Connecticut's ownership. Applicants do not anticipate any appreciable change in patient population mix as a result of this transaction and considering the demographics of the Sharon service area.

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

RESPONSE:

See Response to Question 8a (Public Need & Access to Care) above.

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

RESPONSE:

See OHCA Table 8. Utilization is reported by number of inpatient discharges.

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

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

RESPONSE:

See OHCA Table 9.

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

RESPONSE:

This proposal will have minimal impact, if any, on existing providers. Sharon has been in operation for over 100 years and it serves a geographically remote area from which other Connecticut hospitals are largely inaccessible. The sale of Sharon to Vassar Connecticut will simply allow the Hospital to continue serving the patient population that it has served for more than a century. To the extent that patients are traveling outside of the Sharon area for hospital care, these patients will be able to access more services in their community once the sale is completed. Tertiary service providers, including other hospitals within the Health Quest system and larger hospitals in Connecticut, will continue to receive referrals and transfers of patients who cannot safely or adequately be treated at Sharon.

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

RESPONSE:

Sharon's patients originate from the 14 PSA towns, located in Connecticut and New York, listed in OHCA Table 2. This table also includes SSA towns, and as OHCA Table 8 shows, patients come to the Hospital from elsewhere in Connecticut, New York and other states.

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

RESPONSE:

The Hospital expects its patients to originate from the same service area towns listed in OHCA Tables 2 & 8 under Vassar Connecticut ownership. The only potential changes in referral patterns are due to physician recruitment and the strengthening of tertiary services relationships. With respect to physician services, the recruitment of additional primary care and specialty physicians to practice in the area and serve on the Sharon Medical Staff might result in patients

who would otherwise leave the service area for treatment receiving care in their local community. In addition, the relationship among hospitals in the Health Quest system will encourage the referral of patients in need of tertiary services to VBMC where they can receive the highest-quality coordinated care.

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

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

RESPONSE:

This proposal does not result in the unnecessary duplication of services because Sharon is an existing hospital provider in a remote community with no other acute care options. Vassar Connecticut is not proposing the addition of any services or the acquisition of any equipment in connection with this transaction. Rather, it will assume ownership of the Hospital and stabilize it financially so that Sharon can continue to exist as an essential community resource.

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

33. Explain in detail how the proposal will impact (i.e., positive, negative or no impact) the diversity of health care providers and patient choice in the geographic region.

RESPONSE:

The sale of Sharon to Vassar Connecticut will have a positive impact on the diversity of healthcare in Sharon area. Currently, the only option for hospital services is Sharon and the number of physicians practicing in the area is extremely limited. With this transaction, Sharon will become a member of the Health Quest system. This will bring Health Quest resources, mainly physicians, to the Sharon area and diversify physician service options for local residents. It will also enhance access to Health Quest's other services, mainly tertiary services, for area residents who need to be transferred out of Sharon due to the nature and/or severity of their conditions. While these patients have always had the choice to be transferred to a Health Quest hospital, they will now be able to obtain services at system providers in a better coordinated manner.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Sharon Hospital, Acute Care General Hospital	50 Hospital Hill Road Sharon, CT 06069	See OHCA Tables 2 & 8 for Service Area Towns and Utilization by Town	24 hours/day, 7 days/week	Change of Ownership, Continuation of Services

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TABLE 2
SERVICE AREA TOWNS

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

Town*	Reason for Inclusion
North Canaan, CT Sharon, CT Salisbury, CT Clinton, NY Copake, NY Amenia, NY Pine Plains, NY New Milford, CT Torrington, CT Washington, NY Cornwall, CT Canaan, CT Kent, CT Winchester, CT	These towns comprise the lowest number of contiguous zip codes that account for at least 75% of inpatient discharges at Sharon Hospital in FY 2016 (Primary Service Area).
Pawling, NY Stanford, NY Norfolk, CT Poughkeepsie, NY Ancram, NY Litchfield, CT Rhinebeck NY	These towns contain one or more zip codes that generate at least .5% of inpatient discharges and comprise the Sharon Hospital Secondary Service Area.

* Village or place names are not acceptable.

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TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical, Imaging)	$0
Land/Building Purchase*	$0
Construction/Renovation**	$0
Other (specify): **Purchase Price for the Assets of Sharon Hospital and Affiliated Entities**	$5,000,000.00 + subject to certain adjustments for working capital and other considerations
Total Capital Expenditure (TCE)	$5,000,000.00 + subject to certain adjustments for working capital and other considerations
Lease (Medical, Non-medical, Imaging)***	$0
Total Lease Cost (TLC)	$0
Total Project Cost (TCE+TLC)	$5,000,000.00 + subject to certain adjustments for working capital and other considerations

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

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

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

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TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES

	FY 2017*	FY 2018*	FY 2019*	FY 2020*
Revenue from Operations	$4,648,342	$14,772,159	$16,090,477	$16,549,789
Total Operating Expenses	$1,169,770	$5,001,048	$6,406,302	$7,315,261
Gain/Loss from Operations	**$3,478,572**	**$9,771,111**	**$9,684,175**	**$9,234,528**

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

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TABLE 5
HISTORICAL UTILIZATION BY SERVICE

Service**	Actual Volume (Last 3 Completed FYs)			CFY Volume*
	FY 2013***	FY 2014***	FY 2015***	FY 2016***[5]
Inpatient Discharges	2,878	2,616	2,466	2,411
Outpatient Visits	92,898	92,902	90,592	90,590
Total	**95,776**	**95,518**	**93,058**	**93,001**

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

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TABLE 6
PROJECTED UTILIZATION BY SERVICE

Service* (Inpatient Discharges)[6]	Projected Volume			
	FY 2017**	FY 2018**	FY 2019**	FY 2020**
Inpatient Discharges	2,798	3,686	3,781	3,835
Outpatient Visits	95,309	102,542	105,315	106,894
Total	**98,107**	**106,228**	**109,096**	**110,729**

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.
** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

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[5] Data includes a complete fiscal year from October 1, 2015 through September 30, 2016.
[6] Data for rehabilitation discharges is not included because Sharon Hospital does not provide inpatient rehabilitation services. Instead, ICU discharges have been included in both historic and projected utilization figures.

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX

Payer	Current FY 2016**[7]		Projected					
			FY 2017**		FY 2018**		FY 2019**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	1,318	55%	1,539	55%	2,027	55%	2,080	55%
Medicaid*	434	18%	504	18%	663	18%	681	18%
CHAMPUS & TriCare	12	<1%	20	<1%	28	<1%	28	<1%
Total Government	**1,764**	**73%**	**2,063**	**73%**	**2,718**	**73%**	**2,789**	**73%**
Commercial Insurers	588	24%	672	24%	885	24%	907	24%
Uninsured	55	2%	56	2%	74	2%	76	2%
Workers Compensation	4	<1%	7	<1%	9	<1%	9	<1%
Total Non-Government	**647**	**27%**	**735**	**27%**	**968**	**27%**	**992**	**27%**
Total Payer Mix	**2,411**	**100%**	**2,798**	**100%**	**3,686**	**100%**	**3,781**	**100%**

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

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[7] Data includes a complete fiscal year from October 1, 2015 through September 30, 2016.

TABLE 8
UTILIZATION BY TOWN

Town	Utilization FY 2016**[8]
North Canaan, CT	269 (11.16%)
Sharon, CT	261 (10.82%)
Salisbury, CT	223 (9.25%)
Clinton, NY	208 (8.63%)
Copake, NY	193 (8.00%)
Amenia, NY	167 (6.93%)
Pine Plains, NY	104 (4.31%)
New Milford, CT	79 (3.28%)
Torrington, CT	63 (2.61%)
Washington, NY	63 (2.61%)
Cornwall, CT	59 (2.45%)
Canaan, CT	58 (2.41%)
Kent, CT	49 (2.03%)
Winchester, CT	46 (1.91%)
Pawling, NY	19 (0.79%)
Danbury, CT	18 (0.75%)
Stanford, NY	18 (0.75%)
New York, NY	16 (0.66%)
Norfolk, CT	15 (0.62%)
Poughkeepsie, NY	15 (0.62%)
Waterbury, CT	15 (0.62%)
Ancram, NY	14 (0.58%)
Litchfield, CT	14 (0.58%)
Rhinebeck, NY	14 (0.58%)
Other CT	196 (8.13%)
Other NY	176 (7.30%)
All Other	39 (1.62%)
TOTAL:	**2,411 (100%)**

* List inpatient/outpatient/ED volumes separately, if applicable
** Fill in most recently completed fiscal year.

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[8] Data includes a complete fiscal year from October 1, 2015 through September 30, 2016.

TABLE 9
SERVICES AND SERVICE LOCATIONS OF EXISTING PROVIDERS

Service or Program Name	Population Served	Facility ID* (NPI)	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization (FY 2015 Inpatient Discharges)[9]
Charlotte-Hungerford Hospital	Acute Care General Hospital Patients	1720289861	540 Litchfield Street Torrington, CT 06790	24/7	6,030
Danbury Hospital – New Milford	Acute Care General Hospital Patients	1619938016	21 Elm Street New Milford, CT 06776	24/7	20,558
Danbury Hospital -- Danbury	Acute Care General Hospital Patients	1548293343	24 Hospital Avenue Danbury, CT 06810	24/7	Included in above
Waterbury Hospital	Acute Care General Hospital Patients	1477902641	64 Robbins Street Waterbury, CT 06708	24/7	11,646
St. Mary's Hospital	Acute Care General Hospital Patients	1760426969	56 Franklin Street Waterbury, CT 06706	24/7	11,845
Northern Dutchess Hospital	Acute Care General Hospital Patients	1124072715	6511 Springbrook Avenue Rhinebeck, NY 12572	24/7	5,130
Putnam Hospital Center	Acute Care General Hospital Patients	1972557379	670 Stoneleigh Avenue Carmel, NY 10512	24/7	6,834
Vassar Brothers Medical Center	Acute Care General Hospital Patients	1295794162	45 Reade Place Poughkeepsie, NY 12601	24/7	21,710
Columbia Memorial Hospital	Acute Care General Hospital Patients	1528024718	71 Prospect Avenue Hudson, NY 12534	24/7	5,847
MidHudson Regional Hospital	Acute Care General Hospital Patients	1306013388	241 North Road Poughkeepsie, NY 12601	24/7	5,730

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

[9] Source: Office of Health Care Access 2015 Hospital Financial Dashboard
http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2015/all_dashboards2015.pdf

EXHIBIT A

ESSENT HEALTHCARE OF CONNECTICUT, INC.
SHARON HOSPITAL HOLDING COMPANY, AND
REGIONALCARE HOSPITAL PARTNERS, INC.

ACTION BY WRITTEN CONSENT
OF THE
BOARDS OF DIRECTORS

September 9, 2016

The undersigned, constituting all of members of the boards of directors ("Boards") of Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("Sharon"), Sharon Hospital Holding Company, a Delaware corporation ("SHHC"), and RegionalCare Hospital Partners, Inc., a Delaware corporation ("RCHP") do hereby unanimously consent to taking action without a meeting, by written consent, and hereby take the following actions:

RESOLVED, that the terms and provisions of the Asset Purchase Agreement dated as of September 9, 2016 (the "Asset Purchase Agreement") which has been made available to the Boards, between Sharon, SHHC, Regional Healthcare Associates, LLC, a Connecticut limited liability company ("RHA") , Tri State Women's Services, LLC, a Connecticut limited liability company ("TSWS" and collectively with Sharon, SHHC, and RHA, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest"), and Vassar Health Connecticut, Inc., a Connecticut non-profit corporation ("VHC" and, collectively with Health Quest, the "Buyer") and RCHP, solely for the purposes of Sections 13.32 and 13.33 therein, pursuant to which the Sellers will sell substantially all of their assets to the Buyer as specified in the Asset Purchase Agreement, are hereby approved and confirmed;

RESOLVED FURTHER, that each of the Chairman, Chief Executive Officer, President, Chief Financial Officer, Executive Vice President, Chief Administrative Officer, Associate General Counsel, Corporate Controller, Treasurer, Secretary, Assistant Secretary, Vice President or such other appropriate officer of Sharon, SHHC or RCHP, respectively, acting on behalf of Sharon, SHHC or RCHP, respectively (each an "Officer"), is hereby directed to take, or cause to be taken all action, and to prepare, execute, deliver and file, or cause to be prepared, executed, delivered and filed, all agreements, instruments and documents, including, without limitation, the Asset Purchase Agreement, Management Agreement, Escrow Agreement, Bills of Sale, Assignment and Assumption Agreement, Transition Services Agreement, and any amendments thereto, as such officers, or any of them, deem necessary or advisable to effectuate the intent of the Asset Purchase Agreement and perform the actions required therein, as conclusively evidenced by the execution and delivery thereof;

RESOLVED FURTHER, that any Officer is hereby authorized and directed to do any and all other or further things, and to execute any and all other or further documents and agreements, including any amendments to the documents referenced above, all on behalf of Sharon, SHHC or RCHP, respectively, as each of them, acting in their sole discretion, may deem necessary or desirable to effectuate the purposes of the foregoing resolutions; and

RESOLVED FURTHER, that any actions taken by any Officer prior to the date hereof that would have been authorized hereby except that such actions occurred prior to such date are hereby ratified, confirmed, approved and adopted in all respects.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned have executed this Action by Written Consent as of the date and year set forth above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.
SHARON HOSPITAL HOLDIN COMPANY
REG 'ALCARE HO ART S, INC.

_____
Name: Martin S. Rash
Title: Director

_____
Name: Howard T. Wall III
Title: Director

_____
Name: Michael Wiechart
Title: Director

[Signature Page to Boards Consent]

Health Quest Systems, Inc.
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healthquest.org

Secretary Certificate

I, Cheryl Booth, Assistant Secretary to the Board of Trustees of Health Quest Systems, Inc., hereby certify the resolution attached hereto as **Exhibit A** was unanimously approved and adopted at a meeting of the Board of Trustees of Health Quest Systems, Inc., at its meeting held on July 29, 2016:

Health Quest Systems, Inc.

By: _____
Cheryl Booth
Its: Assistant Secretary

EXHIBIT A

The Board of Trustees of Health Quest Systems, Inc., hereby approves the following:

The Board of Trustees of Health Quest Systems, Inc. hereby approves, adopts and ratifies Management's execution and delivery of an Asset Purchase Agreement (the "APA") to purchase substantially all the assets operated by Sharon Hospital and its affiliates as discussed;

Management's execution, delivery and implementation of a Management Agreement to provide comprehensive management services to Sharon Hospital and its affiliates during the period between execution of APA and the closing of the transaction described therein; and

Management's execution and delivery of a grant or contribution agreement whereby the Foundation for Community Health will provide support for the transaction described in the APA and for Health Quest's operation of the assets post-closing, expected to be valued at approximately $9,000,000.

EXHIBIT B

Internal Revenue Service

Department of the Treasury

Washington DC 20224

VBH Corporation
Reade Place
Poughkeepsie, N.Y. 12601

Person to Contact:

Telephone Number:

Refer Reply to:
OP:E:EO:R:2

Date:
SEP 30 1987

Employer Identification Number: 14-1678068
Key District: Brooklyn, N.Y.
Accounting Period Ending: December 31
Foundation Status Classification: 509(a)(2)
Advance Ruling Period Ends: December 31, 1989

Dear Applicant:

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

Because you are a newly created organization, we are not now making a final determination of your foundation status under Code section 509(a). However, we have determined that you can reasonably be expected to be a publicly supported organization described in the sections shown above.

Accordingly, you will be treated as a publicly supported organization, and not as a private foundation, during the advance ruling period. This advance ruling period begins on the date you were organized and ends on the date shown above.

Before the end of your advance ruling period, you will be asked to furnish to your key District Director information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. (If you received a 2 or 3 year advance ruling, you will be given an opportunity to extend the advance ruling to 5 years.) If you establish that you have been a publicly supported organization, you will be classified as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, (or do not request an extension to 5 years, if appropriate), you will be classified as a private foundation for future periods. Also, if you are classified as a private foundation, you will be treated as a private foundation from the effective date of your exemption for purposes of section 4940, which imposes an excise tax on your net investment income, and section 507(d), which defines, in the event of termination of status, the aggregate tax benefit derived from tax exemption as a section 501(c)(3) organization.

Grantors and donors may rely on the advance ruling that you are not a private foundation until 90 days after your advance ruling period ends. If you submit the required information within the 90 days, grantors and donors may continue to rely on the advance ruling until we make a final determination of your foundation status. However, if notice that you will no longer be treated as the type of organization shown above is published in the Internal Revenue Bulletin, grantors and donors may not rely on this advance ruling after the date of such publication. Also, a grantor or donor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of the foundation classification shown above, or if he or she acquired knowledge that we had given notice that you would be removed from classification as the type of organization shown above.

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

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

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

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

You are required to file Form 990, Return of Organization Exempt from Income Tax, only if your gross receipts each year are normally more than $25,000. If your gross receipts are not normally more than $25,000 we ask that you establish that you are not required to file Form 990 by completing Part I of that Form for your first tax year. Thereafter, you will not be required to file a return until your gross receipts normally exceed the $25,000 minimum. For guidance in determining if your gross receipts are "normally" not more than the $25,000 limit, see the instructions for the Form 990. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. There is a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late unless you establish, as required by section 6652(d)(1), that the failure to file timely was due to reasonable cause.

VBH Corporation

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

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

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

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

Sincerely yours,

Milton Cerny
Chief, Exempt Organizations
Rulings Branch

Attachment:
Form 872-C

Colby Attorneys Service Co.

U.S. Corporate and Information Services

Est. 1939

SEP 15 1999

(800) 832-1220
(518) 463-4426
Fax (518) 434-2574

David Daniels, Esq.
David E. Daniels, Attorneys at Law, P.C.
243 Route 22 P.O. Box 668
Pawling NY 12564-0668

RE: HEALTH QUEST SYSTEMS, INC.

Enclosed, please find the requested copy(ies): 1

Date Completed: 9/3/99

F 990903000104

CERTIFICATE OF

AMENDMENT

OF

VBH CORPORATION

Under Section 803 of the Not for Profit Corporation Law

RECEIVED
SEP 2 9 09 AM '99

RECEIVED
SEP 2 2 35 PM '99

1 cc

STATE OF NEW YORK
DEPARTMENT OF STATE
FILED SEP 03 1999
TAX $ [illegible]
BY: [illegible]
Dutchess

Filed by:

Ruth A. Dennehey
Colby Attorneys Service Co.
41 State Street, Suite 106
Albany, NY 12207

D.C.-08 3 BILLED

990903000111

24 HOUR

DC-08

F99090300104

CERTIFICATE OF AMENDMENT
OF THE CERTIFICATE OF INCORPORATION
OF
VBH CORPORATION

Under Section 803 of the Not-for-Profit Corporation Law

We, the undersigned, Ronald T. Mullahey and Susan Davis being the President and Chief Executive Officer, and Assistant Secretary, respectively, of VBH Corporation, do hereby certify:

(1) The name of the corporation is VBH Corporation.

(2) The certificate of incorporation of VBH Corporation was filed by New York State, Department of State on the 17th day of July, 1985. The said corporation was formed under the Not-For-Profit Corporation Law of the State of New York.

(3) That VBH Corporation is a corporation as defined in subparagraph (a)(5) of section 102 of the Not-For-Profit Corporation Law and is a Type B corporation under section 201 of the said law.

(4) Paragraph First of the certificate of incorporation of VBH Corporation which sets forth the name of the corporation is hereby amended to read as follows:

"The name of the corporation is Health Quest Systems, Inc."

(5) The address to which the Secretary of State shall mail a copy of any process served upon him or her is also changed to read:

The Secretary of State is designated as agent of the Corporation upon whom process against it may be served. The post office address to which the Secretary of State shall mail a copy of any process against the corporation served upon him/her is: c/o Vassar Brothers Hospital, 45 Reade Place, Poughkeepsie, NY 12601, Attn: Chief Executive Officer.

1

(6) This amendment to the certificate of incorporation of VBH Corporation was authorized by the consent of a majority of the entire Board of Trustees of the corporation voting in person at a meeting duly called and held on the 19th day of August, 1999, there being no members entitled to vote thereon.

(7) The Secretary of State is designated as agent of the Corporation upon whom process against it may be served. The post office address to which the Secretary of State shall mail a copy of any process against the corporation served upon him/her is: c/o Vassar Brothers Hospital, 45 Reade Place, Poughkeepsie, NY 12601, Attn: Chief Executive Officer.

IN WITNESS WHEREOF, the undersigned have subscribed this certificate and affirm the statements herein as true under the penalties of perjury this 1st day of September, 1999.

Ronald T. Mullahey, President and Chief Executive Officer

Susan Davis, Ass't. Secretary

2

State of New York
Department of State } ss:

I hereby certify that the annexed copy has been compared with the original document in the custody of the Secretary of State and that the same is a true copy of said original.

Witness my hand and seal of the Department of State on SEP 07 1999

STATE OF NEW YORK ★ DEPARTMENT OF STATE ★

Special Deputy Secretary of State

DOS-1266 (5/96)

BV

COPY

HEALTH QUEST SYSTEMS, INC.
45 Reade Place
Poughkeepsie, New York 12601

March 30, 2000

Internal Revenue Service
Andover, MA 05501

RE: VBH Corporation Name Change
EIN: 14-1678068

To Whom It May Concern:

Please accept this letter as notification that the above-referenced entity has changed its name from VBH Corporation to Health Quest Systems, Inc..

There have been no other changes made to this entity.

Sincerely,

Richard J. Henley
Executive Vice President

State of New York
Department of State } ss:

I hereby certify, that the Certificate of Incorporation of HEALTH QUEST SYSTEMS, INC. was filed on 07/17/1985, under the name of VBH CORPORATION, as a Not-for-Profit Corporation and that a diligent examination has been made of the Corporate index for documents filed with this Department for a certificate, order, or record of a dissolution, and upon such examination, no such certificate, order or record has been found, and that so far as indicated by the records of this Department, such corporation is an existing corporation. I further certify the following:

A certificate changing name to HEALTH QUEST SYSTEMS, INC. was filed on 09/03/1999.

A Certificate of Amendment was filed on 03/07/2001.

A Certificate of Amendment was filed on 11/04/2003.

I further certify that no other documents have been filed by such corporation.

***

Witness my hand and the official seal of the Department of State at the City of Albany, this 27th day of February two thousand and fourteen.

Anthony Giardina
Executive Deputy Secretary of State

201402280217 * J8

EXHIBIT C

ASSET PURCHASE AGREEMENT

AMONG

HEALTH QUEST SYSTEMS, INC.,

VASSAR HEALTH CONNECTICUT, INC.

ESSENT HEALTHCARE OF CONNECTICUT, INC.,

SHARON HOSPITAL HOLDING COMPANY.

REGIONAL HEALTHCARE ASSOCIATES, LLC,

TRI STATE WOMEN'S SERVICES, LLC

AND

REGIONALCARE HOSPITAL PARTNERS, INC.,

(solely for the limited purpose of Section 13.32 and 13.33 herein)

TABLE OF CONTENTS

Exhibits

ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (the "**Agreement**") is made and entered into this 13th day of September, 2016, by and among **ESSENT HEALTHCARE OF CONNECTICUT, INC.** d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**") Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**") Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**") and Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**" and with Sharon, SHHC and RHA, individually a "**Seller**" and collectively, the "**Sellers**"), **HEALTH QUEST SYSTEMS, INC.**, a New York non-profit corporation ("**Health Quest**") and **VASSAR HEALTH CONNECTICUT, INC.**, a Connecticut non-profit corporation ("**Newco**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**"). Sharon, SHHC, RHA, TSWS, Sellers, Health Quest, Newco and Buyer may be referred to individually as a "**Party**" and, collectively, as the "**Parties.**" RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**") joins this Agreement solely for the purposes of Sections 13.32 and 13.33 herein.

RECITALS

WHEREAS, SHHC and Sharon own and operate Sharon Hospital, currently licensed as a 78-bed general acute care community hospital located in Sharon, Connecticut (the "**Hospital**"), and SHHC, Sharon, RHA and TSWS own or lease and operate the other healthcare facilities or operations listed on Exhibit A (collectively, with the Hospital, the "**Facilities**");

WHEREAS, Sharon is an indirect wholly-owned subsidiary of RCHP;

WHEREAS, RHA and TSWS are physician-owned group practice entities that employ or otherwise engage physicians who provide services at the Facilities and both RHA and TSWS are managed by the Hospital;

WHEREAS, the Parties desire to enter into this Agreement to provide for the sale by the Sellers to Buyer of substantially all of the assets, real and personal, tangible and intangible, constituting the Facilities; and

WHEREAS, Sharon and Newco or an affiliate thereof (the "**Manager**") will enter into a management agreement as of the date hereof wherein the Manager will provide management services and other services as set forth therein at the Facilities commencing as of the date hereof until the Closing Date (the "**Management Agreement**").

NOW, THEREFORE, in consideration of the mutual covenants set forth herein and other good and valuable consideration, the adequacy and receipt of which hereby are acknowledged, the Parties, intending to be legally bound, agree as follows:

AGREEMENT

ARTICLE I

DEFINITIONS

"**Actual Closing Net Working Capital Statement**" has the meaning set forth in Section 2.6(b).

"**ADA**" means the Americans with Disabilities Act.

"**Advisory Board**" has the meaning set forth in Section 11.4.

"**Affiliate**" means, as to the entity in question, any person or entity that directly or indirectly controls, is controlled by or is under common control with the entity in question; provided that "Affiliate" shall not include any person or entity that directly or indirectly owns equity securities of RegionalCare Hospital Partners Holdings, Inc. nor any Affiliate or portfolio company of such person or entity that would otherwise be an Affiliate of the entity in question.

"**Agents**" has the meaning set forth in Section 13.17.

"**Agreed Accounting Principles**" means GAAP consistently applied; provided that, with respect to any matter as to which there is more than one generally accepted accounting principle, Agreed Accounting Principles means the generally accepted accounting principles applied in the preparation of the Sellers' most recent audited financial statements.

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

"**AHLA**" has the meaning set forth in Section 13.14(b).

"**ALTA**" means the American Land Title Association.

"**Application**" has the meaning set forth in Section 4.7.

"**Assets**" has the meaning set forth in Section 2.1.

"**Assignment and Assumption Agreements**" has the meaning set forth in Section 3.2(c).

"**Assumed Contracts**" has the meaning set forth in Section 2.1(j).

"**Assumed Liabilities**" has the meaning set forth in Section 2.3.

"**Attorney General**" has the meaning set forth in Section 11.4.

"**Audit Firm**" has the meaning set forth in Section 2.6(c).

"**Balance Sheet Date**" has the meaning set forth in Section 4.4(c).

"**Benefit Plans**" has the meaning set forth in Section 4.13(a).

"**Bills of Sale**" has the meaning set forth in Section 3.2(b).

"**Business**" has the meaning set forth in Section 2.1(a).

"**Buyer**" has the meaning set forth in the Preamble.

"**Buyer Fundamental Representations**" has the meaning set forth in Section 12.4(c).

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.2(a).

"**Certificate of Need**" means a written statement issued by OCHA or other agency having jurisdiction thereof evidencing community need for a new, converted, expanded or otherwise significantly modified health care facility, health service or hospice.

"**Change**" has the meaning set forth in Section 12.4(e).

"**Closing**" has the meaning set forth in Section 3.1.

"**Closing Date**" has the meaning set forth in Section 3.1.

"**Closing Net Working Capital**" has the meaning set forth in Section 2.5.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Commitments**" has the meaning set forth in Section 6.11.

"**Compliance Program**" has the meaning set forth in Section 4.25.

"**Confidential Information**" has the meaning set forth in Section 13.17.

"**Connecticut Facility**" has the meaning set forth in Section 11.8(a).

"**Consent Satisfaction**" has the meaning set forth in Section 2.7.

"**Control**" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity, whether through ownership of voting securities, by contract or otherwise.

"**Corrected Schedules**" has the meaning set forth in Section 13.1.

"**CT DEEP**" has the meaning set forth in Section 11.8.

"**Damages**" means any and all actual losses, liabilities, damages, claims, costs (including, without limitation, court costs and costs for appeal) and expenses (including, without limitation, reasonable attorneys' fees and fees of expert consultants and witnesses) but not including consequential damages, special damages, indirect damages, punitive damages and/or damages based on a purchase price multiple, except to the extent such damages are payable to a third-party in connection with an indemnifiable claim.

"**DEA Power of Attorney**" has the meaning set forth in Section 3.2(m).

"**Disputed Items**" has the meaning set forth in Section 2.6(c).

"**DSS**" means the Connecticut Department of Social Services.

"**EEOC**" means the Equal Employment Opportunity Commission.

"**Effective Time**" has the meaning set forth in Section 13.25.

"**Environmental Claim**" means any claim, action, cause of action, investigation or notice (in each case in writing or, if not in writing, to the knowledge of the Sellers) by any person alleging potential liability (including potential liability for investigatory costs, cleanup costs, governmental response costs, natural resources damages, property damages, personal injuries, or penalties) arising out of, based on or resulting from: (i) the presence, or release or threat of release into the environment, of any Materials of Environmental Concern at any location, whether or not owned or operated by a Seller Party; or (ii) circumstances forming the basis of any violation or alleged violation of any Environmental Law.

"**Environmental Laws**" means, as they exist on the date hereof and as of the Closing Date, all applicable United States federal, state, local and non-U.S. laws, regulations, codes, and ordinances and common law relating to pollution or protection of human health (as relating to the environment or the workplace) and the environment (including ambient air, surface water, ground water, land surface or sub-surface strata), including laws, and regulations relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the use, treatment, storage, disposal, transport or handling of Materials of Environmental Concern, including, but not limited to Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. Section 9601 et seq., Resource Conservation and Recovery Act, 42 U.S.C. Section 6901 *et seq*., Toxic Substances Control Act, 15 U.S.C. Section 2601 *et seq*., Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq*., the Clean Air Act, 42 U.S.C. Section 7401 *et seq*., the Clean Water Act, 33 U.S.C. Section 1251 *et seq*., each as may have been amended or supplemented, and any applicable environmental transfer statutes or laws.

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

"**ERISA Affiliate**" means each Seller, each entity which is treated as a single employer with RCHP for purposes of Section 414 of the IRC, each entity that has adopted or has ever participated in any Benefit Plan, and any predecessor or successor company or trade or business of the Sellers.

"Erroneous Applicability Determination" has the meaning set forth in Section 12.2(a).

"**Escrow Agent**" has the meaning set forth in Section 2.5.

"**Escrow Agreement**" has the meaning set forth in Section 2.5.

"**Escrow Amount**" has the meaning set forth in Section 2.5.

"**Excluded Assets**" has the meaning set forth in Section 2.2.

"**Excluded Liabilities**" has the meaning set forth in Section 2.4.

"**Executive Order 13224**" means Executive Order 13224 on Terrorism Financing, effective September 24, 2001.

"**Executives**" has the meaning set forth in Section 10.1.

"**Exemption Certificate**" means a written statement from OCHA or other agency having jurisdiction thereof stating that a health care project or expenditure is not subject to the Certificate of Need requirements under applicable state law.

"**Existing TI Obligations**" means tenant improvement expenses (including all hard and soft construction costs, whether payable to the contractor or tenant) and tenant allowances which are the obligation of the landlord under any Tenant Lease.

"**Facilities**" has the meaning set forth in the Recitals.

"**Facility Benefit Plans**" has the meaning set forth in Section 4.13(a).

"**Financial Statements**" has the meaning set forth in Section 4.4.

"**GAAP**" means U.S. generally accepted accounting principles, consistently applied by the Seller, in effect at the date of the financial statement to which it refers.

"**Health Quest**" has the meaning set forth in the Recitals.

"**Healthcare Providers**" has the meaning set forth in Section 4.9.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HIPAA**" means collectively the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended and supplemented by the Health Information Technology for Clinical Health Act of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations, when each is effective and as each is amended from time to time.

"**Hired Employees**" has the meaning set forth in Section 10.1(a).

"**Hospital**" has the meaning as set forth in the Recitals.

"**Immaterial Contracts**" means any contract or agreement of the Sellers that is not a Material Contract.

"**Indemnification Deductible**" has the meaning set forth in Section 12.4(a).

"**Indemnified Party**" has the meaning set forth in Section 12.5.

"**Indemnifying Party**" has the meaning set forth in Section 12.5.

"**Information Privacy and Security Laws**" has the meaning set forth in Section 4.9.

"**Interim Statements**" has the meaning set forth in Section 6.6.

"**IRC**" means the Internal Revenue Code of 1986, as amended, and the rules and regulations promulgated thereunder.

"**Joint Commission**" has the meaning set forth in Section 4.8.

"**Knowledge of the Sellers**" has the meaning set forth in Section 4.29.

"**Landlord Estoppel**" has the meaning set forth in Section 6.10.

"**Leased Real Property**" has the meaning set forth in Section 2.1(b).

"**Legal Dispute**" has the meaning set forth in Section 13.14(b).

"**Licensed Environmental Professional**" has the meaning set forth in Section 11.8(a).

"**Management Agreement**" has the meaning set forth in the recitals.

"**Material Adverse Effect**" means (a) the Hospital's exclusion from participation in the Medicare, Medicaid or CHAMPUS/TRICARE programs or the loss of the Hospital's active provider numbers with the Medicare and Medicaid programs; (b) the destruction of or material damage to the Hospital or a majority of the Assets to an extent that would permit Buyer to terminate this Agreement pursuant to Section 13.31; or (c) an event, occurrence, condition, change or circumstance or a series of events, occurrences, conditions, changes or circumstances that, individually or in the aggregate, would prevent, or would reasonably be expected to prevent, Buyer from operating the Hospital in a manner generally consistent with its historic operations. For the avoidance of doubt, none of the following occurring after the date hereof shall constitute a Material Adverse Effect or be taken into account in determining whether a Material Adverse Effect has occurred: (i) changes in the economy of the United States; (ii) changes generally affecting the industry in which the Sellers operate, including changes in any government or private payor programs generally applicable to operators of hospital and health care facilities in the United States; (iii) changes in GAAP or any interpretation thereof; (iv) acts of God, calamities or national political or social conditions (including the engagement by any country in hostilities); (v) changes as a result of the announcement of this transaction; or (vi) changes in the financial condition, prospects or results of operations of the Sellers, the Facilities or the Assets, except to the extent resulting in an event, occurrence, condition, change or circumstance described in (a), (b) or (c), above.

"**Material Contract**" has the meaning set forth in Section 4.18.

"**Materials of Environmental Concern**" means chemicals, pollutants, contaminants, hazardous materials, hazardous substances and hazardous wastes, Medical Waste, toxic substances, petroleum and petroleum products and by-products, asbestos-containing materials, PCBs, toxic mold, and any other chemicals, pollutants, substances or wastes, in each case so defined, identified, or regulated under any Environmental Law.

"**Medical Waste**" includes, but is not limited to, (a) pathological waste, (b) blood, (c) sharps, (d) wastes from surgery or autopsy, (e) dialysis waste, including contaminated disposable equipment and supplies, (f) cultures and stocks of infectious agents and associated biological agents, (g) contaminated animals, (h) isolation wastes, (i) contaminated equipment, (j) laboratory waste and (k) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings or animals. "Medical Waste" also includes any substance, pollutant, material or contaminant listed or regulated as "Medical Waste," "Infectious Waste," or other similar terms by federal, state, regional, county, municipal or other local laws, regulations and ordinances insofar as they purport to regulate Medical Waste or impose requirements relating to Medical Waste and includes "Regulated Waste" governed by the Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq*.

"**Net Working Capital**" means an amount equal to the value of the Sellers' inventories, supplies, and Prepaids, to the extent that each of these assets is an Asset, less the value of the Sellers' accounts payable, construction payable, accrued payroll, accrued vacation, holiday/paid time off, recorded sick time, up to the maximum amount of paid time off that can be accrued under Buyer's paid time off program, and the liability reflected on Schedule 2.3(c) relating to Sellers' assumed unrecorded extended illness benefits, and other current liabilities consistent with the Sellers' historical practices, to the extent that each of these liabilities is a current liability and is an Assumed Liability.

"**Net Working Capital Estimate**" has the meaning set forth in Section 2.6(a).

"**NSPS**" means the National Society of Professional Surveyors.

"**Objection**" has the meaning set forth in Section 2.6(c).

"**OFAC**" means the Office of Foreign Asset Contract.

"**OHCA**" has the meaning set forth in Section 4.7.

"**OIG**" means the Office of Inspector General.

"**Owned Intellectual Property**" has the meaning set forth in Section 2.1(j).

"**Owned Real Property**" has the meaning set forth in Section 2.1(a).

"**Party**" and "**Parties**" has the meaning set forth in the Preamble.

"**PCBs**" means polychlorinated biphenyls.

"**Personal Property**" has the meaning set forth in Section 2.1(c).

"**Permitted Encumbrances**" has the meaning set forth in Section 4.11.

"**Physician Agreement**" means any agreement, whether in writing or oral, between a Seller and either a physician or a legal entity in which a physician has an ownership interest.

"**Prepaids**" means all deposits, prepaid expenses, advances, escrows, prepaid Taxes and claims for refunds in connection with the Facilities or the Assets (including, without limitation, rebates from vendors received subsequent to the Closing).

"**Prohibited Transaction**" has the meaning set forth in Section 6.7.

"**Property Transfer Law**" means Section 22a-134 through 22a-134e of the Connecticut General Statutes, as amended by Public Acts 09-235 and 09-3 and all associated regulations, guidance documents and policies.

"**Providing Party**" has the meaning set forth in Section 13.17.

"**Purchase Price**" has the meaning set forth in Section 2.5.

"**Purchase Price Discount**" has the meaning set forth in Section 2.7.

"**RAC**" means Recovery Audit Contractors.

"**RCHP**" has the meaning set forth in the Preamble.

"**Real Property**" has the meaning set forth in Section 2.1(b).

"**Receiving Party**" has the meaning set forth in Section 13.17.

"**Records**" has the meaning set forth in Section 13.5.

"**RSRs**" has the meaning set forth in Section 11.8.

"**Seller Cost Reports**" has the meaning set forth in Section 2.2(b).

"**Seller Fundamental Representations**" has the meaning set forth in Section 12.4(c).

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.1(a).

"**Seller Leases**" has the meaning set forth in Section 2.1(j).

"**Seller Review Period**" has the meaning set forth in Section 13.2.

"**Sellers**" has the meaning set forth in the Preamble.

"**Sharon**" has the meaning set forth in the Preamble.

"**SNDA**" has the meaning set forth in Section 6.12.

"**Straddle Period**" has the meaning set forth in Section 13.9.

"**Survey Costs**" has the meaning set forth in Section 6.11.

"**Surveys**" has the meaning set forth in Section 6.11.

"**Tax Allocation**" has the meaning set forth in Section 13.2.

"**Tax Return**" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes required or permitted to be filed with a Taxing Authority, including any schedule or attachment thereto, and including any amendment thereof.

"**Taxes**" means any and all federal, state, local, foreign and other net income, tax on unrelated business taxable income, gross income, gross receipts, sales, use, ad valorem, unclaimed property, payments in lieu of taxes, transfer, franchise, profits, license, lease, rent, service, service use, withholding, payroll, employment, excise, severance, privilege, stamp, occupation, premium, property, windfall profits, alternative minimum, estimated, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest and any penalties, additions to tax or additional amounts with respect thereto.

"**Taxing Authority**" means any United States, federal, state, local or any foreign or governmental entity, political subdivision, or agency responsible for the imposition, enforcement, assessment or collection of any Tax

"**Tenant Estoppel**" has the meaning set forth in Section 6.9.

"**Tenant Leases**" has the meaning set forth in Section 2.1(j).

"**Title Company**" has the meaning set forth in Section 6.11.

"**Title Policy Costs**" has the meaning set forth in Section 6.11.

"**Trade Name Cancellation**" has the meaning set forth in Section 11.3.

"**Transition Patients**" has the meaning set forth in Section 2.9.

"**Transition Services**" has the meaning set forth in Section 2.9.

"**Transition Services Agreement**" has the meaning set forth in Section 3.2(h).

"**Updated Schedules**" has the meaning set forth in Section 13.1.

"**USA Patriot Act**" means the United and Strengthening America by Providing Tools Required to Intercept and Obstruct Terrorism Act of 2001, H.R. 3162, Public Law 107-56.

"**WARN Act**" means the Worker Adjustment and Retraining Notification Act.

ARTICLE II

PURCHASE OF ASSETS

2.1 Sale of Assets. Subject to the terms and conditions of this Agreement, on the Closing Date, the Sellers shall sell, assign, convey, transfer and deliver to Buyer, and Buyer shall purchase, the assets that are owned by the Sellers or otherwise used exclusively in connection with the operation of the Facilities, other than the Excluded Assets (hereinafter defined) (the "**Assets**"), including, without limitation, the following:

(a) all real property owned by any of the Sellers and used in connection with the operation of any of the Facilities (collectively, the "**Business**"), as more specifically described in Schedule 2.1(a), together with all buildings, improvements and fixtures located thereupon, all easements, rights of way, and other appurtenances thereto (including appurtenant rights in and to public streets), all architectural plans or design specifications relating to the development thereof and all construction in progress (collectively, the "**Owned Real Property**"), such Schedule 2.1(a) to include a legal description for each such parcel of Owned Real Property consistent with the vesting deed for such Owned Real Property into the applicable Seller;

(b) all real property subject to a leasehold, sub-leasehold, license, concession or other non-owned real estate in favor of any of the Sellers, as tenant, subtenant, licensee, concessionaire or otherwise, and held or used in or ancillary to the operation of the Business, all such leased premises as more specifically described on Schedule 2.1(b) (collectively, the "**Leased Real Property**"; the Owned Real Property and the Leased Real Property being sometimes referred to herein collectively as the "**Real Property**");

(c) all tangible personal property, including, without limitation, all major, minor or other equipment, vehicles, furniture, fixtures, machinery, office furnishings and instruments, the list of which, as of May 31, 2016, is set forth on Schedule 2.1(c) hereto (collectively, the "**Personal Property**");

(d) all supplies, drugs, inventory and other disposables and consumables existing on the Closing Date and located at any of the Facilities or owned by any of the Sellers in connection with the Business;

(e) all Prepaids that exist as of the Closing Date, excluding the settlement amounts described in Section 2.2(b);

(f) all claims, causes of action and judgments in favor of the Sellers relating to the physical condition or repair of the Assets, all insurance proceeds due to Buyer under Section 13.31, and, to the extent assignable, all warranties (express or implied) and rights and claims assertable by (but not against) the Sellers related to the Assets;

(g) to the extent legally assignable or transferable, all financial, patient, medical staff, personnel and other records relating to the Business or the Assets, including, without limitation, all accounts receivable records, equipment records, medical and administrative libraries, medical records, patient billing records, documents, construction plans

and specifications, catalogs, books, records, files, operating manuals and current personnel records; provided, however that Sellers shall be entitled to retain copies of any such Records to which Seller reasonably determines it may need access to following the Closing Date in order to collect any amounts owed to Sellers, to defend Sellers in any action, or to comply with any legal obligation of Sellers.

(h) all rights and interests in, to and under those lease, sublease, license or other agreements pursuant to which any of the Sellers, as landlord, sublandlord, licensor or otherwise, has leased, subleased, licensed or otherwise granted use and occupancy to a third party, as tenant, subtenant, licensee or otherwise, all or some portion of the Owned Real Property or the Leased Real Property, all such agreements being set forth on Schedule 2.1(h) together with all amendments and modifications thereto, collectively, the "**Tenant Leases**");

(i) all rights and interests in, to and under those lease, sublease, license or other agreements pursuant to which any of the Sellers, as tenant, subtenant, licensee or otherwise, is leasing, subleasing, licensing or otherwise using and occupying all or some portion of the Leased Real Property, all such agreements being set forth on Schedule 2.1(i) (together with all amendments and modifications thereto, collectively, the "**Seller Leases**");

(j) other than Excluded Contracts listed on Schedule 2.2(e), all rights and interests in, to and under (i) the Material Contracts listed on Schedule 4.18 and (ii) all Immaterial Contracts (collectively, the contracts in (i) and (ii) are "**Assumed Contracts**");

(k) to the extent assignable or transferable, all licenses, Certificates of Need, Exemption Certificates, provider agreements, provider numbers, franchises, accreditations, registrations, other licenses and permits relating to the ownership, development, and operation of the Facilities (including, without limitation, any pending approvals set forth on Schedule 2.1(k));

(l) all of Sellers' rights and interest in the name "Sharon Hospital" and all patents, trade names, domain names, copyrights, software, computer programs, trade secrets, trademarks, service marks and other intellectual property rights associated with the Business or any of the Assets, all goodwill associated therewith, and all applications and registrations associated therewith (the "**Owned Intellectual Property**");

(m) all goodwill associated with the operation of the Business and the Assets;

(n) all other assets, other than the Excluded Assets, of every kind, character or description used or held for use primarily in the Business or related to the Assets, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by the Sellers in connection with the Business or the Assets; and

(o) all property of the foregoing types arising or acquired by the Sellers between the date hereof and the Closing Date.

The Sellers shall transfer good and marketable title to the Assets to Buyer, free and clear of all claims, assessments, security interests, liens, restrictions and encumbrances, except for (i) the

Assumed Liabilities, (ii) liens and encumbrances related to the Assumed Liabilities, (iii) liens for Taxes not yet due and payable, and (iv) the Permitted Encumbrances.

2.2 Excluded Assets. Those assets of the Sellers described below, together with any assets described on Schedule 2.2 hereto, shall be retained by the Sellers (collectively, the "**Excluded Assets**"), and shall not be conveyed to Buyer:

(a) cash, short-term investments and cash equivalents;

(b) all amounts payable to any of the Sellers in respect of third party payors pursuant to retrospective settlements (including, without limitation, pursuant to Medicare, Medicaid and CHAMPUS/TRICARE cost reports) filed or to be filed by any of the Sellers for periods ending on or prior to the Closing Date ("**Seller Cost Reports**") and all appeals and appeal rights relating to such settlements, including recapture of depreciation and other cost report settlements, for periods ending on or prior to the Closing Date;

(c) all records relating to the Excluded Assets and Excluded Liabilities as well as all records which by law the Sellers are required to maintain in their possession;

(d) the corporate record books, minute books and Tax records of the Sellers;

(e) any Material Contract listed on Schedule 2.2(e) and any other contract listed on Schedule 2.2(e) that Buyer determines in its reasonable discretion is not in compliance with applicable law (the "**Excluded Contracts**");

(f) any reserves or prepaid expenses made in connection with the Excluded Assets and Excluded Liabilities (including, without limitation, prepaid legal expenses or insurance premiums);

(g) all rights to Tax refunds or claims under or proceeds of insurance policies related to the Business or the Assets resulting from the periods ending on or prior to the Closing Date;

(h) except as otherwise provided in Section 13.31, all insurance proceeds (other than payments of patient receivables) arising in connection with the Business or the Assets for periods ending on or prior to the Closing Date and all insurance proceeds relating exclusively to the Excluded Assets and Excluded Liabilities;

(i) the amounts due to any of the Sellers from Affiliates of the Sellers disclosed on Schedule 2.2(i);

(j) prepaid pension costs and other assets associated with the Sellers' qualified employee benefits plans;

(k) all notes receivable, accounts receivable and other rights to receive payment for goods and services provided by the Sellers in connection with the Business, billed and unbilled, recorded or unrecorded, including amounts charged off as bad debt and/or

submitted to collection agencies or otherwise, accrued and existing in respect of services rendered through the Closing Date;

(l) all notes receivable from patients;

(m) all rights of the Sellers under this Agreement;

(n) all claims, causes of action and judgments in favor of the Sellers associated with or arising out of any of the Excluded Assets and/or the Excluded Liabilities;

(o) all self-insured retention trusts related to professional and general liability claims and causes of action;

(p) for the avoidance of doubt, all multi-facility contracts, agreements and arrangements of RCHP and its Affiliates, including information technology contracts and computer software, scheduling systems, business and policy manuals, other media, documentation and manuals and any other proprietary information of RCHP, or an affiliate thereof, licensed or used by Sellers or the Facilities; provided, however, that this provision shall not exclude any contract, agreement, or arrangement where Sellers are the only RCHP Affiliate parties;

(q) any other current and long term assets not related to Sharon's current operating activity except as otherwise expressly included as an Asset under Section 2.1.

2.3 Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer agrees to assume, as of the Effective Time, the payment and performance of the following liabilities of the Sellers (the "**Assumed Liabilities**"):

(a) all obligations accruing, arising or to be performed after the Closing with respect to the Assumed Contracts, the Tenant Leases and the Seller Leases;

(b) the accounts payable, construction payable, and other current liabilities consistent with historical practices of the Sellers, but only to the extent such liabilities are current liabilities that are recorded on the Net Working Capital Estimate and are included within the calculation of Net Working Capital; and

(c) to the extent recorded on the Financial Statements or disclosed on Schedule 2.3(c), obligations and liabilities as of the Closing Date in respect of accrued vacation, sick time and paid time off benefits, and the amount of unrecorded extended illness benefits set forth on Schedule 2.3(c) of the employees at the Facilities who commence employment with Buyer as of the Effective Time, and related Taxes not yet due and payable.

Notwithstanding anything herein to the contrary, Buyer acknowledges and agrees that Seller shall have no liability for the operation of the Facilities, the Business or the Assets after the Effective Time.

2.4 Excluded Liabilities. Except for the Assumed Liabilities, Buyer shall not assume and under no circumstances shall Buyer be obligated to pay, discharge or assume, and

none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment or obligation of any of the Sellers, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following:

(a) any debt, obligation, expense or liability that is not an Assumed Liability;

(b) any liability arising out of or in connection with the ownership or operation of the Facilities, the Business or the Assets prior to the Effective Time, including, without limitation, claims or potential claims for medical malpractice or general liability relating to events asserted to have occurred on or prior to the Closing;

(c) those claims and obligations (if any) specified in Schedule 2.4(c) hereto;

(d) any liabilities or obligations associated with or arising out of any of the Excluded Assets;

(e) liabilities and obligations in respect of periods ending on or prior to the Closing Date arising under the terms of the Medicare, Medicaid, CHAMPUS/TRICARE, Blue Cross or other third party payor programs, including, without limitation, in respect of any Seller Cost Report, any or audit under Medicare's RAC Program or any noncompliance with applicable law or contractual obligations relating to the billing and collection for services;

(f) Tax liabilities or obligations in respect of periods ending on or prior to the Closing Date, or any period that begins before but does not end on the Closing Date to the extent allocable under Section 13.2 to the portion of such period ending on the Closing Date, including, without limitation, any income tax, franchise tax, real or personal property tax, tax recapture, sales and/or use tax and any state and local recording fees and taxes, excluding any Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.3(c) hereof;

(g) liability for any and all claims by or on behalf of current or former employees arising out of or related to acts, omissions, events or occurrences on or prior to the Closing Date, including, without limitation, liability for any EEOC claim, ADA claim, Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations under COBRA, the Public Health Service Act or similar state laws for qualifying events occurring on or prior to the Closing Date (provided, however, that this clause (g) shall not apply to those benefits constituting Assumed Liabilities and identified in Section 2.3 hereof);

(h) any obligation or liability accruing, arising out of or relating to any federal, state or local investigations of, or claims or actions against, any of the Sellers, or any of their respective directors, officers, employees, medical staff, agents, vendors or representatives, with respect to acts or omissions on or prior to the Closing Date, including, but not limited to, any post-Closing defense of any such obligation or liability;

(i) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of any of the Sellers or their respective directors, officers,

employees, medical staff, agents, vendors or representatives claimed to violate any constitutional provision, statute, ordinance or other law, rule, regulation, interpretation or order of any governmental entity;

(j) liabilities or obligations arising out of any breach by any of the Sellers prior to the Closing of any Assumed Contract, Tenant Lease or Seller Lease;

(k) any obligations or liabilities with respect to any Benefit Plans; any post-retiree medical benefits or benefits described in Section 4.13; any other obligations or liabilities of the Sellers or any ERISA Affiliate arising under or in connection with ERISA or the IRC; and any incurred but not paid (regardless of whether reported) medical and dental claims made pursuant to any Benefit Plan;

(l) all deferred compensation liabilities related to periods ending on or prior to the Closing;

(m) any account payable of a Seller to any other Seller or Affiliate thereof;

(n) liabilities or obligations whenever arising relating to any Excluded Contract;

(o) except as otherwise expressly assumed by Buyer under this Agreement, any existing indebtedness of Sellers, including, without limitation, any liability under any capital leases;

(p) any and all liabilities or obligations owed by Sellers to the Hospital's medical staff, except as otherwise expressly assumed by Buyer under this Agreement;

(q) any liability or obligation owed by Sellers to the Medical Foundation for Community Health, Inc., or any affiliate thereof, unless otherwise expressly assumed by Buyer under this Agreement;

(r) any obligation or liability arising from or under any Environmental Law related to acts or omissions of the Sellers or which occurred on or prior to the Closing Date; and

(s) any liability arising from or related to compliance with the Property Transfer Law in connection with the transaction covered by this Agreement.

2.5 Consideration. Subject to the terms and conditions hereof and in reliance upon the representations and warranties of the Sellers set forth herein, as consideration for the conveyance and transfer of the Assets, Buyer shall: (i) pay to the Sellers Five Million Dollars ($5,000,000) less any applicable Purchase Price Discount, which amount shall be increased or decreased by the amount of the Sellers' Net Working Capital as of the Closing Date (the "**Closing Net Working Capital**"), (as so adjusted, the "**Purchase Price**"); and (ii) assume as of the Effective Time the Assumed Liabilities. At the Closing, Buyer shall deposit Five Hundred Thousand Dollars ($500,000) of the Purchase Price (the "**Escrow Amount**") with the escrow agent (the "**Escrow Agent**") identified in that certain Escrow Agreement substantially in the

form of Exhibit B hereto (the "**Escrow Agreement**"), which amount shall be held and disbursed by the Escrow Agent in accordance with the terms of the Escrow Agreement.

2.6 Determination of Purchase Price; Net Working Capital Adjustment.

(a) For purposes of determining the amount of cash or otherwise immediately available funds to be delivered by Buyer at the Closing in accordance with Section 2.5, not later than two (2) business days prior to the Closing Date, the Sellers shall deliver to Buyer their good faith estimate of the amount of the Closing Net Working Capital, together with supporting documentation of reasonable specificity, which shall be subject to review and approval by Buyer (such estimate being the "**Net Working Capital Estimate**"). At the Closing, Buyer shall pay to the Sellers by wire transfer of immediately available funds to an account or accounts of the Sellers' designation Five Million Dollars ($5,000,000), plus or minus the Net Working Capital Estimate, minus the Escrow Amount.

(b) Within one hundred and fifty (150) days after the Closing Date, Buyer shall prepare, or cause to be prepared, and deliver to the Sellers a statement (the "**Actual Closing Net Working Capital Statement**") setting forth an itemized calculation of the Closing Net Working Capital and all supporting schedules for such calculations. The Actual Closing Net Working Capital Statement shall be prepared in accordance with Agreed Accounting Principles.

(c) The Sellers and their accountants shall have forty-five (45) days to review the Actual Closing Net Working Capital Statement after their receipt thereof, and Buyer shall provide Sellers access to all relevant books and records and any work papers of Buyer and its accountants used in preparing the Actual Closing Net Working Capital Statement. If the Sellers dispute the accuracy of the Actual Closing Net Working Capital Statement, the Sellers shall inform Buyer in writing (an "**Objection**") setting forth a specific description of the basis of the Objection, which Objection must be delivered to Buyer on or before the last day of such forty-five (45)-day period. Buyer and the Sellers shall then have thirty (30) additional days to attempt in good faith to reach an agreement with respect to any disputed matters in respect of the Closing Net Working Capital. In reviewing any Objection, Buyer and its accountants shall have reasonable access to the work papers of the Sellers and their accountants. If Buyer and the Sellers are unable to resolve all of their disagreements with respect to the determination of the foregoing items within said thirty (30)-day period, they shall submit the remaining items subject to dispute (the "**Disputed Items**") to KPMG LLP (the "**Audit Firm**"). The Audit Firm shall determine in accordance with this Agreement and Agreed Accounting Principles, and only with respect to the Disputed Items, whether and to what extent, if any, the Actual Closing Net Working Capital Statement requires adjustment. The Parties shall direct the Audit Firm to use all reasonable efforts to render its determination within thirty (30) days after such submission. The Audit Firm's determination of the Closing Net Working Capital shall be conclusive and binding upon the Parties. The fees and disbursements of the Audit Firm in rendering its determination shall be paid fifty percent (50%) by the Sellers and fifty percent (50%) by Buyer. Buyer and the Sellers shall make readily available to the Audit Firm all relevant books and records and any work papers (including those of the Parties' respective accountants) relating to the Actual Closing Net Working Capital Statement and all other items reasonably requested by the Audit Firm. The Closing Net Working Capital shall be deemed to be (i) the amount of Net Working Capital as stated in the Actual Closing Net Working Capital Statement if no Objection is

delivered by the Sellers during the thirty (30)-day period specified above, or (ii) if an Objection is so delivered by the Sellers, the amount of the Closing Net Working Capital as determined by either (A) the agreement of the Parties or (B) the Audit Firm.

(d) If the Closing Net Working Capital is less than the Net Working Capital Estimate, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the Net Working Capital Estimate and the Closing Net Working Capital shall be paid by the Sellers to Buyer via wire transfer of immediately available funds as an adjustment to the Purchase Price. If the Net Working Capital Estimate is less than the Closing Net Working Capital, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the Closing Net Working Capital and the Net Working Capital Estimate shall be paid by Buyer to the Sellers via wire transfer of immediately available funds as an adjustment to the Purchase Price

2.7 Purchase Price Discount. If, as of the Closing Date, (i) consents have been obtained to assign to Buyer commercial payor contracts or (ii) evidence reasonably satisfactory to Buyer that successor or comparable contractual arrangements or non-contracted commercial payor arrangements will continue after the Closing (together, "**Consent Satisfaction**"), that in the aggregate, together with government payment programs, self-pay and non-contracted commercial payment programs constitute at least 90% of the Hospital's revenue for 2015, but less than 95% of the Hospital's revenue for 2015, then the Purchase Price shall be discounted as follows: for each 0.1% below 95% of the Hospital's revenue for 2015 the Purchase Price shall be discounted by $10,000 up to a maximum of $500,000 (the "**Purchase Price Discount**"). For example, if on the Closing Date Consent Satisfaction representing 92.5% percent of the Hospital's revenue for 2015 has been obtained, the Purchase Price will be reduced by $250,000

2.8 Prorations and Utilities. To the extent not otherwise prorated pursuant to this Agreement, Buyer and the Sellers shall prorate as of the Closing Date, charges against the Real Property and the Personal Property, power and utility charges and all other income and expenses that are normally prorated upon the sale of a going concern. As to charges against the Real Property and the Personal Property, all prorations shall be based upon the most recent tax bill(s) received by the Sellers. As to power and utility charges, such amounts shall be prorated as of the Closing Date among the parties on the basis of an estimate of the amounts in accordance with GAAP and mutually agreed upon by Buyer and the Sellers.

2.9 Transition Patients. To compensate Sellers for services rendered and medicine, drugs and supplies provided on or before the Closing Date (the "**Transition Services**") with respect to patients admitted to the Facilities on or before the Closing Date (or who were in the Facilities' emergency department or in observation beds on the Closing Date and immediately thereafter admitted to the Facilities) but who are not discharged until after the Closing Date (such patients being referred to herein as the "**Transition Patients**"), the parties shall take the following actions:

(a) Medicare, Medicaid, TRICARE and Other Seller DRG Transition Patients. As soon as practicable after the Closing Date, Buyer shall deliver to Sellers a schedule identifying the charges, on an itemized basis, for the Transition Services provided by Sellers on

or through the Closing Date to Transition Patients whose care is reimbursed by the Medicare, Medicaid, TRICARE or other third party payor programs on a diagnostic related group ("**DRG**") basis, case rate, or similar basis (each patient a "**Seller DRG Transition Patient**"), as well as a schedule of any DRG and outlier payments, the case rate payments, or other similar payments received by Sellers and any deposits or co-payments made by such Seller DRG Transition Patient to Sellers. Buyer shall include in the amount of Assets in the calculation of Net Working Capital an amount equal to: (x) the DRG and outlier payments, the case rate payments or other similar payments received by Buyer on behalf of each Seller DRG Transition Patient, plus any deposits or co-payments made by such Seller DRG Transition Patient to Buyer multiplied by a fraction, the numerator of which shall be the total charges for Transition Services provided to such Seller DRG Transition Patient by Sellers prior to the Closing Date, and the denominator of which shall be the sum of total charges for all services provided to such Seller DRG Transition Patient both before and after the Closing Date; minus (y) the DRG and outlier payments, the case rate payments or other similar payments received by Sellers, if any, on behalf of each Seller DRG Transition Patient, plus any deposits or co-payments made by such Seller DRG Transition Patient to Sellers multiplied by a fraction, the numerator of which shall be the total charges for Transition Services provided to such Seller DRG Transition Patient by Buyer after the Closing Date, and the denominator of which shall be the sum of total charges of all services provided to such Seller DRG Transition Patient both before and after the Closing Date.

(b) For all Transition Patients not covered by Section 2.9(a), Buyer shall include in the amount of Assets in the calculation of Net Working Capital the amount equal to the amount received by Buyer related to the services provided by Sellers prior to Closing, if separately identifiable on the claim (for example, when services are compensated based on the number of days). If not identifiable on the claim, then the Buyer and Sellers shall follow the process identified in Section 2.9(a) in order to allocate the total payment between the Buyer and Sellers based on total charges, unless the payor requires a separate "cut-off" bill from Sellers, in which case all amounts collected in respect of such cut-off billings shall be included in the amount of Assets in the calculation of Net Working Capital.

ARTICLE III

CLOSING

3.1 Closing. Subject to the satisfaction or waiver by the appropriate Party of all of the conditions specified in ARTICLES VIII and IX hereof, the consummation of the transactions contemplated by and described in this Agreement (the "**Closing**") shall take place on a date mutually agreed to in writing by the Parties that is as soon as practicable after all required regulatory and other approvals for the transaction have been obtained and after all conditions precedent have been satisfied, except those that are to be satisfied on the Closing Date, but in no event later than July 31, 2017 or the first anniversary of the date hereof, whichever is later, or on such later date or at such other location as the Parties may mutually designate in writing (the date of consummation is referred to herein as the "**Closing Date**").

3.2 Actions of the Sellers at the Closing. At the Closing and unless otherwise waived in writing by Buyer, the Sellers shall deliver to Buyer the following:

(a) one or more special warranty deeds in recordable form executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer good and marketable fee title to the Owned Real Property, subject only to the Permitted Encumbrances affecting such parcels;

(b) one or more General Assignments, Conveyances and Bills of Sale in the form attached as Exhibit C (the "**Bills of Sale**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer good and marketable title to the Assets, free and clear of all claims, assessments, liens, security interests, restrictions and encumbrances other than the Permitted Encumbrances, liens for Taxes not yet due and payable and the Assumed Liabilities;

(c) one or more Assignment and Assumption Agreements in the form attached as Exhibit D (the "**Assignment and Assumption Agreements**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer or an Affiliate designated by Buyer all of Sellers' right, title and interest in, to and under the Assumed Contracts, the Tenant Leases and Seller Leases;

(d) a copy of resolutions duly adopted by the governing body of each of the Sellers authorizing and approving such Seller's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing Date by an appropriate officer of such Seller;

(e) a certificate of the President, a Vice President or other appropriate officer of each Seller, certifying the fulfillment of the conditions set forth in ARTICLE VIII;

(f) a certificate of incumbency for the respective officers of each Seller executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(g) evidence from the Sellers or their financing sources (or representatives thereof) in respect of the indebtedness described on Exhibit E that any liens such parties may have on the Assets or the Real Property in respect of such indebtedness shall be released at or prior to the Closing Date;

(h) a Transition Services Agreement, executed by a duly authorized officer of each Seller for such services and in a form agreed by the parties (the "**Transition Services Agreement**");

(i) such documents as may be required by the Title Company to release the Assets from any and all mortgages and security interests created at any time on or prior to the Closing Date, except the Permitted Encumbrances and the Assumed Liabilities, and to insure Buyer's fee ownership interest in the Owned Real Property and Buyer's leasehold interest in the Leased Real Property;

(j) copies of certificates of insurance evidencing the insurance described in Section 6.8;

(k) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets;

(l) an affidavit executed by each Seller certifying that it is not a "blocked person" under Executive Order 13224, which form shall be acceptable to Buyer;

(m) a DEA limited power of attorney fully executed by a duly authorized officer of Sharon (the "**DEA Power of Attorney**"), substantially in the form attached hereto as Exhibit F;

(n) the Management Agreement in the form attached as Exhibit G executed by Sharon;

(o) a certificate of non-foreign status, dated as of the Closing Date, executed by a duly authorized officer of each Seller, in form and substance required under the Treasury Regulations pursuant to Section 1445 of the IRC;

(p) to the extent applicable to the transaction covered by this Agreement, the appropriate Form under the Property Transfer Law, on which Sharon shall sign as transferor and Newco shall sign as transferee, together with an Environmental Condition Assessment Form prepared by a Licensed Environmental Professional and a bank check or money order in the amount of the initial filing fee required by the Property Transfer Law and all other forms and documentation necessary to comply with the Property Transfer Law, provided, however, that if a Form III or Form IV is required under the Property Transfer Law, Sharon shall also sign as the Certifying Party (capitalized terms as defined under the Property Transfer Law); and

(q) such other instruments and documents as Buyer reasonably deems necessary to effectuate the transactions contemplated hereby.

3.3 Actions of Buyer at the Closing. At the Closing and unless otherwise waived in writing by the Sellers, Buyer shall deliver to the Sellers the following:

(a) the amount of the Purchase Price set forth in Section 2.6(a), which shall be transferred to the Sellers by wire transfer of immediately available funds to an account or accounts of Sellers' designation;

(b) the Assignment and Assumption Agreements, fully executed by a duly authorized officer of the appropriate Buyer or Affiliate designated by Buyer, pursuant to which each such Buyer shall assume the future performance of the Assumed Contracts, the Tenant Leases and the Seller Leases as contemplated herein;

(c) the Transition Services Agreement, executed by a duly authorized officer of Buyer;

(d) a copy of resolutions duly adopted by the governing body of each Buyer, authorizing and approving such Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing Date by an appropriate officer of such Buyer;

(e) a certificate of the President, a Vice President or other appropriate officer of each Buyer, certifying the fulfillment of the conditions set forth in ARTICLE IX;

(f) a certificate of incumbency for the officers of each Buyer executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(g) a certificate of existence and good standing of Newco from the Secretary of State of the State of Connecticut and a certificate of existence and good standing of Health Quest from the Secretary of State of the State of New York, each dated the most recent practical date prior to the Closing Date;

(h) the Management Agreement executed by Newco or its affiliate, as Manager; and

(i) such other instruments and documents as the Sellers reasonably deem necessary to effectuate the transactions contemplated hereby.

ARTICLE IV

REPRESENTATIONS AND WARRANTIES OF THE SELLERS

The Sellers, jointly and severally, represent and warrant to Buyer the following, as of the date hereof and as of the Closing Date:

4.1 Existence and Capacity.

(a) Each of RCHP and SHHC is a Delaware corporation, validly existing and in good standing under the laws of the State of Delaware.

(b) Each of TSWS and RHA is a Connecticut limited liability company, validly existing and in good standing under the laws of the State of Connecticut.

(c) Sharon is a Connecticut corporation, validly existing and in good standing under the laws of the State of Connecticut, whose sole shareholder is SHHC, an indirect wholly-owned subsidiary of RCHP. No other party owns, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in Sharon, nor are there any outstanding subscriptions, options, warrants, puts, calls, agreements, understandings, rights of first refusal, or other commitments of any type relating to the issuance, sale, transfer or voting of any securities of Sharon.

(d) None of the Sellers own, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in any corporation, partnership, limited partnership, limited liability company or other entity or association, nor does any Seller own or hold any right of first refusal, purchase option or other rights with respect thereto.

(e) Exhibit A sets forth each of the Facilities owned, leased or operated by the Sellers. Except as set forth on Exhibit A, none of the Sellers own, lease or operate any healthcare facility.

(f) Each of the Sellers has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by the Sellers and all other agreements referenced herein, or ancillary hereto, to which any of the Sellers is a party, and the consummation of the transactions contemplated herein by the Sellers:

(a) are within each Seller's organizational powers, are not in contravention of law or of the terms of such Seller's organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 4.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) except as set forth on Schedule 4.19(d), will not conflict with, require consent under or result in any breach or contravention of, or the creation of any lien, charge, or encumbrance, under any Assumed Contract, Tenant Lease or Seller Lease;

(d) will not violate any statute, law, ordinance, rule or regulation of any governmental authority to which any Seller or the Assets may be subject; and

(e) will not violate any judgment, decree, order, writ or injunction of any court or governmental authority to which any Seller or the Assets may be subject.

4.3 Binding Agreement. This Agreement and all agreements to which any of the Sellers will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of such Seller, and are and will be enforceable against such Seller in accordance with the respective terms hereof or thereof.

4.4 Financial Statements. Each of the Sellers has made available to Buyer copies of the following financial statements of or pertaining to the Business and the Assets (the "**Financial Statements**"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 4.4(a):

(a) unaudited Balance Sheet dated as of May 31, 2016;

(b) unaudited Income Statement for the four month period ended on May 31, 2016; and

(c) audited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal years ended September 30, 2013, September 30, 2014 and for the fiscal year ended September 30, 2015 (the "**Balance Sheet Date**").

Such Financial Statements are true, complete and accurate in all material respects, and conform to GAAP consistently applied, except as set forth in Schedule 4.4(a). The audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such Balance Sheets present fairly in all material respects the financial condition of the Business as of the dates indicated thereon, and such Income Statements present fairly in all material respects the results of operations of the Business for the periods indicated thereon.

4.5 Certain Post-Balance Sheet Results. Except as set forth on Schedule 4.5, since the Balance Sheet Date, there has not been any:

(a) material damage, destruction or loss (whether or not covered by insurance) affecting the Business or the Assets;

(b) threatened employee strike, work stoppage or labor dispute pertaining to the Facilities;

(c) sale, assignment, transfer or disposition of any item of property, plant or equipment included in the Assets having a value in excess of Twenty Five Thousand Dollars ($25,000), except in the ordinary course of business with comparable replacement thereof;

(d) other than in the ordinary course of business and consistent with prior practice or as required by applicable law, increase in the compensation payable by any of the Sellers to any of such entity's employees or independent contractors, or any increase in, or establishment or amendment of, any bonus, insurance, pension, profit-sharing or other employee benefit plan, remuneration or arrangements made to, for or with such employees;

(e) changes in the composition of the medical staff of the Hospital, other than normal turnover occurring in the ordinary course of business;

(f) changes in the rates charged by the Facilities for their services, other than those made in the ordinary course of business;

(g) adjustments or write-offs in accounts receivable or reductions in reserves for accounts receivable outside the ordinary course of business of the Facilities; or

(h) change in accounting policies or procedures of the Sellers.

4.6 Licenses. The Hospital is duly licensed as a general acute care hospital pursuant to the applicable laws of the State of Connecticut. The Hospital (including, without limitation, all ancillary departments located at the Hospital or operated for the benefit of the Hospital that are required to be specially licensed) holds all licenses material to the operation of the Business as presently operated. Each of the other Facilities has all other licenses, registrations, permits and approvals that are needed or required by law to operate the businesses related to or affecting the

Facilities, the Assets or any ancillary services related thereto. Schedule 4.6 sets forth an accurate list of all such licenses, registrations, permits and approvals, identifying specifically each Seller Party and Facility related thereto, all of which if held by a Seller or the Sellers, are now, and as of the Closing Date shall be, in good standing and, to the knowledge of the Sellers, are not subject to meritorious challenge, and except as set forth on Schedule 4.6, no such licenses are subject to renewal within less than one (1) year of the date of this Agreement.

4.7 Certificates of Need. Except as set forth on Schedule 4.7 hereto, no application for any Certificate of Need, Exemption Certificate or declaratory ruling (an "**Application**") has been made by any of the Sellers with the Connecticut Department of Public Health Office of Health Care Access ("**OCHA**") or other agency having jurisdiction thereof that is currently pending or open before such agency. No Seller has prepared, filed, supported or presented opposition to any Application filed by another hospital or other entity within the past three (3) years. Except as set forth on Schedule 4.7 hereto, no Seller has any Application pending nor any approved Application which relates to a project not yet completed. Each Seller a has properly filed all required Applications with respect to any and all improvements, projects, changes in services, zoning requirements, construction and equipment purchases, and other changes for which approval is required under any applicable federal or state law, rule or regulation, and all such Applications are complete and correct in all material respects.

4.8 Medicare Participation; Accreditation. Each of the Facilities are qualified for participation in the Medicare, Medicaid and CHAMPUS/TRICARE programs; have current and valid provider contracts with such programs; are in material compliance with the conditions of participation and, where applicable, conditions of coverage for such programs; have received all approvals or qualifications necessary for reimbursement; and are accredited by the Joint Commission (the "**Joint Commission**"). A copy of the most recent letter from the Joint Commission pertaining to each of the Facilities' accreditation has been made available to Buyer. All billing practices of each of the Sellers, with respect to all third party payors, including the Medicare, Medicaid and CHAMPUS/TRICARE programs (including the Medicare conditions of participation) and private insurance companies, are in material compliance with all applicable laws and regulations and participating provider agreements of such third party payors and the Medicare, Medicaid and CHAMPUS/TRICARE programs, and none of the Sellers or the Facilities has retained any payment or reimbursement in excess of amounts allowed by law. None of the Facilities has been excluded from participation in the Medicare, Medicaid or CHAMPUS/TRICARE programs, nor, to the knowledge of the Sellers, is any such exclusion threatened. Attached as Schedule 4.8 is a listing of each of the Facilities' active provider numbers with the Medicare and Medicaid programs. To the knowledge of the Sellers, each provider agreement to which a Seller is a party is in full force and effect and no events or facts exist that would cause any such provider agreement not to remain in force or effect after the Closing. None of the officers, directors, employees, physicians or independent contractors of any of the Sellers has been excluded from participating in any federal health care program during the past four years, nor, to the knowledge of the Sellers, is any exclusion threatened or pending. Except as set forth on Schedule 4.8, none of the Sellers are aware of or have received any notice from any of the Medicare, Medicaid or CHAMPUS/TRICARE programs, or any other third party payor program, of any pending or threatened investigations.

4.9 Regulatory Compliance. Except as set forth on Schedule 4.9, each of the Facilities, the Business and the Assets has been and presently is in material compliance with all applicable statutes, rules and regulations of any federal, state and local commissions, boards, bureaus, and agencies having jurisdiction over the Facilities and the Assets, including, but not limited to the false claims, false representations, anti-kickback and all other provisions of the Medicare/Medicaid fraud and abuse laws (42 U.S.C. Section 1320a-7 *et seq.*) and the physician self-referral provisions of the Stark Law (42 U.S.C. Section 1395nn). Each of the Sellers has timely filed all material reports, data, and other information required to be filed with such commissions, boards, bureaus, and agencies regarding the Business and the Assets. All of the Sellers' contracts with physicians or other healthcare providers or entities in which physicians or other healthcare providers are equity owners (collectively, "**Healthcare Providers**") involving services, supplies, payments or any other type of remuneration, whether such services or supplies are provided by a Healthcare Provider to a Seller or by a Seller to a Healthcare Provider, and all of Sellers' leases of personal or real property with Healthcare Providers, whether such personal or real property is provided by a Healthcare Provider to a Seller or by a Seller to a Healthcare Provider, are, to the extent required by law, in writing, are signed, set forth the services to be provided, and provide for a fair market value compensation in exchange for such services, space or goods. None of the Sellers, the Facilities or any of their respective officers, directors, or managing employees have engaged in any activities that are prohibited under 42 U.S.C. Section 1320a-7 *et seq.*, or the regulations promulgated thereunder, or under any other federal or state statutes or regulations, including but not limited to the following:

(a) knowingly and willfully making or causing to be made a false statement or representation of a material fact in any application for any benefit or payment;

(b) knowingly and willfully making or causing to be made a false statement or representation of a material fact for use in determining rights to any benefit or payment;

(c) presenting or causing to be presented a claim for reimbursement for services under Medicare, Medicaid or other state or federal healthcare program that is for an item or service that is known, or should be known, to be (i) not provided as claimed or (ii) false or fraudulent;

(d) failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment on its own behalf or on behalf of another, with intent to fraudulently secure such benefit or payment;

(e) knowingly and willfully offering, paying, soliciting or receiving any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind, (i) in return for referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made in whole or in part by Medicare, Medicaid, or a state healthcare program or (ii) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part by Medicare, Medicaid or a state healthcare program;

(f) knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit necessary services to individuals who are under the direct care of the physician and who are entitled to benefits under Medicare, Medicaid or a state healthcare program;

(g) providing to any person information that is known or should be known to be false or misleading that could reasonably be expected to influence the decision when to discharge a patient from any Facility;

(h) knowingly or willfully making or causing to be made or inducing or seeking to induce the making of any false statement or representation (or omitting to state a material fact) required to be stated therein (or necessary to make the statement contained therein not misleading) of a material fact with respect to (i) the conditions or operations of a Facility in order that such Facility may qualify for Medicare, Medicaid, or a state healthcare program certification or (ii) information required to be provided under Section 1124A of the Social Security Act (42 U.S.C. Section 1320a-3a); or

(i) knowingly and willfully (i) charging for any Medicaid service money or other consideration at a rate in excess of the rates established by the state or (ii) charging, soliciting, accepting or receiving, in addition to amounts paid by Medicaid, any gift money, donation or other consideration (other than a charitable, religious, or other philanthropic contribution from an organization or from a person unrelated to the patient) (A) as a precondition of admitting the patient or (B) as a requirement for the patient's continued stay in a Facility.

Each of the Sellers and the Facilities: (i) is in material compliance with HIPAA and any applicable state and federal laws and regulations concerning the privacy and/or security of data (collectively, "**Information Privacy and Security Laws**"); (ii) is not under investigation by any governmental authority for a violation of any Information Privacy and Security Laws; (iii) has not received any written notices or audit requests from any governmental authority, including the United States Department of Health and Human Services Office for Civil Rights, Department of Justice, Federal Trade Commission, or the Attorney General of the United States or any governmental authority of any state relating to any such violations, and (iv) to the knowledge of the Sellers, no such investigation or violation has been threatened by a governmental authority.

4.10 Equipment. Set forth on Schedule 4.10 is a depreciation schedule that lists all Assets having a positive book value as of May 31, 2016. All of the Assets consisting of equipment, whether reflected in the Financial Statements or otherwise, are in good operating condition and repair, reasonable wear and tear excepted and except for items that have been written down in the Financial Statements to a realizable market value. Except as disclosed on Schedule 4.10, the only transactions related thereto since May 31, 2016 have been additions thereto and dispositions thereof in the ordinary course of business.

4.11 Real Property. The Sellers own good, insurable and marketable fee title to the Owned Real Property, together with all appurtenances and rights thereto, and good and insurable leasehold title to the Leased Real Property, which ownership interests, as of the Closing Date, will be free and clear of any and all mortgages, deeds of trust, security interests, mechanics or other liens or encumbrances, covenants, conditions, restrictions, reservations, easements or other

matters of record materially adversely affecting the Real Properties, subject only to those matters more particularly described on Schedule 4.11 (the "**Permitted Encumbrances**"). Except as set forth on Schedule 4.11 or otherwise disclosed to Buyer in a writing referencing this Section 4.11 on the date hereof, all improvements, including all utilities which are a part of the Real Property, have been substantially completed and installed in accordance with the plans and specifications approved by the governmental entities having jurisdiction thereover to the extent required by law and to the extent applicable and are transferable to Buyer. Permanent certificates of occupancy, all licenses, permits, Certificates of Need (if applicable), authorizations and approvals required by all governmental entities having jurisdiction thereover, and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions), have been issued for the Real Property, and, as of the Closing, all of the same will be in full force and effect. Subject to Section 4.12, to the knowledge of the Sellers, the improvements which are a part of the Owned Real Property, as designed and constructed, comply with all statutes, restrictions, regulations and ordinances applicable thereto, including but not limited to the ADA and Section 504 of the Rehabilitation Act of 1973. Subject to Section 4.12, the existing water, sewer, gas and electricity lines, storm sewer and other utility systems on or serving the Real Property are, to the knowledge of the Sellers, adequate to serve the utility needs of the Real Property. All approvals, licenses and permits required for said utilities have been obtained and are, and will be as of the Closing, in full force and effect. All of said utilities are installed and operating, and all installation and connection charges have been paid in full. Subject to Section 4.12, the location, construction, occupancy, operation and use of the Real Property (including the improvements which are a part of the Real Property) do not violate any applicable law, statute, ordinance, rule, regulation, order or determination of any governmental authority or any board of fire underwriters (or other body exercising similar functions), judicial precedent or any restrictive covenant or deed restriction (recorded or otherwise) affecting the Real Property or the location, construction, occupancy, operation or use thereof, including, without limitation, all applicable laws. The Real Property comprises all of the real property currently used in connection with the Business or the Assets. Subject to Section 4.12, with respect to the Real Property:

(a) except as described on Schedule 4.11(a), no Seller has received during the past three (3) years notice of a violation of any applicable ordinance or other law, order, regulation, or requirement or notice of condemnation, lien, assessment, or the like relating to any part of the Owned Real Property or Leased Real Property or the operation thereof, and has no knowledge of any such violation, proceeding, lien or assessment;

(b) except as described on Schedule 4.11(b), such properties and their operation are in compliance with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and no Seller has received a written notice that the buildings and improvements constituting a portion of such properties do not comply with all building codes;

(c) except for the Permitted Encumbrances, such properties, are subject to no easements, covenants, conditions, restrictions, reservations encumbrances, or such other limitations or matters of record so as to make any such property unusable for its current use or the title thereof uninsurable or unmarketable or which restrict or impair its use, marketability, value or insurability;

(d) except as described on Schedule 4.11(d), there is no pending, or to the knowledge of the Sellers, threatened litigation, administrative action or complaint (whether from a state, federal or local government or from any other person, group or entity) relating to the Real Property, including compliance of any of such properties with the Rehabilitation Act of 1973, Title III of the ADA or any comparable state statute related to accessibility;

(e) with respect to the Owned Real Property and the Leased Real Property, there are no tenants or other persons or entities occupying any space in such properties other than pursuant to the Tenant Leases described in Schedule 2.1(h);

(f) except as described on Schedule l2.1(j), no Seller is a party to any Seller Lease;

(g) attached as Schedule 4.11(g) is a "rent roll" for all Tenant Leases that sets forth (i) the premises covered; (ii) the date of the Tenant Lease and all amendments and modifications thereto; (iii) the name of the tenant, subtenant, licensee or occupant; (iv) the term; (v) the rents and other charges payable thereunder; (vi) the rents or other charges in arrears or prepaid thereunder, if any, and the period for which any such rents and other charges are in arrears or have been prepaid; (vii) the nature and amount of the security deposits thereunder, if any; and (viii) options to renew or extend the term contained in the Tenant Lease;

(h) except as described on Schedule 4.11(h), no Seller has received any written notice, and has no knowledge, of any existing, proposed or contemplated plans to modify or realign any street or highway or any existing, proposed or contemplated eminent domain proceeding that would result in the taking of all or any part of such properties or that would adversely affect the current use of any part thereof;

(i) except as described on Schedule 4.11(i), the existing improvements located upon such properties do not, with respect to the Facilities, encroach upon adjacent premises or upon existing utility company easements, and existing restrictions are not violated by the improvements located on such properties;

(j) except as described on Schedule 4.11(j), no party owns or holds any right of first refusal to purchase or lease or an option to purchase or lease all or any portion of the Real Property;

(k) except as set forth in Schedule 4.11(k), there will be no incomplete construction projects affecting the Real Property as of the Closing Date. Schedule 4.11(k) identifies all design service contracts, engineering services contracts, construction contracts and construction management contracts relating to those construction projects that will be incomplete as of the Closing Date;

(l) except as set forth in Schedule 4.11(l), all Existing TI Obligations will have been fully performed and funded by each of the Sellers on or before the Closing Date;

(m) no Seller is a person or entity with whom U.S. persons are restricted from doing business with under regulations of the OFAC of the Department of Treasury (including those named on the OFAC's Specially Designated and Blocked Persons list) or under any statute,

executive order (including Executive Order 13224), or the USA Patriot Act, or any other governmental action;

(n) no subdivision shall be required for the lawful conveyance of the Owned Real Property to Buyer; and

(o) no brokerage or leasing commissions or other compensation will be due or payable as of Closing to any person, firm, corporation or other entity with respect to, or on account of, any Tenant Lease, any Seller Lease or any extensions or renewals thereof.

With respect to each Seller Lease, (i) Sellers are not in default beyond any applicable cure or grace period in any respect under any of such Seller Leases, and, to Sellers' knowledge, no other party to any such Seller Lease is in default thereunder, and to Sellers' knowledge, no conditions or events exist which, with the giving of notice or passage of time, or both, would constitute a default under any such Seller Lease, (ii) Sellers' possession and quiet enjoyment of the Leased Real Property under any such Seller Lease is not being disturbed as of the date of this Agreement, and there are no current material disputes with respect to any such Seller Lease that has not been disclosed to Buyer, (iii) no security deposit or portion thereof deposited with respect to such Seller Lease has been applied in respect of a breach or default under such Seller Lease which has not been redeposited in full, (iv) Sellers do not owe, nor will owe in the future, any brokerage commissions or finder's fees with respect to such Seller Lease, and (v) Sellers have not collaterally assigned or granted any security interest in such Seller Lease or any interest therein.

4.12 Title, Condition, and Sufficiency of the Assets.

(a) As of the Closing Date, the Sellers shall own and hold good and valid title to all of the Assets, subject only to the Permitted Encumbrances and Assumed Liabilities. Sellers are the sole and exclusive owners of the Assets.

(b) Except as otherwise set forth on Schedule 4.12, in respect of their physical condition and defects, the Real Property and all machinery and equipment used in the operation of the Business are in good operating condition and repair, reasonable wear and tear excepted, and suitable for the purpose for which they are intended. Except as set forth on Schedule 4.12, there are no material defects, structural or other, in any of the Assets, including, without limitation, the Real Property and the implements, machinery and equipment used in the Business. All of the Personal Property is located at one of the Facilities unless noted on Schedule 2.1(c). Except for the Excluded Assets and services provided under the Transition Services Agreement, the Assets comprise substantially all of the assets and properties currently used in connection with the operation of the Business.

4.13 Employee Benefit Plans.

(a) Schedule 4.13(a) includes a true, complete and correct list of all "employee benefit plans," as defined in ERISA, all specified fringe benefit plans as defined in Section 6039D of the IRC, and all other pension, profit-sharing, stock bonus, stock option, deferred compensation, or other retirement plans; welfare benefit plans; executive compensation, bonus, or incentive plans; severance plans; salary continuation plans, programs, or arrangements;

vacation, holiday, sick-leave, paid-time-off, or other employee compensation, bonus, or incentive plans, procedures, programs, payroll practices, policies, agreements, commitments, contracts, or understandings; or any annuity contracts, custodial agreements, trusts or other agreements related to any of the foregoing (collectively, the "**Benefit Plans**"), whether qualified or nonqualified, funded or unfunded, (i) that are currently, or have been within the past six (6) years, sponsored, maintained or contributed to by any of the Sellers or any ERISA Affiliate; (ii) with respect to which any of the Sellers or any ERISA Affiliate has any liability or obligation to any current or former officer, employee or service provider, or the dependents of any thereof; or (iii) which could result in the imposition of liability or any obligation of any kind or nature, whether accrued, absolute, contingent, direct, indirect, perfected or inchoate or otherwise, and whether or not now due or to become due to any of the Sellers or any ERISA Affiliate. Schedule 4.13(a) shall further identify which of the Benefit Plans listed on the Schedule have any individuals providing services at the Facilities participating in such Benefit Plan (the "**Facility Benefit Plans**")

(b) With respect to the Facility Benefit Plans, Sellers have made available to Buyer accurate and complete copies of the Facility Benefit Plans; the Facilities Benefit Plan's insurance contracts or any other funding instruments; governmental rulings or other correspondence pertaining to the Facility Benefit Plans; determination, advisory, notification, or opinion letters with respect to the Facility Benefit Plans; summary plan descriptions, modifications, memoranda, employee handbooks, and other material written communications regarding the Facility Benefit Plans; and such other documents, records, or other materials related thereto reasonably requested by Buyer. All returns, reports, disclosure statements, and premium payments with respect to any Facilities Benefit Plan have been or will be timely filed, delivered, or paid, as applicable and as required by applicable law.

(c) Except as set forth on Schedule 4.13(c), none of the Sellers or any ERISA Affiliate has ever participated in or sponsored, contributed to, or had an obligation to contribute to a plan subject to Section 412 of the IRC, Section 302 of ERISA and/or Title IV of ERISA, which is a multiemployer plan, which is a multiple employer plan or single employer plan to which at least two or more of the contributing sponsors are not part of the same controlled group; participated in any benefit plan that is a multiple employer welfare arrangement.

(d) Each Benefit Plan that is a pension or other retirement plan and each related trust agreement, annuity contract, or other funding instrument is and has been since its inception qualified and tax-exempt under the provisions of Sections 401(a) and 501(a) of the IRC, respectively; each Benefit Plan that is a nonqualified deferred compensation plan and each related trust agreement, insurance contract, or other funding instrument is in compliance with the requirements of Section 409A of the IRC; and no governmental entity has instituted or threatened a proceeding to terminate any Benefit Plan or to appoint a new trustee for such Benefit Plan. All Benefit Plans have been operated and administered in accordance with their terms and all applicable laws, including ERISA and the IRC.

(e) No Benefit Plan is currently or has been within the last six (6) years under audit, inquiry, or investigation by any governmental entity, and there are no outstanding issues with reference to the Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or

investigations pending or, to the knowledge of the Sellers, threatened against or with respect to any of the Benefit Plans or their assets.

(f) Each of the Sellers and each of the ERISA Affiliates is in material compliance with the continuation coverage provisions of COBRA with respect to all current and former employees and their beneficiaries who provide services at the Facilities. No Facility Benefit Plans provide for the continuation of, medical, dental, vision, life or disability insurance coverage for any current or former employees performing services at the Seller Facility, or their spouses, their dependents or beneficiaries, for any period of time beyond termination of employment (except to the extent of coverage required under COBRA).

(g) The consummation of the transactions contemplated by this Agreement will not accelerate the time of vesting or payment, or increase the amount of any compensation payable to any current or former employee of Seller.

4.14 Litigation or Proceedings. Except as set forth on Schedule 4.14, there are no claims, actions, suits, proceedings, investigations, judgments, decrees, orders, writs or injunctions pending or, to the knowledge of the Sellers, threatened against or related to any of the Sellers, the Business or the Assets, at law or in equity, or before or by any governmental entity. None of the Sellers are in default under any judgment, decree, order, writ or injunction of any court or governmental entity.

4.15 Hill-Burton and Other Liens. None of the Sellers nor any of their predecessors have received any loans, grants or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act or the Community Mental Health Centers Act, as amended, or similar laws or acts relating to healthcare facilities that remain unpaid or which impose restrictions on the operation of the Facilities or the Assets.

4.16 Taxes. Each of SHHC and Sharon have, and except as set forth on Schedule 4.16, to Seller's knowledge RHA and TSWS have, filed all Tax Returns required to be filed by them (all of which are true and correct in all material respects). All Taxes due and owing by each of SHHC and Sharon and, to Sellers' knowledge, RHA and TSWS, (whether or not shown on any Tax Return) have been paid. Neither SHHC nor Sharon and to Seller's knowledge, neither RHA nor TSWS, has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency. Except as set forth on Schedule 4.16(a), neither SHHC nor Sharon is currently the beneficiary of any outstanding extension of time within which to file any Tax Return. Each of SHHC and Sharon has withheld and paid and to SHHC's knowledge, RHA and TSWS have withheld and paid, all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no dispute or claim concerning any Tax liability of either SHHC or Sharon or to Sellers' knowledge, of RHA or TSWS, either (i) claimed or raised in writing by any governmental authority or (ii) as to which the Sellers have knowledge. Except as set forth on Schedule 4.16(b), no Tax Returns of SHHC, or Sharon or to Sellers' knowledge RHA or TSWS, have been audited during the last five (5) years or are currently under audit by any governmental authority. Within

the preceding five (5) years, neither SHHC nor Sharon, and to Sellers' knowledge, neither RHA nor TSWS have received a written claim by a governmental authority in a jurisdiction where any Seller does not file Tax Returns that it is or may be subject to taxation by that jurisdiction due to the operation of the Business or the location of the Assets. Neither Sharon nor SHHC have taken, and to SHHC's knowledge, neither RHA nor TSWS have taken, and will not take any action in respect of any Taxes (including, without limitation, any withholdings required to be made in respect of employees) that may have a material adverse Tax impact upon the Facilities or the Assets as of or subsequent to the Closing Date. Neither SHHC nor Sharon, and to Sellers' knowledge, neither RHA nor TSWS is a party to any Tax allocation or sharing agreement or to any "closing agreement" as described in Code Section 7121 (or any corresponding or similar provision of state, local or non-U.S. tax law), other than (i) any agreement that will terminate as of the Closing Date or (ii) contained in a lease or other contract whose primary purpose is not Tax. There are no Tax liens on any of the Assets or Facilities other than statutory liens for Taxes not yet overdue and, to the knowledge of the Sellers, no basis exists for the imposition of any such liens. Except as provided on Schedule 4.16(c), none of the Assets constitutes an ownership interest in a joint venture, partnership or other arrangement or contract that, to the knowledge of the Sellers, could be treated as a partnership for federal income tax purposes.

4.17 Employee Relations.

(a) Except as set forth on Schedule 4.17(a), all employees who provide services at any of the Facilities are employees of the Sellers. The Sellers are not a party to or bound by any collective bargaining agreement, project labor agreement, memorandum of understanding, letter agreement, side agreement, contract or any other agreement or understanding with a labor union or labor organization. There has not been within the last three (3) years, there is not presently pending or, to the knowledge of the Sellers, threatened, any strike, slowdown, picketing, work stoppage, or employee grievance process, or any proceeding against or affecting any of the Sellers relating to an alleged violation of any legal requirements pertaining to labor relations, including any charge, complaint or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any governmental entity, organizational activity, or other labor dispute against or affecting any of the Sellers or their operations or assets.

(b) Each of the Sellers has materially complied with all legal requirements relating to employment; employment practices; terms and conditions of employment; equal employment opportunity; nondiscrimination; immigration; wages; hours; benefits; payment of employment, social security, and similar taxes; occupational safety and health; and plant closing. Except as set forth on Schedule 4.17(b), there are no pending or, to the knowledge of the Sellers, threatened claims for failure to comply with any of the foregoing legal requirements. The Sellers will give all notices and make all filings required to comply with the provision of the Worker Adjustment and Retraining Notification Act or any similar state law (collectively referred to as the "**WARN Act**").

(c) The Sellers have made available to Buyer, to the extent requested by Buyer, the personnel records for all employees of the Sellers potentially affected by the transactions contemplated by this Agreement, including records reflecting salary or wages, and sick (or extended illness), paid-time-off, and vacation leave that is accrued or credited but unused

or unpaid. Schedule 4.17(c)(i) lists each employment, consulting, independent contractor, bonus or severance agreement to which any of the Sellers is a party. Each of the Benefit Plans, Sellers and all ERISA Affiliates has properly classified individuals providing services to any of the Sellers as independent contractors or employees, as the case may be. As of the Closing Date, Schedule 4.17(c)(ii) shall set forth the employees who had an "employment loss," as such term is defined in the WARN Act or any similar state or local legal requirements, within the ninety (90) days preceding the Closing Date; in relation to the foregoing, the Sellers have not violated the WARN Act or any similar state or local legal requirements.

4.18 Agreements and Commitments. Schedule 4.18 sets forth an accurate list of all commitments, contracts, leases, and agreements, written or oral, relating to the Business or the Assets to which any Seller is a party or by which any of the Sellers or the Assets or any portion thereof is bound that are: (a) Physician Agreements, (b) those that by their terms do not expire or are not terminable prior to the first anniversary of the date hereof, (c) the Hospital's top eight contracts, which together with the government payment programs, self-pay and other non-contracted payers, including out-of-state Blue Cross plans other than the Empire and Anthem contracts provided, represent not less than 95% of the Hospital's revenue for 2015, or (d) any other contracts or commitments not identified in (a)-(c) above, except for managed care contracts and contracts that involve the provision of items or services to more than one hospital owned directly or indirectly by RCHP, whether in the ordinary course of business or not, which involve future payments, performance of services or delivery of goods or materials, to or by any of the Sellers in an amount exceeding $25,000 on an annual basis (collectively "**Material Contracts**").

4.19 The Material Contracts, Tenant Leases and Seller Leases. Schedule 2.1(h) sets forth an accurate list of the Tenant Leases. Schedule 2.1(i) sets forth an accurate list of the Seller Leases. The Sellers have made available to Buyer accurate copies of the Material Contracts, the Tenant Leases and the Seller Leases. The Sellers represent and warrant with respect to the Material Contracts, the Tenant Leases and the Seller Leases that:

(a) the Material Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of one or more of the Sellers and are enforceable against such Sellers in accordance with their respective terms, and, to the knowledge of the Sellers, the Material Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of the other party or parties to the Material Contracts, the Tenant Leases and the Seller Leases and are enforceable against such parties in accordance with their terms;

(b) each Material Contract, Tenant Lease or Seller Lease constitutes the entire agreement by and between the respective parties thereto with respect to the subject matter thereof;

(c) all obligations required to be performed by one or more of the Sellers under the terms of the Material Contracts, the Tenant Leases and the Seller Leases have been performed in all material respects, and no Seller has received notice that any act or omission by any such Seller has occurred or failed to occur which, with the giving of notice, the lapse of time or both, would constitute a default under any such Material Contract, Tenant Lease or Seller Lease, and each of such Material Contracts, Tenant Leases and Seller Leases is now and at the Closing Date will be in full force and effect without default on the part of any of the Sellers;

(d) except as expressly set forth on Schedule 4.19(d), none of Material Contracts, the Tenant Leases or the Seller Leases requires consent to its assignment to and assumption by Buyer; and

(e) except as expressly set forth on Schedule 4.19(e), the assignment of the Material Contracts, the Tenant Leases and the Seller Leases to and the assumption of such Material Contracts, Tenant Leases and Seller Leases by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits or obligations of any party thereunder.

4.20 Supplies. All the inventory and supplies constituting any part of the Assets are of a quality and quantity usable and saleable in the ordinary course of business of the Business.

4.21 Insurance. Schedule 4.21 sets forth an accurate schedule disclosing the Sellers' insurance policies covering the Business and the Assets, which Schedule reflects the policies' numbers, identity of insurers, amounts, coverage, and, with respect to professional liability coverage, identifies whether such coverage is on an occurrence basis or on a claims made basis. All of such insurance policies are in full force and effect with no premium arrearage. Each of the Sellers has given in a timely manner to its respective insurers all notices required to be given under such insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Except as set forth on Schedule 4.21, none of the Sellers has (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies and, to the knowledge of the Sellers, no such cancellation or amendment is threatened or (b) failed to give any required notice or to present any claim which is still outstanding under any of such policies with respect to the Business or any of the Assets.

4.22 Third Party Payor Cost Reports. Each of the Sellers has duly filed all required Seller Cost Reports for all fiscal years through and including the fiscal year ended September 30, 2015. All of such Seller Cost Reports accurately reflect the information required to be included thereon and such cost reports do not claim, and none of the Facilities nor any of the Sellers have retained, reimbursement in any amount in excess of the amounts provided by law or any applicable agreement. Schedule 4.22 indicates which of such Seller Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances and any and all other unresolved claims or disputes in respect of such cost reports. Each of the Sellers has established adequate reserves to cover any potential reimbursement obligations that such Seller may have in respect of any such Seller Cost Reports, and such reserves are accurately set forth in the Financial Statements.

4.23 Medical Staff Matters. The Sellers have made available to Buyer true, correct and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital, as well as a list of all current members of the medical staff. Except as set forth on Schedule 4.23, there are no adverse actions with respect to any medical staff member of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the knowledge of the Sellers, threatened disputes with applicants, staff members or health professional affiliates, and all appeal periods in respect of any adverse actions

against any medical staff member or applicant have expired. Schedule 4.23 sets forth a brief description of all adverse actions taken against medical staff members or applicants during the past three (3) years that could result in claims or actions against any of the Sellers and which are not disclosed in the minutes of the meetings of the Medical Executive Committee of the Medical Staff of the Hospital, which minutes have been made available to Buyer.

4.24 Experimental Procedures. During the past five (5) years, the Facilities have not performed or permitted the performance of any experimental or research procedure or study involving patients in the Facilities not authorized and conducted in accordance with applicable law and the procedures of the Facilities.

4.25 Compliance Program. The Sellers have made available to Buyer a copy of the Facilities' current compliance program materials, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth on Schedule 4.25, none of the Sellers (a) are a party to an outstanding Corporate Integrity Agreement with the OIG of HHS, (b) have reporting obligations pursuant to any settlement agreement entered into with any governmental entity, (c) to the knowledge of the Sellers, have been the subject of any government payor program investigation conducted by any federal or state enforcement agency, or (d) to the knowledge of the Sellers, have been a defendant in any *qui tam*/False Claims Act litigation and, to the knowledge of the Sellers, no such litigation is threatened. For purposes of this Agreement, the term "**compliance program**" refers to provider programs of the type described in the compliance guidance published by the OIG of HHS.

4.26 Environmental Matters. Except as set forth on Schedule 4.26:

(a) The operations and properties of each of the Sellers are and at all times have been in compliance with the Environmental Laws, which compliance includes but is not limited to the possession by the appropriate Seller of all permits and governmental authorizations required under applicable Environmental Laws, and compliance with the terms and conditions thereof, all such permits and governmental authorizations are valid and in good standing and there is no action pending or threatened to revoke, cancel, terminate, modify or otherwise limit any such permit or governmental authorization.

(b) None of the Sellers has (nor, to the knowledge of the Sellers, has any third party) treated, stored, managed, disposed of, transported, handled, released or used any Material of Environmental Concern, except in the ordinary course of its business and in compliance with all Environmental Laws.

(c) There are no Environmental Claims pending or, to the knowledge of the Sellers, threatened against any of the Sellers, and, to the knowledge of the Sellers, no circumstances exist that could reasonably be expected to lead to the assertion of an Environmental Claim against any Seller Party.

(d) To the knowledge of the Sellers, there are no off-site locations where any of the Sellers have stored, disposed or arranged for the disposal of Materials of Environmental

Concern in violation of any Environmental Laws or that are listed on the Comprehensive Environmental Response, Compensation and Liability Act National Priority List or any state equivalent, and none of the Sellers has been notified in writing that it or any such entity is a potentially responsible party at any such location under any Environmental Laws.

(e) None of the Sellers has assumed or undertaken or otherwise become subject to any liability or corrective, investigatory or remedial obligation of any other person relating to any Environmental Law.

(f) (i) except as set forth on Schedule 4.26(f)(i), there are no underground storage tanks located on property owned, leased or operated by any of the Sellers; (ii) there is no asbestos-containing material (as defined under Environmental Laws) contained in or forming part of any building, building component, structure or office space owned, leased or operated by any of the Sellers; and (iii) there are no PCBs or PCB-containing items contained in or forming part of any building, building component, structure or office space owned, leased or operated by any of the Sellers.

(g) No property used in the Sellers' operation is subject to an encumbrance imposed by or arising under any Environmental Law, and except as disclosed on Schedule 4.26(g), there is no proceeding pending or, to the knowledge of the Sellers, threatened for the imposition of such encumbrance, nor to the knowledge of the Sellers, is there any basis for any such encumbrance or proceeding.

(h) The operations of each of the Sellers are and have been for the past four (4) years in material compliance with laws concerning Medical Waste.

(i) The Sellers have provided to Buyer all material reports, assessments, audits, citations, notices, surveys, studies and investigations in the possession, custody or control of the Sellers concerning compliance with or liability or obligation under Environmental Law, including without limitation those concerning the environmental condition of the properties owned, leased or operated by the Sellers.

(j) Except as set forth on Schedule 4.26(j), neither this Agreement nor the consummation of the transaction that is the subject of this Agreement will result in any obligations for site investigation or cleanup, or notification to or consent of government agencies or third parties, pursuant to any of the so-called "transaction-triggered" or "responsible property transfer" Environmental Law, including the Connecticut Transfer Act, Sections 11a-134 through 22a-134e of the Connecticut General Statutes, and any associated regulations and guidance.

4.27 Intellectual Property Rights.

(a) Schedule 4.27(a) contains a true, complete and correct list of all intellectual property that is owned by the Sellers. Except as set forth in Schedule 4.27(a), all Owned Intellectual Property is owned by the Sellers free and clear of all liens, claims and encumbrances. At the Closing, the Sellers will transfer to Buyer good and valid title to the Owned Intellectual Property, free and clear of all liens, claims and encumbrances. Except as described in Schedule 4.27(a), no Seller has granted any license to any person or entity relating to any of the Owned Intellectual Property.

(b) Schedule 4.27(b) contains a true, complete and correct list of all intellectual property (other than software available on reasonable terms on a commercial off the shelf basis from third party vendors) that is used by the Sellers and constitutes all intellectual property (other than the Owned Intellectual Property) used in connection with the operation of the Business.

(c) No Seller has received notice of any unresolved claim asserting a conflict with the rights of another person or entity in connection with the use by it of any of the intellectual property listed in Schedule 4.27(a) or 4.27(b).

(d) Except as set forth on Schedule 4.27(d), all patents, registered copyrights and registered trademarks that are a portion of the intellectual property of the Sellers and applications with respect thereto, (i) have been duly maintained including without limitation the proper, sufficient and timely submission of all necessary filings and fees, (ii) have not lapsed, expired or been abandoned, and (iii) are not the subject of any opposition, interference, cancellation, or other proceeding before any governmental registration or other authority in any jurisdiction.

(e) None of the Sellers has received any notice that infringement exists by it on the intellectual property rights of any other person or entity that results in any way from the Business or the Assets.

4.28 Absence of Undisclosed Liabilities. Except (i) as and to the extent reflected or reserved against in the Financial Statements (which reserves are believed adequate in amount as of the date of such Financial Statements), and (ii) liabilities incurred in the ordinary course of business since May 31, 2016, none of the Sellers has, and is not subject to, any liability or obligation of any nature that is of a type required to be disclosed or reflected in the Financial Statements in accordance with GAAP, whether accrued, absolute, contingent or otherwise, asserted or unasserted, known or unknown.

4.29 Brokers. Except as set forth on Schedule 4.29, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of the Sellers.

4.30 The Sellers' Knowledge. When used herein, the phrases "**to the knowledge of the Sellers**," "**known**" and similar references to the knowledge of the Sellers shall mean and refer to all matters with respect to which (a) any Seller has received a written notice or (b) the actual knowledge of the representatives of the Sellers set forth on Schedule 4.30 after due inquiry of officers and department heads as to the matter in question.

ARTICLE V

REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to the Sellers the following:

5.1 Existence and Capacity. Newco is a nonstock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Health Quest is a New York not-for-profit corporation, duly organized and validly existing in good standing under the laws of the State of New York. Each Buyer has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted.

5.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by the Buyer and all other agreements referenced herein, or ancillary hereto, to which the Buyer is a party and the consummation of the transactions contemplated herein by the Buyer:

(a) are within each Buyer's organizational powers, are not in contravention of law or of the terms of such Buyer's organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 5.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge or encumbrance under, any indenture, agreement, lease, instrument or understanding to which each Buyer is a party or by which it is bound;

(d) will not violate any statute, law, rule or regulation of any governmental authority to which each Buyer may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which each Buyer may be subject.

5.3 Binding Agreement. This Agreement and all agreements to which Buyer will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of Buyer and are and will be enforceable against Buyer in accordance with their respective terms.

5.4 Legal Proceedings. There are no claims, proceedings or investigations pending or, to the knowledge of Buyer, threatened against Buyer before any court or governmental body (whether judicial, executive or administrative) in which an adverse determination would have a Material Adverse Effect on the consummation of the transactions contemplated herein. Buyer is not subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generally) applicable to Buyer that would have a Material Adverse Effect on the consummation of the transactions contemplated herein.

5.5 Brokers. Except as set forth on Schedule 5.5, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated herein based upon arrangements made by or on behalf of Buyer.

ARTICLE VI

COVENANTS OF THE SELLERS PRIOR TO THE CLOSING

Between the date of this Agreement and the Closing Date:

6.1 Information. To the extent Buyer does not already have access pursuant to the Management Agreement and subject to applicable law and attorney-client privilege or other applicable privileges, each of the Sellers shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer reasonable access to, and the right to inspect the plants, properties, books, and records of, the Facilities and Assets at such times and in such manner as Buyer may from time to time reasonably request of the Sellers. In addition, subject to applicable law and attorney-client privilege or other applicable privileges, each of the Sellers shall furnish Buyer with such additional financial and operating data and other information in respect of the Business and the Assets as Buyer may from time to time reasonably request to the extent Buyer does not have access to such information pursuant to the Management Agreement.

6.2 Operations. Each of the Sellers, to the extent they have retained control of related aspects of the Business pursuant to the Management Agreement, will:

(a) carry on the Business in substantially the same manner as presently conducted and not make any material change in personnel, general and fiscal policies, charity care policies, accounting policies or real or personal property affecting the Business or the Assets;

(b) maintain the Facilities and the Assets and all parts thereof in their current operating condition, ordinary wear and tear excepted;

(c) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Business or the Assets; and

(d) use its reasonable best efforts to maintain and preserve its business organizations intact, retain its present employees and maintain its relationships with physicians, suppliers, customers, and others having business relations with any of the Sellers.

6.3 Positive Covenants. As, and to the extent, permitted by applicable law, and subject to the terms and conditions of a Collaboration Agreement between the parties, Sellers will collaborate with Buyer on clinical and other initiatives to facilitate the transition of the Facilities into the Health Quest system.

6.4 Negative Covenants. None of the Sellers will, without the prior written consent of Buyer, which shall not be unreasonably withheld, conditioned or delayed:

(a) amend, renew or terminate any of the Assumed Contracts, the Tenant Leases or the Seller Leases or enter into any new Tenant Leases or Seller Leases, except in the ordinary course of business and consistent with prior practice;

(b) enter into any contract or commitment obligating any Seller or Facility to (i) purchase any supplies, assets or services in excess of $25,000, (ii) enter into any contract or arrangement with a term of greater than one year or (iii) enter into any contract or arrangement with a referral source regardless of the amount of consideration under such contract or arrangement, except in the ordinary course of business and consistent with prior practice;

(c) increase compensation payable or to become payable or make or increase any bonus payment to or otherwise enter into one or more bonus agreements with any employee of any of the Sellers, except in the ordinary course of business in accordance with existing personnel policies and consistent with prior practice;

(d) institute, amend or increase the benefits, rights or obligations under any Benefit Plan, policy or arrangement other than as required by applicable law;

(e) create, assume or permit to exist any new debt, lease, mortgage, pledge or other lien or encumbrance upon any of the Assets, whether now owned or hereafter acquired, except in the ordinary course of business and consistent with prior practice;

(f) acquire (whether by purchase or lease) or sell, assign, lease or otherwise transfer or dispose of any personal property, plant, equipment or Real Property, except for dispositions or retirement of equipment in the normal course of business with comparable replacement thereof;

(g) enter into a collective bargaining agreement;

(h) enter into negotiations with or recognize voluntarily a bargaining representative;

(i) take any action outside the ordinary course of business (apart from those actions contemplated by this Agreement), including but not limited to the disposition of any Assets; and

(j) change the titles of, or outside the ordinary course of business change the assignment of, the senior executives of Sellers set forth on Schedule 6.4(j).

6.5 Governmental Approvals; Third Party Consents. Each of the Sellers shall (i) use commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow it to perform its obligations under this Agreement; and (ii) reasonably assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material which may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein. The Sellers shall use commercially reasonable efforts to obtain the consent of each other party to the assignment of the Material Contracts to the extent required by such agreements.

6.6 Additional Financial Information. No later than twenty (20) calendar days after Manager has complied with its reporting obligations in the Management Agreement, the Sellers shall deliver to Buyer true and complete copies of the unaudited balance sheets and the related

unaudited statements of income (collectively, the "**Interim Statements**") of, or relating to, the Facilities for each month then-ended, together with a year to date compilation and the notes, if any, related thereto, which presentation shall be true, correct and complete in all material respects, shall have been prepared from and in accordance with the books and records of the Sellers and shall fairly present the financial position and results of operations of the Facilities as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such Interim Statements need not include required footnote disclosures.

6.7 No-Shop Clause. Each of the Sellers agrees that it shall not, and shall direct and cause its officers, directors, employees, agents and representatives (including any investment banker, broker, attorney or accountant retained by it) not to directly or indirectly: (i) offer for sale or lease all or any portion of the Assets or any ownership interest in any entity owning any of the Assets or otherwise solicit, initiate, participate in negotiations with any third party contemplating a transaction involving all or any portion of the Asset, directly or indirectly, whether by sale, merger, consolidation, sale of assets, lease affiliation joint venture or other form of transaction (collectively, a "**Prohibited Transaction**"), (ii) solicit offers to purchase all or any portion of the Assets or any ownership interest in any entity owning any of the Assets, (iii) initiate, encourage or provide any documents or information to any third party in connection with, or discuss or negotiate with any person regarding any inquires, proposals or offers relating to, any disposition of all or any portion of the Assets or a merger or consolidation of any entity owning any of the Assets or (iv) enter into any agreement or discussions with any party (other than Buyer) with respect to the sale, assignment or other disposition of all or any portion of the Assets or any ownership interest in any entity owning any of the Assets or with respect to a merger or consolidation of any entity owning any of the Assets; provided, however, that the Parties agree that this Section shall not apply to the use or consumption of Sellers' supplies, drugs, inventory and other disposables and consumables in the ordinary course of business prior to the Closing. Each Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction, and will notify the third party of the existence of this covenant. Without limiting the foregoing, it is understood that any violation of the restrictions set forth in this Section 6.8 shall be deemed a material breach of this Agreement by the Sellers.

6.8 Tail Insurance. For each general or professional liability insurance policy that is underwritten on a claims-made basis, the Sellers, at their sole cost and expense, shall either self-insure or obtain "tail" insurance to insure against professional and general liabilities of the Sellers, the Facilities and/or the Assets relating to all periods from the date of Sellers' acquisition of the Facilities or the Assets and ending on or prior to the Closing Date. Such tail insurance or self-insurance shall have coverage levels equal to those in place as of the date hereof.

6.9 Tenant Estoppels. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, either in the form attached hereto as Exhibit H (the "**Tenant Estoppel**") or in such other form as may be prescribed in any relevant Tenant Lease, estoppel certificates for all Tenant Leases, pursuant to which each such tenant shall certify as of a date within thirty (30) days of the Closing Date all of the matters set forth on the Tenant Estoppel or on the form prescribed in the relevant Tenant Lease, as the case may be, including, but not limited to, confirming no defaults exist under such Tenant Lease.

6.10 Landlord Estoppels. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, either in the form attached hereto as Exhibit I (the "**Landlord Estoppel**") or in such other form as may be prescribed in any relevant Seller Lease, landlord estoppel certificates for all Seller Leases, pursuant to which each such landlord shall certify as of a date within thirty (30) days of the Closing Date all of the matters set forth on the Landlord Estoppel or on the form prescribed in the relevant Seller Lease, as the case may be, including, but not limited to, confirming no defaults exist under such Tenant Lease.

6.11 Title Insurance and Survey.

(a) Buyer has heretofore received commitments (the "**Commitments**") from Chicago Title Insurance Company (the "**Title Company**") to issue as of the Closing Date an ALTA owner's policy of title insurance (Form 2006), which policy shall be issued with endorsements for extended coverage, zoning (ALTA 3.1 plus parking and loading docks), owner's comprehensive (ALTA 9.2), access, tax parcel, same as survey, subdivision, location, utility facility, environmental lien, waiver of arbitration, non-imputation and contiguity, for the Owned Real Property, together with improvements, buildings and fixtures thereon, in amounts equal to the reasonable value assigned to such Owned Real Property by Buyer and in the customary form prescribed for use in the State of Connecticut, but with any mandatory arbitration provision deleted therefrom. Buyer ordered the Commitments through the Title Company's National Commercial Services office located at 10 South LaSalle Street, Suite 3100, Chicago, Illinois 60603, and such National Commercial Services office shall be responsible for all underwriting decisions with respect to the policy or policies issued pursuant to the Commitments. The Commitments provide for the issuance of such policy (or policies) to Buyer as of the Closing and insure fee simple title to the Owned Real Property subject only to the Permitted Encumbrances. Buyer has heretofore received as-built surveys of the land and improvements comprising the Owned Real Property (collectively, the "**Surveys**") from a registered Connecticut surveyor, which Surveys were prepared in accordance with the "Minimum Standard Detail Requirements for ALTA/NSPS Land Title Surveys" jointly established and adopted by ALTA and NSPS in 2016, and shall include Items 1, 2, 3, 4, 6(a), 6(b), 7(a), 7(b)(1), 7(c), 8, 9, 10, 11, 13, 14, 16, 17, 18, 19 and 20 of Table A thereof. The Surveys have been issued certified to Buyer, the Sellers, and the Title Company and include a surveyor's certification reasonably acceptable to Buyer and the Title Company. The legal description of the Owned Real Property described in the Commitments and the Surveys shall be used to convey title to Buyer per the special warranty deed or deeds described in Section 3.2(a).

(b) The Sellers agree to deliver any information or documentation as may be reasonably required by the Title Company under the Commitments or otherwise in connection with the issuance of Buyer's title insurance policies. The Sellers also agree to provide an affidavit of title consistent with a special warranty deed with respect to the Owned Real Property and/or such other information as the Title Company may reasonably require in order for the Title Company to insure over the "gap" (i.e., the period of time between the effective date of the Title Company's last checkdown of title to such Owned Real Property and the Closing Date) and to cause the Title Company to delete all standard exceptions (including any exception for mechanics liens related to the Owned Real Property) from the final title insurance policies. The costs of such title policy or policies (including the endorsements to such policy or policies, but

after taking into account all credits available, including any reissue credits) (the "**Title Policy Costs**") and the costs of such surveys (the "**Survey Costs**") shall be shared equally by Buyer and the Sellers in accordance with the provisions of Section 13.16 herein.

6.12 Subordination and Non-disturbance Agreements. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, in a form reasonably acceptable to Buyer or such other form as may be prescribed in any Seller Lease, a commercially reasonable subordination and non-disturbance agreement (the "**SNDA**") executed by any lender with a mortgage or deed of trust on the land and improvements relating to any Leased Real Property for all Sellers.

6.13 Discharge of Indebtedness. At or before the Closing, the Sellers shall discharge all of their indebtedness, their capital lease obligations, their unfunded pension liabilities and any other indebtedness secured by any of the Assets or to which any of the Assets may be subject, including intercompany obligations.

6.14 Insurance Rating. Each of the Sellers shall take all action reasonably requested by Buyer to enable Buyer to succeed to its Workmen's Compensation and Unemployment Insurance ratings, property, automobile or any other insurance policies, deposits and other interests with respect to the operation of the Business and other ratings for insurance or other purposes established by such Seller. Buyer shall not be obligated to succeed to any such rating, insurance policy, deposit or other interest, except as it may elect to do so.

6.15 Best Efforts to Close. Each Seller shall use its reasonable best efforts to proceed toward the Closing and to cause Buyer's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Each Seller shall notify Buyer as soon as practicable of any event or matter that comes to such Seller's attention that may reasonably be expected to prevent the conditions of such Seller's obligations being met.

6.16 Notice; Efforts to Remedy. Each Seller shall promptly give notice to Buyer upon becoming aware of the impending occurrence of any event that would cause or constitute a breach of any of the representations, warranties or covenants contained or referred to in this Agreement or cause, or be likely to cause, a Material Adverse Effect and shall use its commercially reasonable efforts to prevent or promptly remedy the same.

6.17 Management Agreement. The Sellers and Manager shall have entered the Management Agreement, pursuant to which Manager shall provide services to Sellers to operate the Facilities. Sellers' obligations to provide information to Buyer relating to the operation of the Facilities from the date hereof until the Effective Date, including updating and correcting schedules pursuant to Section 13.1, shall be subject to Manager's performance of its obligations in the Management Agreement.

ARTICLE VII

COVENANTS OF BUYER PRIOR TO THE CLOSING

7.1 Governmental Approvals; Third Party Consents. Between the date of this Agreement and the Closing Date, Buyer shall (i) use commercially reasonable efforts to obtain

all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement; and (ii) assist and cooperate with the Sellers and their representatives and counsel in obtaining all governmental consents, approvals and licenses that the Sellers deem necessary or appropriate and in the preparation of any document or other material that may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein. Buyer will use commercially reasonable efforts to obtain all consents of all third parties necessary or desirable for the purpose of (i) consummating the transactions contemplated herein or (ii) enabling Buyer to operate the Facilities and the Assets in the ordinary course after the Closing.

7.2 Best Efforts to Close. Buyer shall use its reasonable best efforts to proceed toward the Closing and to cause each Seller's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Buyer shall notify the Sellers as soon as practicable of any event or matter that comes to Buyer's attention that may reasonably be expected to prevent the conditions of Buyer's obligations being met.

7.3 Cooperation with Sellers to Provide Information. Buyer shall cause Manager to comply with its obligations in the Management Agreement, to the extent applicable, with respect to providing Sellers with material reports, data and other information necessary for Sellers to comply with their obligations in ARTICLE VI, Section 8.8 and Section 13.1 hereof.

ARTICLE VIII

CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.1 Governmental Approvals.

(a) All material consents, authorizations, orders and approvals of (or filings or registrations with) any government entity required in connection with the execution, delivery and performance of this Agreement, as set forth on Schedule 8.1(a), shall have been obtained, except for any documents required to be filed, or consents, authorizations, orders or approvals required to be issued, after the Closing Date.

(b) The Parties shall have received confirmation from all applicable licensure agencies, as set forth on Schedule 8.1(b), that upon the Closing all licenses required by law to operate each of the Facilities and the Assets as currently operated will be transferred to, or issued or reissued in the name of, Buyer.

8.2 Adverse Change. Since the date hereof, there shall not have occurred any event, change or occurrence that has or would reasonably be expected to have a Material Adverse Effect.

8.3 Injunctions. No injunction shall have been issued and no action or other proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the transactions herein contemplated.

8.4 Bankruptcy. None of the Sellers shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have been adjudicated bankrupt or (iv) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against any of the Sellers.

8.5 Closing Deliveries. The Sellers shall have made the deliveries required to be made by it under Section 3.2 hereof, other than any deliveries pursuant to Section 3.2(q).

8.6 Consents. All consents and estoppels to those certain Material Contracts set forth on Schedule 8.6 shall have been obtained.

8.7 Employee Benefit Plans and Employees. Sellers shall have (i) terminated the employment of all employees of the Facilities, effective as of the close of business on the Closing Date, and (ii) promptly paid all wages, salaries and other sums due such employees, including without limitation, severance pay and accrued leave benefits (in excess of any accrued paid time off that is included within the calculation of Sellers' Closing Net Working Capital or the maximum amount of paid time off that can be accrued under Buyer's paid time off program), through the close of business on the Closing Date.

8.8 Schedules. Subject to Section 7.3, Buyer shall have been furnished with the Schedules required to be revised pursuant to Section 13.1 that shall be updated (but not corrected) as of the Closing Date to the extent of any changes therein.

8.9 Managed Care Plans. Consent Satisfaction, that in the aggregate, together with government payment programs, self-pay and non-contracted commercial payment programs constitute no less than 90% of the Hospital's revenue for 2015, shall have been obtained.

ARTICLE IX

CONDITIONS PRECEDENT TO OBLIGATIONS OF THE SELLERS

Notwithstanding anything herein to the contrary, the obligations of the Sellers to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by the Sellers at the Closing:

9.1 Governmental Approvals. All material consents, authorizations, orders and approvals of (or filings or registrations with) any government entity required in connection with the execution, delivery and performance of this Agreement, as set forth on Schedule 8.1, shall have been obtained, except for any documents required to be filed, or consents, authorizations, orders or approvals required to be issued, after the Closing Date.

9.2 Actions/Proceedings. No injunction shall have been issued and no action or other proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the transactions herein contemplated.

9.3 Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

9.4 Closing Deliveries. Buyer shall have made the deliveries required to be made by it under Section 3.3 hereof, other than any deliveries pursuant to Section 3.3(i).

ARTICLE X

PARTICULAR COVENANTS OF BUYER

10.1 Employee Matters.

(a) As of the effective date of the Management Agreement, Buyer shall offer employment to the Chief Executive Officer, Chief Financial Officer and the Chief Nursing Officer of the Hospital (the "**Executives**"), provided such individuals satisfy Buyer's screening requirements (including but not limited to background checks and drug screenings), such employment effective at 12:01 a.m. on the first day following the effective date of the Management Agreement. As of the Effective Time, Buyer shall offer employment to all active employees who satisfy Buyer's screening requirements (including but not limited to background checks and drug screenings), commencing as of the Closing Date (collectively with the Executives, the "**Hired Employees**"). Buyer shall not be obligated to continue any employment relationship with any employee for any specific period of time, and the foregoing shall not affect the status of the Hired Employees as employees "at will." Nothing herein shall be deemed to affect or limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. Within the ninety (90) days following the Effective Time, Buyer shall not take any action that would result in WARN Act liability with respect to the Hired Employees. Buyer shall recognize the existing seniority and service credit with the Sellers of all Hired Employees for purposes of determining accrued paid time off under Buyer's paid time off program.

(b) Consistent with Section 2.3(c), Buyer shall give credit to all Hired Employees for their accrued but unused paid time off, up to the maximum amount of paid time off that can be accrued under Buyer's paid time off program, and shall credit each Hired Employee with the unused extended illness benefits hours each such Hired Employee accrued while employed by the Sellers, but only to the extent disclosed on Schedules 2.3(c).

10.2 Cost Reports. Buyer shall forward to the Sellers any and all correspondence relating to the Seller Cost Reports within five (5) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to the Seller Cost Reports (without any offset or setoff of the same for any claim for indemnification under ARTICLE XII hereof) within five (5) business days after receipt by Buyer and shall forward to the Sellers any demand for payments within five (5) business days after receipt by Buyer.

ARTICLE XI

ADDITIONAL COVENANTS

11.1 Employee Matters.

(a) As of the effective date of the Management Agreement, Sellers shall terminate the Executives. As of the Closing Date, the Sellers shall terminate all of their employees providing services at the Facilities. Within the period of ninety (90) days before the Closing Date, the Sellers shall not take any action that would result in WARN Act liability.

(b) Effective as of the Closing Date, the Sellers shall (i) make or cause to be made all contributions due for all periods prior to the Closing Date, including a prorated contribution for the 2016 plan year, on behalf of all employees who are participants in the Sellers' tax-qualified retirement Benefit Plan; (ii) fully vest all accounts of employees who are participants in tax-qualified retirement Benefit Plan; and (iii) take all necessary actions to terminate the tax-qualified retirement Benefit Plan as of the Closing Date. With respect to the foregoing and for all other purposes, the Sellers shall amend the Benefit Plans and take any other necessary action to comply fully with the requirements under ERISA and the IRC related to Benefit Plans and other applicable law at all times.

(c) Notwithstanding anything herein to the contrary, the Sellers acknowledge and agree that Buyer does not assume or agree to discharge any liability of the Sellers for any benefits under COBRA, the Public Health Service Act or otherwise for individuals incurring a qualifying event prior to the Closing, and any such liabilities shall remain solely the responsibility of the Sellers, including any liability with respect to any M&A Qualified Beneficiaries.

(d) Effective as of the Closing Date, the Sellers shall pay out any unused paid time off that is in excess of any accrued paid time off that is included within the calculation of Sellers' Closing Net Working Capital and the limits for paid time off under Buyer's paid time off program.

11.2 Terminating Cost Reports. The Sellers, at their expense, shall prepare and file within sixty (60) days of the Closing all terminating and other cost reports required or permitted by law to be filed under Medicare, Medicaid and other third party payor programs or with DSS for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein. The Sellers shall retain all rights and obligations under the Seller Cost Reports including without limitation any amounts receivable or payable or recaptured, in respect of such Seller Cost Reports or reserves relating to such Seller Cost Reports. Such rights

shall include the right to appeal any Medicare or Medicaid determinations relating to the Seller Cost Reports. Notwithstanding the foregoing, the Sellers shall not open, refile or amend any Seller Cost Report without the prior written consent of Buyer, which consent shall not be withheld unreasonably. The Sellers shall retain the originals of the Seller Cost Reports, correspondence, work papers and other documents relating to the Seller Cost Reports. The Sellers agree to furnish copies of the Seller Cost Reports, correspondence, work papers and other documents to Buyer upon request.

11.3 Trade Name Cancellation. The Sellers acknowledge and agree that Buyer will acquire as part of the Assets the exclusive right to use the name "Sharon Hospital", and any variation thereof and the goodwill associated therewith, and that none of the Sellers will use such name(s) or any derivative thereof subsequent to the Closing. Sharon further covenants and agrees to file, immediately after Closing, a Certificate of Cancellation or equivalent filing to terminate its trade name certification for "Sharon Hospital" and any similar certifications held by any Affiliates (the "**Trade Name Cancellation**").

11.4 Advisory Board of Trustees. Unless otherwise approved by the Attorney General of the State of Connecticut (the "**Attorney General**"), Newco will continue to recognize the Advisory Board of Trustees ("**Advisory Board**") currently at the Hospital. The Advisory Board is comprised of community representatives and physicians on the medical staff of the Hospital. The Advisory Board shall consist of no fewer than nine (9) members and shall be so constituted that:

(a) at least three (3) members of the Advisory Board shall be elected public officials currently holding office in the Hospital's primary service area, or their designees;

(b) at least three (3) members of the Advisory Board shall be members of the medical staff of the Hospital;

(c) at least three (3) members of the Advisory Board shall be nominated and selected by the elected public officials or their designees serving on the Advisory Board; and

(d) Newco may select two (2) additional members of the Advisory Board beyond the nine (9) set forth above.

Newco shall meet with the Advisory Board at least quarterly and will seek input of the Advisory Board with respect to various decisions affecting the Hospital, including, but not limited to, management evaluations, monitoring of clinical quality at the Hospital and the overall strategic direction of the Hospital. The Advisory Board shall establish procedures to assume maximum feasible participation in the operation, scope of services and overall strategic direction of the Hospital.

Newco agrees to consult with the Advisory Board prior to implementing material changes in the operation and management of the Hospital. Newco further agrees to consider and implement, as warranted, considerations by the Advisory Board. All recommendations to Newco by the Advisory Board shall be in writing and shall be retained by Newco for inspection by members of the public upon written notice to Newco.

11.5 Indigent and Charity Care. Unless the Attorney General provides otherwise, Newco will continue the Hospital's existing practice as of the date hereof with respect to the provision of indigent and charity care. In addition, Newco will include this covenant in any subsequent sale of the Hospital after the Closing Date.

11.6 2001 Order. Buyer agrees to comply with the obligations and requirements of Sharon that are established by that certain Final Decision, Docket No. 01-486-01, by the State of Connecticut Office of the Attorney General, dated November 26, 2001 to the extent that such obligations and requirements are required to be assigned to future owners of the Hospital by such Final Decision.

11.7 Attorney General Discussions. Sellers and Buyer acknowledge that Buyer may seek discussions with the Attorney General regarding modifying or eliminating the covenants set forth in Sections 11.4, 11.5 and 11.6. Newco shall comply with such provisions unless modified by the Attorney General in writing.

11.8 Property Transfer Law Matters.

(a) Within thirty (30) days of the date hereof, Sellers shall engage at their sole cost and expense an environmental professional licensed pursuant to Connecticut General Statutes § 22a-133v ("**Licensed Environmental Professional**") who shall render an opinion as to whether the property and Facility located at 50 Hospital Hill Road, Sharon, Connecticut (the "**Connecticut Facility**") is an "establishment" under the Property Transfer Law. If the Connecticut Facility is an "establishment" under the Property Transfer Law, then Sellers shall as promptly as reasonably practical comply with the Property Transfer Law through final LEP Verification (as defined by the Property Transfer Law) or a no further action letter from the Connecticut Department of Energy & Environmental Protection ("**CT DEEP**"), as applicable, under the Property Transfer Law. Sellers shall also cooperate with and provide CT DEEP any and all information and data requested by CT DEEP in connection with any audit undertaken by CT DEEP and take all other actions as may be properly requested by CT DEEP as follow-up to any CT DEEP audit. Sellers shall provide Buyer as soon as reasonably practicable (but in any event at least five (5) days prior to delivery), with advance copies of all documents or correspondence to be filed with CT DEEP or prepared under the Property Transfer Law and shall incorporate any reasonable substantive comments provided by Buyer into such filings. Sellers shall promptly provide to Buyer copies of correspondence and documents received from or submitted to CT DEEP. Without limiting the generality of the foregoing, with respect to the Connecticut Facility, the Sellers, at their own cost and expense, shall, as appropriate and necessary, conduct all investigation, sampling, monitoring, remediation, cleanup, removal and other corrective action or closure work necessary to comply with the Property Transfer Law and prepare and submit all documents and reports and pay all fees, costs and expenses necessary to comply with the Property Transfer Law.

(b) Subject to the terms of this Agreement, Sellers shall retain control of the actions necessary and appropriate to comply with the Property Transfer Law. Sellers expressly reserve the right to design and implement any remedial actions pursuant to which Sellers obligations under the Property Transfer Law can be satisfied in accordance with the Connecticut Remediation Standard Regulations, R.C.S.A. 22a-133k-1 through 22a-133k-3 ("**RSRs**"),

including, but not limited to, the development of alternative criteria for soil, sediment, surface water or groundwater at the Connecticut Facility, and the placement of one or more Environmental Land Use Restrictions (as defined and set forth under the RSRs) on the Connecticut Facility; provided that no such remedial action may materially interfere with Buyer's use and operation of the Connecticut Facility.

(c) Buyer shall use commercially reasonable efforts to cooperate with the Sellers in connection with their actions with respect to compliance with the Property Transfer Law, including providing access to the Connecticut Facility after the Closing Date and executing any forms necessary to allow the parties hereto to timely consummate the transactions contemplated by this Agreement in accordance with the Property Transfer Law requirements; provided, that if any obligation or liability is imposed pursuant to such forms such obligation or liability shall constitute an Excluded Liability and shall be subject to the terms and conditions of Article 12 hereof.

ARTICLE XII

INDEMNIFICATION

12.1 Indemnification by Buyer.

(a) Buyer shall indemnify and hold harmless the Sellers, and their respective officers, directors, employees and Affiliates (collectively, the "**Seller Indemnified Parties**"), from and against Damages that any Seller Indemnified Party incurs as a result of, or with respect to, (i) any misrepresentation or breach of warranty by Buyer under this Agreement or the other agreements and documents executed and delivered by Buyer pursuant to this Agreement, (ii) any breach by Buyer of any covenant or agreement of Buyer under this Agreement or the other agreements contemplated hereby or (iii) any of the Assumed Liabilities.

(b) For purposes of calculating the amount of any Damages incurred, arising out of or relating to a breach or inaccuracy for purposes of Section 12.1, no effect shall be given to any materiality or Material Adverse Effect qualification of any representation, warranty, covenant or agreement of Buyer.

12.2 Indemnification by the Sellers.

(a) Each of the Sellers, jointly and severally, shall indemnify and hold harmless Buyer, and its officers, directors, employees, stockholders, members and Affiliates (collectively, the "**Buyer Indemnified Parties**"), from and against any and all Damages that any such Buyer Indemnified Party incurs as a result of, or with respect to, (i) any misrepresentation or breach of warranty by any of the Sellers under this Agreement or the other agreements and documents executed and delivered by any or all of the Sellers pursuant to this Agreement, (ii) any breach by any of the Sellers of any covenant or agreement of any of the Sellers under this Agreement or the other agreements contemplated hereby, (iii) an erroneous interpretation or determination by Sellers or a Licensed Environmental Professional retained by Sellers that the Connecticut Facility is not an "establishment" for purposes of the Property Transfer Law or that the Property Transfer Law does not apply to the transaction covered by this Agreement for some

other or alternative reason ("**Erroneous Applicability Determination**"), or (iv) any of the Excluded Liabilities.

(b) For purposes of calculating the amount of any Damages incurred, arising out of or relating to a breach or inaccuracy for purposes of Section 12.2, no effect shall be given to (i) any materiality or Material Adverse Effect qualification of any representation, warranty, covenant or agreement of any of the Sellers or (ii) any Corrected Schedule.

12.3 Survival. Except as otherwise expressly provided in this Agreement, all representations and warranties contained in this Agreement or in any document delivered at the Closing pursuant hereto shall (i) be deemed to be material and to have been relied upon by the Parties, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, (ii) not be deemed merged into any instruments or agreements delivered at the Closing or thereafter and (iii) survive the Closing and shall be fully effective and enforceable for a period of two (2) years following the Closing Date, except for the representations and warranties set forth in (a) Sections 4.1 (Existence and Capacity), 4.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.) (other than 4.2(c)), and 4.3 (Binding Agreement) which shall survive the Closing indefinitely, (b) Sections 4.8 (Medicare Participation; Accreditation) and 4.9 (Regulatory Compliance) which shall survive until the fifth anniversary of the Closing Date, and (c) Section 4.12(a) (Title, Condition, and Sufficiency of the Assets) and Section 4.16 (Taxes) which shall survive until the expiration of the applicable statute of limitations taking into account all valid extensions.

12.4 Limitations.

(a) The Sellers shall be liable under Section 12.2(a)(i) only when total indemnification claims made under Section 12.2(a)(i) exceed One Hundred Thousand Dollars ($100,000) (the "**Indemnification Deductible**"), after which the Sellers shall be liable for the amount of Damages in excess of the Indemnification Deductible.

(b) Buyer shall be liable under Section 12.1(a)(i) only when total indemnification claims made under Section 12.1(a)(i) exceed the Indemnification Deductible, after which Buyer shall be liable for only for the amount of Damages in excess of the Indemnification Deductible.

(c) Notwithstanding the foregoing in (a) and (b), any Damages incurred by (i) a Buyer Indemnified Party as a result of an Erroneous Applicability Determination or as a result of a breach or inaccuracy of any representation or warranty made by any of the Sellers in Sections 4.1 (Existence and Capacity), 4.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.), 4.3 (Binding Agreement), 4.11 (Real Property), 4.12(a) (Title, Condition, and Sufficiency of the Assets), or 4.16 (Taxes) (collectively, the "**Seller Fundamental Representations**"), Section 4.9 (Regulatory Compliance), information disclosed on any Corrected Schedule, or information that should have been disclosed on an Updated Schedule or Corrected Schedule but was fraudulently withheld; (ii) a Seller Indemnified Party as a result of a breach or inaccuracy of any representation or warranty made by Buyer in Sections 5.1 (Existence and Capacity), 5.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.) or 5.3

(Binding Agreement) (collectively, the "**Buyer Fundamental Representations**"); or (iii) in the case of fraud, shall not count towards, nor be subject to, the Indemnification Deductible.

(d) The maximum aggregate liability of Sellers for indemnification under Section 12.2(a)(i) (other than with respect to breaches of the Seller Fundamental Representations, breaches of Section 4.9 (Regulatory Compliance), breaches with respect to information set forth on any Corrected Schedule, breaches with respect to information that should have been disclosed on an Updated Schedule or Corrected Schedule but was fraudulently withheld, and claims of fraud) and Buyer for indemnification under Section 12.1(a)(i), respectively (other than with respect to breaches of the Buyer Fundamental Representations and claims of fraud) shall be limited to an amount equal to Two Million Five Hundred Thousand Dollars ($2,500,000). The maximum aggregate liability of: (i) Sellers for indemnification under Section 12.2(a)(ii), for breaches of the Seller Fundamental Representations; and (ii) Buyer for indemnification under Section 12.1(a)(ii), for breaches of the Buyer Fundamental Representations, and breaches with respect to information set forth on any Corrected Schedule that causes Damages, respectively, shall be limited to an amount equal to the Purchase Price. For the avoidance of doubt, Sellers' liability for an Erroneous Applicability Determination, for breaches of Section 4.9 (Regulatory Compliance), for breaches set forth on any Corrected Schedule, and/or for breaches with respect to information that should have been disclosed on an Updated Schedule or Correct Schedule but was fraudulently withheld, that cause Damages shall not be subject to any limitation on indemnification under this Agreement.

(e) Notwithstanding anything else to the contrary in this Agreement, Sellers shall have no obligation to indemnify Buyer for any Damages relating to any events, circumstances, conditions, occurrences or changes in the Assets or Business during the term of the Management Agreement ("Change") if Buyer had knowledge of such Change in its capacity as Manager under the Management Agreement, failed to provide Sellers notice of such Change prior to Closing, and none of the individuals listed on Schedule 4.30 (other than the Executives) otherwise had knowledge of such Change

12.5 Notice and Control of Litigation. If any claim or liability is asserted in writing by a third party against a Party entitled to indemnification under this ARTICLE XII (the "**Indemnified Party**") which would give rise to a claim under this ARTICLE XII, the Indemnified Party shall notify the person giving the indemnity (the "**Indemnifying Party**") in writing of the same within ten (10) days of receipt of such written assertion of a claim or liability. The Indemnifying Party shall have the right to defend a claim and control the defense, settlement and prosecution of any litigation. If the Indemnifying Party, within ten (10) days after notice of such claim, fails to defend such claim, the Indemnified Party shall (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise or settlement of such claim on behalf of and for the account and at the risk of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise or final determination thereof. Anything in this Section 12.5 notwithstanding, (i) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense and subject to the written consent of the Indemnifying Party (which consent shall not be unreasonably withheld, conditioned or delayed), to defend, compromise and settle such claim, and (ii) the Indemnifying

Party shall not, without the written consent of the Indemnified Party (which consent shall not be unreasonably withheld, conditioned or delayed), settle or compromise any claim or consent to the entry of any judgment that does not include a term thereof the giving by the claimant to the Indemnified Party of an unconditional release from all liability in respect of such claim. All Parties agree to cooperate fully as necessary in the defense of such matters. Should the Indemnified Party fail to notify the Indemnifying Party in the time required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.6 Notice of Claim. If an Indemnified Party becomes aware of any basis for a claim for indemnification under this ARTICLE XII (except as otherwise provided for under Section 12.5), the Indemnified Party shall notify the Indemnifying Party in writing of the same within thirty (30) days after becoming aware of such claim, specifying in detail the circumstances and facts which give rise to a claim under this ARTICLE XII. Should the Indemnified Party fail to notify the Indemnifying Party within the time frame required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have nonetheless resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.7 Exclusive Remedy. Except (i) in cases of fraud or (ii) as set forth in Section 13.17 and Section 13.28, the sole and exclusive remedy for any breach or inaccuracy of any representation, warranty or covenant contained herein shall be the remedies provided for in this ARTICLE XII.

ARTICLE XIII

MISCELLANEOUS

13.1 Schedules and Other Instruments. Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until the Closing Date, the Sellers or Buyer shall update their Schedules, either as a result of (i) matters hereafter arising which, if existing or occurring at the date of this Agreement, would have been required to be set forth or described in such Schedules or that are necessary to correct any information in such Schedules which has been rendered materially inaccurate thereby (the "**Updated Schedules**") or (ii) matters that existed or occurred at or before the date of this Agreement and should have been set forth or described in such Schedules, but were not (the "**Corrected Schedules**"). The Schedules shall be modified and superseded as contemplated by such Updated or Corrected Schedule for all purposes hereunder. Any other provision herein to the contrary notwithstanding, each party shall deliver all Updated Schedules and Corrected Schedules, if any, shall be delivered to the other party hereto: (a) with respect to Schedules 4.8, 4.9, 4.14, and 4.25, within five (5) business days of any material changes thereto, provided that Manager has complied with Section 7.3; and (b) with respect to all other Schedules every ninety (90) days from the date hereof, to the extent preparing Party has discovered an inaccuracy of a Schedule. Notwithstanding the foregoing, in the event the information to be disclosed on an

Updated or Corrected Schedule would reasonably be considered material to the operations of the Facilities, the disclosing party must disclose within ten (10) days of discovery. If any matter described in an Updated Schedule results in any Damage to the non-disclosing Party for which such Party is entitled to indemnification pursuant to ARTICLE XII (*e.g.* such Updated Schedule would render a representation and warranty made as of the date hereof inaccurate or constitute a breach of a covenant made as of the date hereof), then the Indemnified Party shall be entitled to pursue all remedies pursuant to ARTICLE XII; provided, however, that if Buyer's Damages (x) are a result of Buyer's (or its Affiliate's) breach of the Management Agreement, (y) are a result of actions taken by or caused by the Buyer or its Affiliates or (z) are based on an inaccuracy attributable to information possessed by the Buyer and not delivered to Sellers as required by Section 7.3, Buyer shall not be entitled to pursue remedies pursuant to ARTICLE XII.

13.2 Allocation. The Parties agree that Buyer shall prepare a preliminary allocation (the "**Tax Allocation**") of the Purchase Price (and all other capitalizable costs incurred in connection with the transactions hereunder) among the Assets in accordance with Section 1060 of the IRC and the Treasury Regulations thereunder (and any similar provisions of state, local or foreign law, as appropriate). Buyer shall deliver its preliminary Tax Allocation to the Sellers within forty-five (45) days after the Purchase Price has been agreed upon or otherwise determined pursuant to Section 2.6, and the Sellers shall have forty-five (45) days after receiving the preliminary Tax Allocation (the "**Seller Review Period**") to object to the preliminary Tax Allocation. If the Sellers timely raise any such objections, Buyer and the Sellers will attempt to resolve such objections in good faith; provided, however, that if Buyer and the Sellers are unable to resolve such issues within thirty (30) days after the end of the Seller Review Period, then either Buyer and the Sellers may elect, by written notice to the other, to have the objections resolved by the Audit Firm, whose decision shall be binding on the Parties in the absence of manifest error and whose fees and expenses shall be paid fifty percent (50%) by Buyer and fifty percent (50%) by the Sellers. If the Sellers fail to object to the preliminary Tax Allocation within the Seller Review Period, then such preliminary Tax Allocation shall be deemed acceptable to the Sellers and such preliminary Tax Allocation shall be binding upon the Parties. Thereafter, Buyer, the Sellers and their respective Affiliates shall report, act and file all Tax Returns (as defined below) (including, but not limited to, Internal Revenue Service Form 8594) in all respects and for all purposes consistent with such finally determined Tax Allocation. Neither Buyer, the Sellers nor any of their respective Affiliates shall take any position (whether in audits, Tax Returns or otherwise) that is inconsistent with such Tax Allocation, unless required to do so by applicable law.

13.3 Termination Prior to Closing. Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) on or prior to the Closing, by mutual consent of the Sellers and Buyer; (ii) by Buyer or the Sellers, if the Closing shall not have taken place on or before July 31, 2017 or the first anniversary of the date hereof, whichever is later, which date may be extended by mutual agreement of Buyer and the Sellers; provided, however, that no termination may be made under this Section 13.3; (ii) by a Party if the failure to close on or prior to such date shall be caused by the failure of such Party to fully comply with its obligations under this Agreement; (iii) in the event the Sellers, on one hand, or Buyer, on the other hand, commit a material breach of any of the terms hereof and such breach would prevent a condition to Closing from being satisfied, by the non-breaching Party, provided however, if such breach is

capable of cure, then the breaching party shall have thirty (30) days to effect such cure prior to termination;(iv) by Buyer in accordance with the provisions of Section 13.31.

13.4 Post-Closing Access to Information. The Sellers and Buyer acknowledge that subsequent to the Closing each Party may need access to information or documents in the control or possession of the other Party for the purposes of concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, subject to applicable law and attorney-client privilege or other applicable privileges, the Sellers and Buyer agree that for a period of six (6) years after the Closing Date each will make reasonably available to the other's agents, independent auditors, counsel and/or governmental agencies upon written request and at the expense of the requesting Party such documents and information as may be available relating to the Business or the Assets for periods ending on or prior to the Closing Date to the extent necessary to facilitate concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

13.5 Preservation and Access to Records After the Closing. Buyer agrees to maintain all patient, medical and other records of the Facilities delivered to Buyer at the Closing in accordance with applicable law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. Section 1395(v)(l)(i)), HIPAA and applicable state requirements with respect to medical privacy and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated at the Facilities after the Closing. For purposes of this Agreement, the term "**records**" includes all documents, electronic data and other compilations of information in any form. Buyer acknowledges that as a result of entering into this Agreement and operating the Facilities it will gain access to patient and other information that is subject to rules and regulations regarding confidentiality, and agrees to abide by any such rules and regulations relating to the confidential information it acquires. Upon reasonable notice, during normal business hours, at the sole cost and expense of the Sellers and upon Buyer's receipt of appropriate consents and authorizations, Buyer will afford to the representatives of the Sellers, including their counsel and accountants, full and complete access to, and copies of, the records transferred to Buyer at the Closing (including, without limitation, access to patient records in respect of patients treated by the Sellers at the Facilities). Upon reasonable notice, during normal business hours and at the sole cost and expense of the Sellers, Buyer shall also make its officers and employees available to the Sellers at reasonable times and places after the Closing. In addition, the Sellers shall be entitled, at the Sellers' sole risk, to remove from the Facilities copies of any such patient records, but only for purposes of pending litigation involving a patient to whom such records refer, as certified in writing prior to removal by counsel retained by the Sellers in connection with such litigation and only upon Buyer's receipt of appropriate consents and authorizations. Any patient record so removed from the Facilities shall be promptly returned to Buyer following its use by the Sellers. Any access to the Facilities, their records or Buyer's personnel granted to the Sellers in this Agreement shall be upon the condition that any such access not unreasonably interfere with the business operations of Buyer.

13.6 CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the Certificate of Need statute of any state, until the appropriate governmental agencies shall have granted a Certificate

of Need or the appropriate approval or ruled that no Certificate of Need or other approval is required.

13.7 Cooperation on Tax Matters. Following the Closing, the Parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting Party, and to any Taxing Authority, all information, records or documents relating to Tax liabilities or potential Tax liabilities of the Sellers or the Buyer and any information that may be relevant to determining the amount payable under this Agreement, and shall preserve all such information, records and documents at least until the expiration of any applicable statute of limitations or extensions thereof. Upon request of Buyer, the Sellers shall use their commercially reasonable efforts to obtain any certificate or other document from any governmental authority or any other person as may be necessary to mitigate, reduce or eliminate any Taxes that could be imposed (including, but not limited to, with respect to the transactions contemplated hereby).

13.8 Misdirected Payments, Etc. Each of the Sellers and Buyer covenant and agree to remit, with reasonable promptness, to the other Party any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other Party. In addition, in the event of a determination by any governmental or third party payor that payments to the Sellers or the Facilities resulted in an overpayment or other determination that funds previously paid by any program or plan to the Sellers or the Facilities must be repaid, including, without limitation, pursuant to a RAC audit, the Sellers shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date and not arising out of the actions or policies of the Sellers. In the event that, following the Closing, Buyer suffers any offsets against reimbursement under any third party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by the Sellers, the Sellers shall promptly upon demand from Buyer pay to Buyer the amounts so offset. Notwithstanding the foregoing, any obligation of Sellers to make any payment to the Buyer hereunder is, where the Buyer is the recipient of the notice of the audit and/or underpayment, conditioned upon the Buyer's delivery of written notice of the audit and/or underpayment to the Sellers within ten (10) business days of Buyer's receipt of the same in order that Sellers may contest the assessment should they so desire; provided, however, that should the Buyer fail to notify the Seller in the time required above, the payment with respect to the subject matter of the required notice shall be limited to the payment that would have resulted had the Buyer notified the Seller in the time requirement above after taking into account such actions the Seller could have taken had it received timely notice from the Buyer.

13.9 Tax Returns. Each of the Sellers will timely file all Tax Returns, accurately report all income and loss, and pay all Taxes due for tax years or periods ending on or before the Closing Date and shall provide a copy of each such return to Buyer upon filing. Buyer shall make any books and records necessary or helpful to the preparation of such returns available to the Sellers during normal business hours. In addition to any other indemnification obligations hereunder, each Seller shall indemnify Buyer for (A) any liability for unpaid Taxes of each Seller; and (B) any Taxes levied with respect to the Assets or Business for (i) any Tax year

ending on or before the Closing Date; and (ii) in the case of any period that begins before but does not end on the Closing Date (a "**Straddle Period**"), to the extent allocable to the portion of the Straddle Period ending on the Closing Date. The amount of any Taxes based on or measured by income, receipts or expenses for the portion of the Straddle Period ending on the Closing Date shall be determined based on an interim closing of the books as of the Closing Date, and the amount of other Taxes for a Straddle Period which relate to the portion of the period ending on the Closing date shall be deemed to be the amount of such Tax for the entire period, multiplied by a fraction, the numerator of which is the number of days in the taxable period ending on the Closing Date, and the denominator of which is the number of days in in such Straddle Period.

13.10 Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the Parties except as may be herein specifically provided to the contrary; provided, however, at the request of a Party, the other Parties shall execute such additional instruments and take such additional actions as the requesting Party may reasonably deem necessary to effectuate this Agreement. In addition and from time to time after the Closing, the Sellers shall execute and deliver such other instruments of conveyance and transfer, and take such other actions as Buyer reasonably may request, more effectively to convey and transfer full right, title, and interest to, vest in, and place Buyer in legal and actual possession of, any and all of the Assets. The Sellers shall also furnish Buyer with such information and documents in their possession or under their control, or which the Sellers can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Facilities or the Assets. Additionally, the Sellers shall cooperate and use their best efforts to have their present directors, officers and employees cooperate with Buyer on and after the Closing in furnishing information, evidence, testimony and other assistance in connection with any action, proceeding, arrangement or dispute of any nature with respect to matters pertaining to all periods ending on or prior to the Closing Date in respect of the items subject to this Agreement.

13.11 Consented Assignment. Anything contained herein to the contrary notwithstanding, this Agreement shall not constitute an agreement to assign any claim, right, contract, license, lease, commitment, sales order or purchase order if an attempted assignment thereof without the consent of the other party thereto would constitute a breach thereof or in any material way affect the rights of the Sellers thereunder, unless such consent is obtained. Each of the Sellers shall use commercially reasonable efforts to obtain any third party consents to the transactions contemplated by this Agreement. If such consent is not obtained, or if an attempted assignment would be ineffective or would materially affect the rights thereunder of the Sellers so that Buyer would not in fact receive all such rights, the Sellers and Buyer shall cooperate in good faith in any reasonable arrangement designed to provide for Buyer the benefits under any such claim, right, contract, license, lease, commitment, sales order or purchase order, including, without limitation, enforcement of any and all rights of the Sellers against the other party or parties thereto arising out of the breach or cancellation by such other party or otherwise.

13.12 Consents, Approvals and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a Party, or whenever a Party must or may exercise discretion, the Parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

13.13 Legal Fees and Costs. In the event there is a dispute between the Parties and a Party elects to incur legal expenses to enforce or interpret any provision of this Agreement by judicial proceedings, the prevailing Party will be entitled to recover such legal expenses, including, without limitation, reasonable attorneys' fees, costs and necessary disbursements at all court levels, in addition to any other relief to which such Party shall be entitled.

13.14 Choice of Law; Mediation.

(a) The Parties agree that this Agreement shall be governed by and construed in accordance with the laws of the State of New York without regard to conflict of laws principles.

(b) In the event that any disagreement, dispute, controversy or claim arising out of or relating solely to this Agreement (a "**Legal Dispute**") arises between the Parties arising out of or relating to this Agreement, the matter shall first be submitted to non-binding mediation. The mediation process shall be initiated by either Party giving written notice to the other party of its desire to mediate. Within thirty (30) days of such written notice, the Parties shall agree on a mediator, or, if the Parties are unable to agree, the mediator shall be selected by the American Health Lawyers Association (the "**AHLA**"), and in that event, the mediation shall be administered by the AHLA under its Rules of Procedure for Arbitration and Mediation. The mediator shall be a practicing attorney who has experience with mediating controversies involving complex commercial transactions or the subject matter of the particular dispute involved. The mediation shall be held at a neutral site mutually agreed upon by the Parties, provided, however, that if the Parties cannot agree on such site within fifteen (15) days after written notice of mediation, then the site shall be the location selected by the mediator.

Each Party shall bear its own costs and expenses and an equal share of the mediator's fees and administrative fees of mediation, if any. If at any time more than five (5) hours into the mediation conference the mediator determines that the controversy cannot be settled in mediation, the mediator may declare an impasse and the mediation process shall end at that point. The mediation shall be held within thirty (30) days after selection or appointment of the mediator.

(c) In the event that a Legal Dispute arises between the Parties arising out of or relating to this Agreement, and following declaration of an impasse by the mediator pursuant to Section 13.14(b), either Party may pursue whatever legal or equitable remedies as are available.

(d) Nothing in this Section 13.14 shall preclude either Party from seeking interim or provisional relief, including a temporary restraining order, preliminary injunction or other interim equitable relief concerning a Legal Dispute, either prior to or during any mediation hereunder, if necessary to protect the interests of such Party. This Section 13.14(d) shall be specifically enforceable.

13.15 Benefit/Assignment. Subject to provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, successors and permitted assigns. Neither the Sellers, on one hand, nor Buyer, on

the other hand, may assign this Agreement without the prior written consent of the other Party. Notwithstanding the foregoing, either Party may collaterally assign and grant a security interest in, all of its rights hereunder in favor of one or more lenders in connection with any credit facility, whether now existing or hereafter entered into, to which such Party or any Affiliate is or becomes a party.

13.16 Cost of Transaction. Whether or not the transactions contemplated hereby shall be consummated, the Parties agree as follows: (i) the Sellers shall pay the fees, expenses and disbursements of the Sellers and their agents, representatives, accountants and legal counsel incurred in connection with the subject matter hereof and any amendments hereto; (ii) Buyer shall pay the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and legal counsel incurred in connection with the subject matter hereof and any amendments hereto; and (iii) the Sellers shall pay one-half and Buyer shall pay one-half of all costs of any title search, title commitment, title policy, surveys and endorsements to title policies, as well as all transfer and recording taxes and fees, relating to the Owned Real Property and incurred in connection with the transactions contemplated by this Agreement, provided that Buyer shall pay for any zoning reports and all fees and expenses related thereto.

13.17 Confidentiality. It is understood by the Parties that any information provided by another Party (the "**Providing Party**") concerning such Providing Party obtained, directly or indirectly, from the Providing Party in connection with the transactions contemplated by this Agreement ("**Confidential Information**"), and the documents and other written information delivered to a receiving Party (the "**Receiving Party**"), or its stockholders, members, Affiliates, officers, employees or agents (collectively, "**Agents**"), are of a confidential and proprietary nature. To the extent permitted by law, the Receiving Party agrees that it will, and will use its reasonable best efforts to cause the Agents to, maintain the confidentiality of all such Confidential Information, and will only disclose such Confidential Information to Agents as necessary to effect the transactions contemplated hereby. Notwithstanding the foregoing, the Sellers may provide the Confidential Information to their or their Affiliates' debt or equity financing sources and investors who sign a customary confidentiality agreement. The parties further agree that if the transactions contemplated hereby are not consummated, the Receiving Party will return, and will use its reasonable best efforts to cause its Agents to return, all documents and other written information acquired from the Providing Party or its Affiliates and all copies thereof in their possession to the Providing Party. Each of the Parties hereto recognizes that any breach of this Section 13.17 would result in irreparable harm to the other Parties to this Agreement and their Affiliates and that therefore either the Sellers or Buyer shall be entitled to an injunction to prohibit any such breach or anticipated breach, without the necessity of posting a bond, cash, or otherwise, in addition to all of its other legal and equitable remedies. Nothing in this Section 13.17, however, shall prohibit the use of such Confidential Information, documents or information for such governmental filings as in the opinion of the Sellers' counsel or Buyer's counsel are required by law or governmental regulations or are otherwise required to be disclosed pursuant to applicable law. The foregoing restrictions in this Section 13.17 shall not apply to any information that (i) is on the date hereof or hereafter becomes generally available to the public other than as a result of a disclosure, directly or indirectly, by the Receiving Party or its Agents, (ii) was in the possession of the Receiving Party on a non-confidential basis prior to its disclosure or (iii) becomes available to the Receiving

Party on a non-confidential basis from a source other than the Providing Party or its representatives, which source was not itself bound by a confidentiality agreement.

13.18 Public Announcements. No Party hereto shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the other Parties, except for information and filings reasonably necessary to be directed to governmental agencies to fully and lawfully effect the transactions herein contemplated or as required by law. Notwithstanding the foregoing, the Sellers, in consultation with Buyer, may make periodic announcements to their employees regarding the transactions contemplated by this Agreement. Notwithstanding the foregoing, in the event a Party hereto determines that the terms hereof will be the subject of discovery in any litigation involving such Party, such Party shall promptly notify the other Parties hereto of such determination and if Sellers, on one hand, and Buyer, on the other hand, conclude that such disclosure through discovery is inevitable, then (i) the Parties shall make a public announcement of the terms hereof prior to such discovery taking place, (ii) such public announcement shall be made in a manner and at a time mutually agreed by the Parties and (iii) the Parties shall be represented at, and permitted to participate in, such announcement.

13.19 Waiver of Breach. The waiver by any Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to constitute, a waiver of any subsequent breach of the same or any other provision hereof.

13.20 Notice. Any notice, demand, or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered, when received by overnight delivery or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

The Sellers:	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital c/o RegionalCare Hospital Partners, Inc. 103 Continental Place, Suite 410 Brentwood, TN 37027 Attention: General Counsel Email: howard.wall@regionalcare.net
With simultaneous copies to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, Tennessee 37219 Attention: George W. Bishop III, Esq. Email: george.bishop@wallerlaw.com

Buyer:	Health Quest Systems, Inc. 1351 Route 55, Suite 200 Lagrangeville, NY 12540 Attention: Michael Holzhueter, Senior Vice President and General Counsel Email: mholzhue@health-quest.org
With a simultaneous copy to:	McDermott, Will & Emery LLP 227 West Monroe Street, Suite 4700 Chicago, Illinois 60606-5096 Attention: John M. Callahan, Esq. Email: jcallahan@mwe.com

or to such other address, and to the attention of such other person or officer as any Party may designate, with copies thereof to the respective counsel thereof as notified by such Party.

13.21 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be and remain in full force and effect, enforceable in accordance with its terms.

13.22 Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

13.23 Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Agreement.

13.24 Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

13.25 Accounting Date. The transactions contemplated hereby shall be effective for accounting purposes as of 12:01 a.m. on the day following the Closing Date (the "**Effective Time**"), unless otherwise agreed in writing by the Sellers and Buyer.

13.26 No Inferences. Inasmuch as this Agreement is the result of negotiations between sophisticated parties of equal bargaining power represented by counsel, no inference in favor of,

or against, either Party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such Party.

13.27 No Third Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of Buyer and the Sellers and their respective successors and permitted assigns, and it is not the intention of the Parties to confer, and this Agreement shall not confer, third party beneficiary rights upon any other person or entity.

13.28 Enforcement of Agreement. The Parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement was not performed in accordance with its specific terms or was otherwise breached. It is accordingly agreed that the Parties shall be entitled to an injunction or injunctions (without the need to post bond or other security) to prevent breaches of this Agreement and to enforce specifically the terms and provisions hereof in any court of competent jurisdiction, this being in addition to any other remedy to which they are entitled at law or in equity.

13.29 Entire Agreement/Amendment. This Agreement, together with its Schedules, Exhibits and documents delivered at the Closing, supersedes all previous contracts or understandings, including any offers, letters of intent, proposals or letters of understanding, and constitutes the entire agreement of whatsoever kind or nature existing between or among the Parties with respect to the subject matter hereof. As between or among the Parties, no oral statements or prior written material not specifically incorporated herein shall be of any force and effect. The Parties specifically acknowledge that in entering into and executing this Agreement, the Parties are relying solely upon the representations and agreements contained in this Agreement and its Schedules and Exhibits, and no others. No changes in, or additions to, this Agreement shall be recognized unless and until made in writing and signed by all Parties hereto.

13.30 Counterparts. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. Facsimile signatures on this Agreement and signatures sent by PDF shall be deemed to be original signatures for all purposes.

13.31 Risk of Loss. The risk of loss in respect to casualty to the Assets shall be borne by the Sellers until the Closing, and by Buyer on and after the Closing. Notwithstanding the foregoing, if any material part of the Hospital is damaged so as to be rendered unusable or destroyed prior to the Closing, Buyer may elect to terminate this Agreement for a period of thirty (30) days after the expiration of the cure period set forth below and all obligations of the parties hereunder; provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction within forty-five (45) days following such event. In the event the Assets are destroyed or damaged, but such destruction or damage does not entitle Buyer or Buyer does not elect to terminate this Agreement, and provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction, then Buyer shall be entitled to all insurance proceeds paid prior to the Closing in respect of such damage or destruction prior to the Closing. Following the Closing, in the event insurance proceeds are not paid prior to the Closing and provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction, Buyer shall be entitled to receive all proceeds payable in respect of such damage or destruction and the Sellers shall use their commercially reasonable efforts to obtain all

such proceeds that may be payable pursuant to their insurance policies with respect to such matters. This Section 13.31 shall survive the Closing.

13.32 RCHP Guarantee. RCHP hereby unconditionally and irrevocably guarantees, as a primary obligor and not only a surety (the "**RCHP Guarantee**"), the prompt and complete payment and performance (not just collection) of any and all of the Sellers' obligations to the Buyer Indemnified Parties under this Agreement, the Escrow Agreement or any Collaboration Agreement executed and delivered by any or all of the Sellers pursuant to this Agreement (the "**Obligations**"), if, as, when and to the extent that such Obligations are required to be performed pursuant to such agreements. If a Seller does not perform an Obligation, RCHP shall promptly perform the Obligation. The obligations of RCHP under the RCHP Guarantee are independent of the obligations of the Sellers under the Agreement and a separate action or actions may be brought against RCHP, whether action is brought against the Sellers or whether the Sellers are joined in any such action or actions; provided, however, as a condition precedent to the commencement of any action against RCHP, (i) Sellers shall have first failed to satisfy an Obligation in the time specified in the Agreement, taking into account any notice and cure periods, and (ii) Buyer (and its Affiliates) shall have an ongoing duty to provide to Sellers any notices required under this Agreement. Except as set forth in this Section 13.32, RCHP hereby waives all rights and defenses of a surety under applicable law. Notwithstanding the foregoing, RCHP shall be entitled to assert as a defense to any claim under this Section 13.32, (i) that the Obligations in respect of which a demand has been made are not yet due under the terms of this Agreement, (ii) that such Obligations have been previously performed in full, and (iii) any claims, defenses, counter claims, setoffs or circumstances excusing payment or performance which the Sellers would be entitled to assert under this Agreement. Except as specifically set forth in this Section 13.32, the RCHP Guarantee is an absolute, irrevocable, primary, continuing, unconditional, and unlimited guaranty of performance and payment subject to and within the limitations of this Agreement. The RCHP Guarantee shall remain in full force and effect (and shall remain in effect notwithstanding any amendment to this Agreement) for RCHP until all of the obligations of the Sellers have been paid, observed, performed, or discharged in full.

13.33 Limited Recourse. Notwithstanding anything in this Agreement to the contrary except for Section 13.32 which shall remain fully binding on RCHP, all Damages arising out of this Agreement and the transactions contemplated hereby will be limited to the Parties to this Agreement and the Management Agreement, no Non-Recourse Party will have any liability hereunder or with respect to the transactions contemplated hereby. For the purpose of this Section 13.33, "Non-Recourse Party" means, with respect to a Party to this Agreement, any of such Party's former, current and future equity holders, controlling Persons, directors, officers, employees, agents, representatives, Affiliates, members, managers, general or limited partners (or any former, current or future equity holder, controlling Person, director, officer, employee, agent, representative, Affiliate, member, manager, general or limited partner, or assignee of any of the foregoing), other than the Manager; provided, that, for the avoidance of doubt, neither RCHP nor any Party to this Agreement will be considered a Non-Recourse Party.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

SHARON HOSPITAL HOLDING COMPANY

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

REGIONAL HEALTHCARE ASSOCIATES, LLC,

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

TRI STATE WOMEN'S SERVICES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

HEALTH QUEST SYSTEMS, INC.

By:_____

Name:_____

Title:_____

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF SECTIONS 13.32 and 13.33 OF THIS AGREEMENT:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

REGIONAL HEALTHCARE ASSOCIATES, LLC,

By:_____

Name:_____

Title:_____

HEALTH QUEST SYSTEMS, INC.

By: _____

Name: Robert Friedberg

Title: President

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF SECTIONS 13.32 and 13.33 OF THIS AGREEMENT:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____

Name:_____

Title:_____

TRI STATE WOMEN'S SERVICES, LLC

By:_____

Name:_____

Title:_____

VASSAR HEALTH CONNECTICUT, INC.

By: _____

Name: Robert Friedberg

Title: President

Exhibit A

Facility List

Owned Property

1. Medical Arts Center located at 29 Hospital Hill Rd, Sharon, Connecticut 06069.
2. Community Health Building located at 1 Low Rd (with accompanying Thrift Shop at 3 Low Rd), Sharon, Connecticut 06069, used for community outreach.
3. Building used for Hospital storage located at 33 Hospital Hill Rd, Sharon, Connecticut.

Leased Property

1. Kent Primary Care located at 64 Maple Street, Kent, Connecticut 06757.
2. Time share office space at 75 Church Street, Canaan, Connecticut.
3. Time share office space at 9 Aspetuck Avenue, New Milford, Connecticut.
4. New Milford OB/GYN located at 2 Old Park Lane, New Milford, Connecticut 06776.
5. Associated Northwest Urology and apartment for on-call staff located at 17 Hospital Hill Road, Sharon Connecticut.
6. Winstead Health Center located at 115 Spencer Street, Winsted, Connecticut.
7. Tri State Women's Services located at 50 Amenia Road, Sharon, Connecticut.
8. Associated Northwest Urology located at 120 Park Lane Road, New Milford, Connecticut

EXHIBIT B

ESCROW AGREEMENT

This Escrow Agreement (this "**Agreement**"), dated as of _____, 2017 (the "**Effective Date**"), is made and entered into by and among **Health Quest Systems, Inc.**, a New York non-profit corporation, not individually but solely in its capacity as representative of the Buyer (as defined below) (the "**Buyer Representative**"), RegionalCare Hospital Partners, Inc., a Delaware corporation, not individually but solely in its capacity as representative of the Sellers (as defined below) (the "**Seller Representative**"), and **Wells Fargo Bank, National Association**, a national banking association, as escrow agent (the "**Escrow Agent**"). The Buyer Representative and the Seller Representative are referred to collectively herein as the "**Parties**" and each individually as a "**Party**."

WITNESSETH:

WHEREAS, Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), and Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**" and together with Sharon, SHHC, and RHA, the "**Sellers**"), the Buyer Representative, Vassar Health Connecticut, Inc., a Connecticut non-profit corporation ("**VHC**" and together with the Buyer Representative, the "**Buyer**"), and the Seller Representative, solely for the purposes of Sections 13.32 and 13.33 of the Purchase Agreement, entered into that certain Asset Purchase Agreement dated as of September __, 2016 (the "**Purchase Agreement**"), pursuant to which Buyer agreed to purchase from the Sellers substantially all of the assets, real and personal, tangible and intangible, constituting the Facilities (as defined in the Purchase Agreement) and assume the Assumed Liabilities (as defined in the Purchase Agreement), subject to the terms and conditions set forth in the Purchase Agreement;

WHEREAS, pursuant to Section 2.5 of the Purchase Agreement, the Parties have agreed that the Buyer Representative shall deliver Five Hundred Thousand Dollars ($500,000) (the "**Escrow Amount**") to the Escrow Agent on the date of this Agreement pursuant to the terms of this Agreement, which Escrow Amount shall be held in an account deemed the "**Escrow Account**";

WHEREAS, the Parties desire to engage the Escrow Agent so that the Escrow Amount can be held, invested, administered and distributed by the Escrow Agent, all in accordance with the terms set forth in this Agreement;

WHEREAS, the Parties desire that the Escrow Agent serve as escrow agent on the terms and conditions provided in this Agreement;

WHEREAS, capitalized terms used in this Agreement but not otherwise defined herein shall have the respective meanings given to them in the Purchase Agreement; *provided, however*, that the Escrow Agent will not be responsible to determine or to make inquiry into any term, capitalized or otherwise, not defined herein;

WHEREAS, the Parties acknowledge that the Escrow Agent is not a party to, is not bound by, and has no duties or obligations under, the Purchase Agreement, that all references in this Agreement to the Purchase Agreement are for convenience, and that the Escrow Agent shall have no implied duties beyond the express duties set forth in this Agreement; and

WHEREAS, Schedule I to this Agreement sets forth the wire transfer instructions (or payment instructions) for the Parties.

NOW, THEREFORE, in consideration of the mutual covenants of the parties set forth in this Agreement and the Purchase Agreement and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

AGREEMENT

1. Appointment of Escrow Agent. The Buyer Representative (on behalf of the Buyer) and the Seller Representative (on behalf of the Sellers) hereby appoint the Escrow Agent as their agent to hold, invest, and disburse the Escrow Amount and all interest and other income, and interest earned on such interest and other income related to the Escrow Amount ("**Escrow Interest**" and, together with the Escrow Amount, the "**Escrow Funds**") in accordance with the terms of this Agreement.

2. Appointment of the Seller Representative.

(a) The Sellers have appointed the Seller Representative as the designated representative of both of the Sellers and have authorized the Seller Representative to take or cause to be taken all action in furtherance of the Sellers' rights and obligations with respect to the Escrow Funds.

(b) Each of the Escrow Agent and the Buyer Representative shall be entitled to rely on all action taken by the Seller Representative and shall have no liability with respect to its reliance thereon. The Seller Representative is serving in that capacity solely for purposes of administrative convenience. Notwithstanding anything to the contrary contained in this Agreement, the Seller Representative, absent fraud or intentional misconduct, shall not have any liability under this Agreement in excess of its pro rata share of the collective liability of all of the Sellers.

3. Appointment of the Buyer Representative.

(a) The Buyer has appointed the Buyer Representative as the designated representative of the entities comprising the Buyer and has authorized the Buyer Representative to take or cause to be taken all action in furtherance of the Buyer's rights and obligations with respect to the Escrow Funds.

(b) Each of the Escrow Agent and the Seller Representative shall be entitled to rely on all action taken by the Buyer Representative and shall have no liability with respect to its reliance thereon. The Buyer Representative is serving in that capacity solely for purposes of administrative convenience.

4. Delivery of Funds to Escrow Agent. Pursuant to Section 2.5 of the Purchase Agreement, the Buyer Representative shall deposit the Escrow Amount with the Escrow Agent on the Effective Date. The Escrow Agent shall hold the Escrow Funds on behalf of the Buyer Representative and each of the Sellers under the terms of this Agreement and distribute the Escrow Funds in accordance with Section 8 or Section 9 hereto.

5. Investment.

(a) The Escrow Agent shall invest any and all of the Escrow Funds as directed in writing jointly by the Parties in obligations issued or guaranteed by the United States of America or any agent or instrumentality thereof or a mutual fund which invests solely in such obligations.

(b) In the absence of complete joint written investment instructions from the Parties, the Escrow Agent shall deposit and invest the Escrow Funds in the Money Market Deposit Account, certain aspects of which are further described on Exhibit A attached hereto. The Parties acknowledge that each has read and understands Exhibit A.

(c) The Escrow Agent shall have the right to liquidate any investments held in order to provide funds necessary to make required payments under this Agreement. The Parties may direct in writing the Escrow Agent as to which investments to liquidate to make such required payments. The Escrow Agent, in its capacity as escrow agent hereunder, shall not have any liability for any loss sustained as a result of any investment made pursuant to the instructions of the Parties or as a result of any liquidation of any investment prior to its maturity or for the failure of the Parties to give the Escrow Agent instructions to invest or reinvest the Escrow Funds.

(d) The Escrow Agent shall have no responsibility or liability for any loss that may result from any investment or sale of investment made pursuant to this Agreement. The Escrow Agent is hereby authorized, in making or disposing of any investment permitted by this Agreement, to deal with itself or with any one or more of its affiliates, whether it or any such affiliate is acting as agent of the Escrow Agent or for any third person or dealing as principal for its own account. The Parties acknowledge that the Escrow Agent is not providing investment supervision, recommendations, or advice.

6. Monthly Statements. As soon as reasonably practicable following each month during the term of this Agreement, the Escrow Agent shall deliver to the Parties a statement setting forth (a) the value of the Escrow Funds as of such date, (b) the amount of Escrow Interest during the period covered by such statement, (c) the amount of payments and distributions made during the period covered in such statement and the payee thereof and (d) confirmations of permitted investment transactions, to the extent applicable. The Parties agree that confirmations of permitted investments are not required to be issued by the Escrow Agent for each month in which a monthly statement is rendered. No statement need be rendered for any fund or account if no activity occurred in such fund or account during such month.

7. Payment of Taxes.

(a) Consistent with proposed Treasury Regulation section 1.468B-8, the Buyer Representative shall be treated as the owner of the Escrow Funds for federal income tax purposes and shall be responsible for paying all foreign, federal, state, and local income taxes payable on the Escrow Funds, and all interest and other income, and interest earned on such interest and other income related to the Escrow Funds (any such taxes being herein called "**Income Taxes**") until the amount of and parties entitled to the distribution of the Escrow Funds (or portion thereof) are determined and the Income Taxes shall thereafter be the responsibility of the Buyer Representative, on the one hand, and the Sellers, on the other hand, in accordance with their respective interests in the amount of the Escrow Funds subject to distribution consistent with proposed Treasury Regulations section 1.468B-8. Each of the Parties shall file all tax returns in a manner consistent with the foregoing, and the responsible Party shall pay the taxes directly to the taxing authority. The Parties agree that, for tax reporting purposes, all interest or other income earned on the investment of the Escrow Funds shall, as of the end of each calendar year and to the extent required by the Internal Revenue Service, be reported as having been earned by the Buyer Representative, whether or not such income was disbursed during such calendar year. Notwithstanding anything in this Agreement to the contrary, each responsible Party shall pay on its own behalf all such Income Taxes at or before the time any such Income Taxes become due and payable (taking into account any extension of the due date thereof) after any distribution of the Escrow Funds to such Party.

(b) The Escrow Agent shall have no responsibility under this Section 7 for the payment of Income Taxes or the filing of any returns in connection therewith other than to provide the Parties with copies of such records in the Escrow Agent's possession as are reasonably requested by the Parties in connection with the filing of any such returns.

(c) For certain payments made pursuant to this Agreement, the Escrow Agent may be required to make a "reportable payment" or "withholdable payment" and in such cases the Escrow Agent shall have the duty to act as a payor or withholding agent, respectively, that is responsible for any tax withholding and reporting required under Chapters 3, 4, and 61 of the United States Internal Revenue Code of 1986, as amended (the "**Code**"). The Escrow Agent shall have the sole right to make the determination as to which payments are "reportable payments" or "withholdable payments." The Parties shall provide an executed IRS Form W-9 or appropriate IRS Form W-8 (or, in each case, any successor form) to the Escrow Agent prior to the date hereof, and shall promptly update any such form to the extent such form becomes obsolete or inaccurate in any respect. The Escrow Agent shall have the right to request from any Party, or any other person or entity entitled to payment hereunder, any additional forms, documentation or other information as may be reasonably necessary for the Escrow Agent to satisfy its reporting and withholding obligations under the Code. To the extent any such forms to be delivered under this Section 6.5(c) are not provided prior to the date hereof or by the time the related payment is required to be made or are determined by the Escrow Agent to be incomplete and/or inaccurate in any respect, the Escrow Agent shall be entitled to withhold (without liability) a portion of any interest or other income earned on the investment of the Escrow Amount or on any such payments hereunder to the extent withholding is required under Chapters 3, 4, or 61 of the Code, and shall have no obligation to gross up any such payment.

(d) To the extent that the Escrow Agent becomes liable for the payment of any taxes in respect of income derived from the investment of the Escrow Funds, the Escrow

Agent shall satisfy such liability to the extent possible from the Escrow Funds. The Parties shall indemnify, defend, and hold the Escrow Agent harmless jointly and severally from and against any tax, late payment, interest, penalty, or other cost or expense that may be assessed against the Escrow Agent on or with respect to the Escrow Funds and the investment thereof that is the responsibility of the Sellers or the Buyer Representative, as the case may be, hereunder unless such tax, late payment, interest, penalty, or other expense was directly caused by the gross negligence or willful misconduct of the Escrow Agent. The indemnification provided by this paragraph shall survive the resignation or removal of the Escrow Agent and the termination of this Agreement.

8. Delivery of Escrow Funds by Escrow Agent. The Escrow Agent shall hold the Escrow Funds until instructed or otherwise required to deliver the same or any portion thereof in accordance with Section 9 hereto.

9. Distributions.

(a) Indemnification Claims. Subject to the terms, conditions and limitations set forth in Article XII of the Purchase Agreement, if at any time prior to the second (2nd) anniversary of the Closing Date (the "**Indemnification Claims Cutoff Date**"), the Buyer Representative delivers to the Escrow Agent and the Seller Representative a certificate in substantially the form of Exhibit B attached hereto (an "**Indemnification Claim Certificate**") instructing the Escrow Agent to distribute all or a portion of the Escrow Funds to the Buyer Representative in satisfaction of any unpaid indemnification claim (a "**Claim**") asserted by the Buyer Representative pursuant to Article XII of the Purchase Agreement, then the Escrow Agent shall pay to the Buyer Representative the amount of Escrow Funds from the Escrow Account set forth in the Indemnification Claim Certificate in accordance therewith on the first (1st) business day after the thirtieth (30th) calendar day after it receives the Indemnification Claim Certificate; *provided, however*, that if the Escrow Agent receives from the Seller Representative a certificate in the form of Exhibit C attached hereto (an "**Indemnification Objection Notice**"), pursuant to which the Seller Representative objects to all or any portion of such Claim in specific detail, including the dollar amount in dispute and a specific written description of the reason(s) for the dispute, then (x) the Escrow Agent shall hold the amount disputed (the "**Disputed Amount**"), as set forth in the Indemnification Objection Notice, until receipt of notice of a Final Order (as defined below) in the form of Exhibit D attached hereto or joint notification in the form of Exhibit E attached hereto, and (y) the Escrow Agent shall as soon as reasonably practicable pay the amount, if any, not disputed to the Buyer Representative in accordance with the Indemnification Claim Certificate. The Buyer Representative shall deliver its Indemnification Claim Certificate to the Seller Representative at or prior to delivery of such Indemnification Claim Certificate to the Escrow Agent. In the event the Seller Representative fails to deliver an Indemnification Objection Notice to the Escrow Agent within such thirty (30) calendar day period, the Escrow Agent shall pay to the Buyer Representative the amount of the Escrow Funds set forth in the Indemnification Claim Certificate.

(b) In the event that an arbitration award, final judgment, or decree of any court of competent jurisdiction has been entered or awarded, in accordance with the Purchase Agreement, when the time for appeal, if any, shall have expired and no appeal shall have been taken or when all appeals taken shall have been finally determined (the "**Final Order**"), relating

to a Claim in favor of the Buyer Representative or any other the Buyer Representative Indemnified Party, in the case of Section 9(a) above, then the Buyer Representative shall deliver to the Escrow Agent and the Seller Representative, promptly after the issue of any such Final Order, a written notice in substantially the form of Exhibit D attached hereto, executed by the Buyer Representative, instructing the Escrow Agent to deliver to the Buyer Representative the Escrow Funds in accordance with Section 9(a) above in the amount of such judgment or award. Such notice shall state the amount of the Escrow Funds in accordance with Section 9(a) above, as appropriate, which the Escrow Agent shall deliver and the date upon which such delivery shall be made (which shall be no earlier than the date set forth in the next sentence) and be accompanied by a true and correct copy of the Final Order. The Escrow Agent shall deliver the stated amount of Escrow Funds in accordance with Section 9(a) above on the fifth (5^{th}) business day after it receives such notice or such later date as set forth in accordance with such notice. The Escrow Agent shall not be liable to the Seller Representative or the Buyer Representative or any other person in the event that the Escrow Agent makes a payment hereunder pursuant to a Final Order and such Final Order is subsequently reversed, modified, annulled, set aside, or vacated. Any Final Order shall be accompanied by an opinion of counsel for the presenting Party that such order is final and non-appealable and from a court of competent jurisdiction upon which opinion the Escrow Agent shall be entitled to conclusively rely without further investigation.

(c) In the event the Buyer Representative and the Seller Representative mutually agree to settle any claim for indemnification or other matter relating to the Purchase Agreement, then the Buyer Representative and the Seller Representative shall deliver to the Escrow Agent a written notice in substantially the form of Exhibit E attached hereto, duly executed by the Buyer Representative and the Seller Representative, instructing the Escrow Agent to deliver to the Buyer Representative all or a portion of such Escrow Funds. Such joint notice shall state the amount of the Escrow Funds which the Escrow Agent shall deliver to recipient and the date upon which such delivery shall be made.

(d) On the business day immediately following the Indemnification Claims Cutoff Date, or such earlier time that the Buyer Representative and the Seller Representative shall jointly instruct the Escrow Agent in writing, the Escrow Agent shall promptly deliver to the Seller Representative (for the benefit of the Sellers) from the Escrow Funds the amount, if any, by which (i) the remaining Escrow Funds exceed (ii) the sum of all Disputed Amounts then held by Escrow Agent payable pursuant to any unresolved Indemnification Claim Certificates that were delivered in accordance with Section 9(a) prior to the Indemnification Claims Cutoff Date. The Escrow Agent shall continue to hold Disputed Amounts until such Disputed Amounts are resolved in accordance with this Agreement.

(e) If any portion of a Disputed Amount remains undistributed after all Claims for disbursement are paid and resolved, the Escrow Agent shall, upon the receipt of written direction from the Seller Representative (with a copy to the Buyer Representative), if the Buyer Representative does not object in writing to the Escrow Agent (with a copy to the Seller Representative) within five (5) business days of such written direction, in accordance with the notice and delivery requirements set forth in Section 21 hereto, deliver such amount, if any, to the Seller Representative (for the benefit of the Sellers) within one (1) business day following the later of such resolution or payment.

(f) No release to the Seller Representative of Escrow Funds hereunder shall limit the Buyer Representative's right to seek indemnification, which shall only be limited as described in the Purchase Agreement. The Escrow Funds held pursuant to this Agreement are intended to provide a non-exclusive source of funds to the Buyer Representative for the payment of any amounts which may become payable with respect to indemnification claims asserted by the Buyer Representative pursuant to Article XII of the Purchase Agreement.

10. Security Procedure for Funds Transfers. The Escrow Agent shall confirm each funds transfer instruction received in the name of a Party by means of the security procedure selected by such Party and communicated to the Escrow Agent through a signed certificate in the form of Exhibit G-1 or Exhibit G-2 attached hereto, which upon receipt by the Escrow Agent shall become a part of this Agreement. Once delivered to the Escrow Agent, Exhibit G-1 or Exhibit G-2 may be revised or rescinded only by a writing signed by an authorized representative of the Party. Such revisions or rescissions shall be effective only after actual receipt and following such period of time as may be necessary to afford the Escrow Agent a reasonable opportunity to act on it. If a revised Exhibit G-1 or Exhibit G-2 or a rescission of an existing Exhibit G-1 or Exhibit G-2 is delivered to the Escrow Agent by an entity that is a successor-in-interest to such Party, such document shall be accompanied by additional documentation satisfactory to the Escrow Agent showing that such entity has succeeded to the rights and responsibilities of the Party under this Agreement.

The Parties understand that the Escrow Agent's inability to receive or confirm funds transfer instructions pursuant to the security procedure selected by such Party may result in a delay in accomplishing such funds transfer, and they agree that the Escrow Agent shall not be liable for any loss caused by any such delay.

11. Duties of Escrow Agent. The Escrow Agent hereby accepts its obligations under this Agreement and represents that it has the legal power and authority to enter into this Agreement and perform its obligations hereunder. The Escrow Agent further agrees that all Escrow Funds held by the Escrow Agent hereunder shall be segregated from all other property held by the Escrow Agent and shall be identified as being held in connection with this Agreement. Segregation may be accomplished by appropriate identification on the books and records of the Escrow Agent. The Escrow Agent agrees that its documents and records with respect to the transactions contemplated hereby will be available for examination by authorized representatives of the Buyer Representative and the Seller Representative during normal business hours of the Escrow Agent upon not less than two (2) business days' prior written notice and at the requesting Party's expense. Any fees charged by the Escrow Agent shall be paid equally by the Buyer Representative on the one hand, and the Seller Representative (on behalf of the Sellers), on the other hand. The fees of the Escrow Agent are attached hereto as Exhibit F and initial escrow fees shall be paid on the Effective Date. The Escrow Agent shall have, and is hereby granted, a prior lien upon the Escrow Funds with respect to its unpaid fees, non-reimbursed expenses, and unsatisfied indemnification rights, superior to the interests of any other persons or entities. The Escrow Agent shall be entitled and is hereby granted the right to set off and deduct any unpaid fees, non-reimbursed expenses, and unsatisfied indemnification rights from the Escrow Funds.

12. No Other Duties. Notwithstanding any provision to the contrary, the Escrow Agent is obligated only to perform the duties specifically set forth in this Agreement, which shall be deemed purely ministerial in nature. Under no circumstance will the Escrow Agent be deemed to be a fiduciary to the Buyer Representative, the Seller Representative or any other person under this Agreement. The Escrow Agent shall not have any duties or responsibilities hereunder except as expressly set forth herein. References in this Agreement to any other agreement, instrument, or document are for the convenience of the Buyer Representative and the Seller Representative, and the Escrow Agent has no duties or obligations with respect thereto.

13. Reliance on Documentary Evidence by the Escrow Agent. The Escrow Agent shall be entitled to rely upon any notice, certificate, affidavit, letter, document, or other communication that is reasonably believed by the Escrow Agent to be genuine and to have been signed or sent by the proper Party or Parties, and the Escrow Agent may rely on statements contained therein without further inquiry or investigation. Concurrently with the execution of this Agreement, the Buyer Representative and the Seller Representative shall deliver to the Escrow Agent Exhibit G-1 or Exhibit G-2 attached hereto, which contain authorized signer designations in Part I thereof. The Parties represent and warrant that each person signing this Escrow Agreement are duly authorized and has legal capacity to execute and deliver this Escrow Agreement, along with each exhibit, agreement, document, and instrument to be executed and delivered by the Parties to this Escrow Agreement.

14. Attorneys and Agents. The Escrow Agent shall be entitled to rely on and, except in the case of its own gross negligence or willful misconduct, shall not be liable for any action taken or omitted to be taken by the Escrow Agent in accordance with the advice of competent counsel or other competent professionals retained or consulted by the Escrow Agent. The Escrow Agent shall not be responsible for the negligence or misconduct of agents or attorneys appointed by it with reasonable care.

15. Liability of the Escrow Agent. The Escrow Agent shall not be liable for any action taken in accordance with the terms of this Agreement, including, without limitation, any release or distribution of Escrow Funds in accordance with Section 8 or Section 9 hereto. THE ESCROW AGENT SHALL NOT BE LIABLE, DIRECTLY OR INDIRECTLY, FOR ANY DAMAGES, LOSSES, OR EXPENSES ARISING OUT OF THE SERVICES PROVIDED HEREUNDER, OTHER THAN DAMAGES, LOSSES, OR EXPENSES THAT HAVE BEEN FINALLY ADJUDICATED TO HAVE DIRECTLY RESULTED FROM THE ESCROW AGENT'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT. THE ESCROW AGENT SHALL NOT BE LIABLE, DIRECTLY OR INDIRECTLY, FOR SPECIAL, PUNITIVE, INDIRECT, OR CONSEQUENTIAL DAMAGES OR LOSSES OF ANY KIND WHATSOEVER (INCLUDING, WITHOUT LIMITATION, LOST PROFITS), EVEN IF THE ESCROW AGENT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH LOSSES OR DAMAGES AND REGARDLESS OF THE FORM OF ACTION.

16. Indemnification of the Escrow Agent. The Buyer Representative and the Seller Representative hereby agree to jointly and severally indemnify the Escrow Agent, and defend and hold the Escrow Agent harmless, from and against any and all claims, costs, expenses, demands, judgments, losses, damages, and liabilities (including, without limitation, reasonable attorneys' fees and disbursements) ("**Escrow Damages**") arising out of or in connection with the

Escrow Agent's performance of its duties pursuant to this Agreement, except such Escrow Damages as may be finally adjudicated to have been directly caused by the gross negligence or willful misconduct of the Escrow Agent. The provisions of this Section 16 shall survive the termination of this Agreement and the resignation or removal of the Escrow Agent. Solely as between the Buyer Representative and Seller Representative, each of the Buyer Representative, on the one hand, and the Seller Representative, on the other hand, shall have a right of contribution from the other parties (other than Escrow Agent) in any action in which the Escrow Agent claims indemnification pursuant to this Agreement in the event such Party or Parties fail(s) to pay its or their pro rata share of such claim. No provision of this Agreement shall require the Escrow Agent to risk or advance its own funds or otherwise incur any financial liability or potential financial liability in the performance of its duties or the exercise of its rights hereunder.

17. Resignation or Removal of the Escrow Agent. The Escrow Agent may at any time resign by giving not less than thirty (30) calendar days' prior written notice of such resignation to the Buyer Representative and the Seller Representative. The Escrow Agent may be removed as escrow agent hereunder if both the Buyer Representative and the Seller Representative agree to such removal and give not less than thirty (30) calendar days' prior written notice thereof to the Escrow Agent. The Escrow Agent shall not be discharged from its duties and obligations hereunder until a successor escrow agent shall have been jointly designated by the Buyer Representative and the Seller Representative, and shall have executed and delivered an escrow agreement in substantially the form of this Agreement, and all Escrow Funds then held by the Escrow Agent hereunder, less any fees and expenses then due and owing to the Escrow Agent, shall have been delivered to such successor escrow agent. If the Buyer Representative and the Seller Representative have failed to appoint a successor escrow agent prior to the expiration of thirty (30) calendar days following the delivery of such notice of resignation or removal, the Escrow Agent may petition any court of competent jurisdiction for the appointment of a successor escrow agent or for other appropriate relief, and any such resulting appointment shall be binding upon the Buyer Representative and the Seller Representative.

18. Interpleader. If the Buyer Representative and the Seller Representative shall disagree about the interpretation of this Agreement, or about the rights and obligations or the propriety of any action contemplated by the Escrow Agent hereunder, or the Escrow Agent shall be uncertain how to act in a situation presented hereunder, the Escrow Agent may, in its discretion, refrain from taking action until directed in writing jointly by the Buyer Representative and the Seller Representative or, after sixty (60) calendar days' notice to the Parties of its intention to do so, file an action of interpleader in the appropriate court of competent jurisdiction and deposit all of the Escrow Funds with such court. Upon the filing of such action, the Escrow Agent shall be relieved of all liability as to the Escrow Funds and shall be entitled to recover reasonable attorneys' fees, expenses, and other costs incurred in commencing and maintaining any such interpleader action unless such costs, fees, charges, disbursements, or expenses shall have been finally adjudicated to have directly resulted from the willful misconduct or gross negligence of the Escrow Agent.

19. Merger or Consolidation. Any corporation or association into which the Escrow Agent may be converted or merged, or with which it may be consolidated, or to which it may sell

or transfer all or substantially all of its corporate trust business and assets as a whole or substantially as a whole, or any corporation or association resulting from any conversion, sale, merger, consolidation, or transfer to which the Escrow Agent is a party, shall be and become the successor escrow agent under this Agreement and shall have and succeed to the rights, powers, duties, immunities, and privileges as its predecessor, without the execution or filing of any instrument or paper or the performance of any further act, any provision herein to the contrary notwithstanding.

20. Attachment of Escrow Funds; Compliance with Legal Orders. In the event that any of the Escrow Funds shall be attached, garnished, or levied upon by any court order, or the delivery thereof shall be stayed or enjoined by an order of a court, or any order, judgment, or decree shall be made or entered by any court with respect to the Escrow Funds, the Escrow Agent is hereby expressly authorized, in its sole discretion, to respond as it reasonably deems appropriate or to comply with all writs, orders, or decrees so entered or issued, or which it is advised by legal counsel of its own choosing is binding upon it, whether with or without jurisdiction. In the event that the Escrow Agent obeys or complies with any such writ, order, or decree, it shall not be liable to the Buyer Representative, the Seller Representative, or to any other person, firm, or corporation, should, by reason of such compliance notwithstanding, such writ, order, or decree be subsequently reversed, modified, annulled, set aside, or vacated.

21. Notices. All notices and communications (including certificates and notices delivered pursuant to Section 9 hereto) by the Buyer Representative or the Seller Representative to the Escrow Agent shall be delivered contemporaneously to the other Party in the same manner as provided to the Escrow Agent. All notices and other communications under this Agreement shall be in writing and shall be deemed effectively given when personally delivered, when received by overnight delivery or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to the Buyer Representative: Health Quest Systems, Inc.
1351 Route 55, Suite 200
Lagrangeville, NY 12540
Attention: Michael Holzhueter, Senior Vice President and General Counsel

With a Copy to: McDermott Will & Emery LLP
28 State Street
Boston, MA 02109-1775
Attention: Charles Buck

If to the Seller Representative: RegionalCare Hospital Partners, Inc.
103 Continental Place, Suite 410
Brentwood, TN 37027
Attention: General Counsel

With a Copy to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, TN 37219 Attention: George W. Bishop III
If to Escrow Agent:	Wells Fargo Bank, National Association 150 East 42nd Street 40th Floor Corporate, Escrow, and Municipal Solutions New York, NY 10017 Attention: Kweku Asare Phone: 917.260.1551 Facsimile: 917.260.1592 E-mail: kweku.a.asare@wellsfargo.com

or to such other address, and to the attention of such other person or officer as any party may designate, with copies thereof to the respective counsel thereof as notified by such party.

22. Assignment. This Agreement shall not be assigned by any party without the written consent of the other parties and any attempted assignment without such written consent shall be null and void and without legal effect. This Agreement shall be binding upon and inure to the benefit of the respective parties hereto and, if any consent required by this Section 22 is properly secured, the successors and assigns of such party. Nothing herein is intended or shall be construed to give any other person any right, remedy, or claim under, in or with respect to this Agreement or any property held hereunder.

23. Waivers and Amendments. This Agreement may be amended, modified, extended, superseded, canceled, renewed, or extended, and the terms and conditions hereof may be waived, only by a written document signed by the Buyer Representative, the Seller Representative, and the Escrow Agent or, in the case of a waiver by the Buyer Representative or the Seller Representative, by the Party or Parties waiving compliance. No delay on the part of the Buyer Representative or the Seller Representative in exercising any right, power or privilege hereunder shall operate as a waiver thereof nor shall any waiver on the part of the Buyer Representative or the Seller Representative of any right, power, or privilege hereunder nor any single or partial exercise of any right, power, or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, power, or privilege hereunder.

24. Governing Law. All issues and questions concerning the construction, validity, interpretation, and enforceability of this Agreement and the exhibits and schedules hereto shall be governed by, and construed in accordance with, the laws of the State of New York, without giving effect to any choice of law or conflict of law rules or provisions (whether of the State of New York or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of New York.

25. Resolution of Disputes; Court Proceedings; Attorneys' Fees and Costs. The parties to this Agreement shall act in good faith to resolve any dispute or other controversy arising under this Agreement. Absent agreement resolving a dispute within ten (10) calendar days after the dispute has arisen, any party shall have the right to seek to settle the matter by

court action or, if the parties agree at the time, by arbitration. If any party should institute legal proceedings to enforce such party's rights under this Agreement, or otherwise with respect to the subject matter of this Agreement, the prevailing party or parties shall recover, in addition to all other costs and damages awarded, and the losing party or parties shall pay, the reasonable attorneys' fees and costs at trial, on appeal, upon petition for review, or in any bankruptcy proceeding, of the prevailing party or parties, whether or not such fees and costs are prescribed by statute, and shall pay the fees and costs of the Escrow Agent incurred in connection with such dispute, including reimbursement to the prevailing party of such fees and costs previously paid, in each case as determined by the court at trial or upon any appeal. Any lawsuit or proceeding permitted by the terms of this Agreement to be filed in a court, which lawsuit or proceeding is brought to enforce, challenge, or construe the terms or making of this Agreement and any claims arising out of or related to this Agreement, shall be exclusively brought and litigated exclusively in a state or federal court having subject matter jurisdiction and located in the State of New York. For the purpose of any lawsuit or proceeding instituted with respect to any claim arising out of or related to this Agreement, each party hereby irrevocably submits to the exclusive jurisdiction of the state or federal courts having subject matter jurisdiction and located in the State of New York. Each party hereby irrevocably waives any objection or defense which it may now or hereafter have of improper venue, forum non conveniens, or lack of personal jurisdiction.

26. Waiver of Jury Trial. AS A SPECIFICALLY BARGAINED INDUCEMENT FOR EACH OF THE PARTIES TO ENTER INTO THIS AGREEMENT (EACH PARTY HAVING HAD OPPORTUNITY TO CONSULT COUNSEL), EACH PARTY EXPRESSLY WAIVES THE RIGHT TO TRIAL BY JURY IN ANY LAWSUIT OR PROCEEDING RELATING TO OR ARISING IN ANY WAY FROM THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREIN.

27. Counterparts. This Agreement may be executed in two or more counterparts, and by different parties hereto on separate counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or electronic mail in PDF or similar format shall be effective as delivery of a mutually executed counterpart to this Agreement.

28. Termination. This Agreement shall terminate upon the earlier of: (a) one-hundred twenty (120) days after Escrow Agent's delivery of all the Escrow Funds, or (b) the joint written instructions of the Buyer Representative and the Seller Representative; except that the provision of Sections 7, 15, 16, 25, and 26 shall survive the termination of this Agreement.

29. Severability. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, and the parties hereto shall amend or otherwise modify this Agreement to replace any prohibited or invalid provision with an effective and valid provision that gives effect to the intent of the parties to the maximum extent permitted by applicable law.

30. Force Majeure. The Escrow Agent shall not be responsible or liable for any failure or delay in the performance of its obligation under this Agreement arising out of or caused, directly or indirectly, by circumstances beyond its reasonable control, including, without limitation, acts of God; earthquakes; fire; flood; wars; acts of terrorism; civil or military disturbances; sabotage; epidemic; riots; interruptions, loss or malfunctions of utilities, computer (hardware or software) or communications services; accidents; labor disputes; acts of civil or military authority or governmental action; it being understood that the Escrow Agent shall use commercially reasonable efforts that are consistent with accepted practices in the banking industry to resume performance as soon as reasonably practicable under the circumstances.

31. Publication; Disclosure. By executing this Agreement, the parties acknowledge that this Agreement (including related attachments) contains certain information that is sensitive and confidential in nature and agree that such information needs to be protected from improper disclosure, including the publication or dissemination of this Agreement and related information to individuals or entities not a party to this Agreement. The parties hereto further agree to take reasonable measures to mitigate any risks associated with the publication or disclosure of this Agreement and information contained therein, including, without limitation, the redaction of the manual signatures of the signatories to this Agreement, or, in the alternative, the publication of a conformed copy of this Agreement. If a party must disclose or publish this Agreement or information contained therein pursuant to any stock exchange request or any regulatory, statutory, or governmental rule or requirement, as well as any judicial or administrative order, subpoena, or discovery request, it shall notify in writing the other parties at the time of execution of this Agreement of the legal requirement to do so. If any party hereto becomes aware of any threatened or actual unauthorized disclosure, publication, or use of this Agreement, such party shall promptly notify in writing the other parties and shall be liable for any unauthorized release or disclosure.

[SIGNATURE PAGES FOLLOW]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the Effective Date.

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name:_____
Title:_____

ESCROW AGENT:

WELLS FARGO BANK, NATIONAL ASSOCIATION, solely in its capacity as Escrow Agent hereunder

By:_____
Name:_____
Title:_____

EXHIBIT A

Agency and Custody Account Direction
For Cash Balances
Wells Fargo Money Market Deposit Accounts

Directions to use the following Wells Fargo Money Market Deposit Accounts for Cash Balances for the escrow account (the "Account") established under the Escrow Agreement to which this Exhibit A is attached.

In the absence of complete, joint written investment instructions from the Parties, the Escrow Agent is hereby directed to deposit, as indicated below, or as the Parties shall direct further in writing from time to time, all cash in the Account in the following money market deposit account of Wells Fargo Bank, National Association:

Wells Fargo Money Market Deposit Account ("MMDA")

The Parties understand that amounts on deposit in the MMDA are insured, subject to the applicable rules and regulations of the Federal Deposit Insurance Corporation ("FDIC"), in the basic FDIC insurance amount of $250,000 per depositor, per insured bank. This includes principal and accrued interest up to a total of $250,000. The Parties understand that deposits in the MMDA are not secured.

The Parties acknowledge that the Parties collectively have full power to direct investments of the Account.

The Parties understand that the Parties may jointly change this direction at any time and that it shall continue in effect until revoked or modified by the Parties by joint written notice to the Escrow Agent.

EXHIBIT B

Indemnification Claim Certificate

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Indemnification Claim Certificate is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement. This is to notify you, as the Escrow Agent, and the Seller Representative, of a Claim under the Purchase Agreement for $_____ out of the Escrow Funds.

Unless you receive from the Seller Representative an Indemnification Objection Notice in response to this Indemnification Claim Certificate on or before the thirtieth (30th) calendar day after your receipt hereof, you are hereby instructed to deliver on the first (1st) business day after the thirtieth (30th) calendar day after your receipt hereof the sum of $_____ out of Escrow Funds from the Escrow Account to the Buyer Representative by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

cc: RegionalCare Hospital Partners, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.

Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT C

Indemnification Objection Notice

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Indemnification Objection Notice is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

The undersigned hereby objects to $_____ (the "**Disputed Amount**") of the Claim that the Buyer Representative asserted in the Indemnification Claim Certificate. Accordingly, you are hereby instructed not to deliver the Disputed Amount to the Buyer Representative.

The reasons for this dispute are as follows (or are attached): _____
_____
_____
_____
_____
_____

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name:_____
Title:_____

cc: Health Quest Systems, Inc.
Vassar Health Connecticut, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT D

Notice of a Final Order

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku AsarePhone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Notice of a Final Order ("**Notice**") is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

The undersigned hereby certifies that: (a) a Final Order exists with respect to a Claim; (b) a true and correct copy of the Final Order or other evidence of the Final Order accompanies this certificate,; and (c) the undersigned is entitled to receive Escrow Funds from the Escrow Account in accordance with the Purchase Agreement and said Escrow Agreement.

You are hereby instructed to deliver payment on the fifth (5th) business day after your receipt of this Notice $_____ of Escrow Funds from the Escrow Account to the Buyer Representative, by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

cc: RegionalCare Hospital Partners, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.
Regional Healthcare Associates, LLC

Tri State Women's Services, LLC

EXHIBIT E

Joint Notification

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: kweku.a.asare@wellsfargo.com

This Joint Notification is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

You are hereby instructed to deliver **[immediately]** **[on date]** $_____ of Escrow Funds to the Buyer Representative, by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name:_____
Title:_____

cc: Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.
Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT F

Escrow Agent Fees

See attached.

Corporate Trust Services

Schedule of fees to provide escrow agent services
Health Quest Systems, Inc. / RegionalCare Hospital Partners, Inc.
Indemnification Escrow Account
Approximate size: $500,000

Exhibit F

Acceptance fee	Waived

A one-time fee for our initial review of governing documents, account set-up and customary duties and responsibilities related to the closing. This fee is payable at closing.

Annual administration fee	$3,500

An annual fee for customary administrative services provided by the escrow agent, including daily routine account management; cash management transactions processing (including wire and check processing), disbursement of funds in accordance with the agreement, tax reporting for one entity, and providing account statements to the parties. The administration fee is payable annually in advance per escrow account established. The first installment of the administrative fee is payable at closing.

Out-of-pocket expenses	At cost

Out-of- pocket expenses will be billed as incurred at cost at the sole discretion of Wells Fargo.

Extraordinary services	Standard rate

The charges for performing services not contemplated at the time of execution of the governing documents or not specifically covered elsewhere in this schedule will be at Wells Fargo's rates for such services in effect at the time the expense is incurred. The review of complex tax forms, including by way of example but not limited to IRS Form W-8IMY, shall be considered extraordinary services.

Assumptions

This proposal is based upon the following assumptions with respect to the role of escrow agent:

- Number of escrow accounts to be established: 1
- Amount of escrow: $500,000
- Term of escrow: 36 - 48 months
- Number of tax reporting parties: 1
- Number of parties to the transaction: 3
- Number of cash transactions (deposits/disbursements): 2 deposits/5 disbursements
- Fees quoted assume all transaction account balances will be held uninvested or invested in select Wells Fargo deposit products.
- Disbursements shall be made only to the parties specified in the agreement. Any payments to other parties are at the sole discretion and subject to the requirements of Wells Fargo and shall be considered extraordinary services.

Terms and conditions

- The recipient acknowledges and agrees that this proposal does not commit or bind Wells Fargo to enter into a contract or any other business arrangement, and that acceptance of the appointment described in this proposal is expressly conditioned on (1) compliance with the requirements of the USA Patriot Act of 2001, described below, (2) satisfactory completion of Wells Fargo's internal account acceptance procedures, (3) Wells Fargo's review of all applicable governing documents and its confirmation that all terms and conditions pertaining to its role are satisfactory to it and (4) execution of the governing documents by all applicable parties.

Together we'll go far

Corporate Trust Services
Schedule of fees to provide escrow agent services
Health Quest Systems, Inc. / RegionalCare Hospital Partners, Inc.
Indemnification Escrow Account
Approximate size: $500,000

- Should this transaction fail to close or if Wells Fargo determines not to participate in the transaction, any acceptance fee and any legal fees and expenses may be due and payable.
- Legal counsel fees and expenses, any acceptance fee and any first year annual administrative fee are payable at closing.
- Any annual fee covers a full year or any part thereof and will not be prorated or refunded in a year of early termination.
- Should any of the assumptions, duties or responsibilities of Wells Fargo change, Wells Fargo reserves the right to affirm, modify or rescind this proposal.
- The fees described in this proposal are subject to periodic review and adjustment by Wells Fargo.
- Invoices outstanding for over 30 days are subject to a 1.5% per month late payment penalty.
- This fee proposal is good for 90 days.

Important information about identifying our customers

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person (individual, corporation, partnership, trust, estate or other entity recognized as a legal person) for whom we open an account.

What this means for you: Before we open an account, we will ask for your name, address, date of birth (for individuals), TIN/EIN or other information that will allow us to identify you or your company. For individuals, this could mean identifying documents such as a driver's license. For a corporation, partnership, trust, estate or other entity recognized as a legal person, this could mean identifying documents such as a Certificate of Formation from the issuing state agency.

Date: September 8, 2016

EXHIBIT G-1

Buyer Representative Security Agreement

The Buyer Representative certifies that the names, titles, telephone numbers, e-mail addresses, and specimen signatures set forth in Parts I and II of this Exhibit G-1 identify the persons authorized to provide direction and initiate or confirm transactions, including funds transfer instructions, on behalf of the Buyer Representative, and that the option checked in Part III of this Exhibit G-1 is the security procedure selected by the Buyer Representative for use in verifying that a funds transfer instruction received by the Escrow Agent is that of the Buyer Representative.

The Buyer Representative has reviewed each of the security procedures and has determined that the option checked in Part III of this Exhibit G-1 best meets its requirements given the size, type, and frequency of the instructions it will issue to the Escrow Agent. By selecting the security procedure specified in Part III of this Exhibit G-1, the Buyer Representative acknowledges that it has elected to not use the other security procedures described and agrees to be bound by any funds transfer instruction, whether or not authorized, issued in its name and accepted by the Escrow Agent in compliance with the particular security procedure chosen by the Buyer Representative.

NOTICE: The security procedure selected by the Buyer Representative will not be used to detect errors in the funds transfer instructions given by the Buyer Representative. If a funds transfer instruction describes the beneficiary of the payment inconsistently by name and account number, payment may be made on the basis of the account number even if it identifies a person different from the named beneficiary. If a funds transfer instruction describes a participating financial institution inconsistently by name and identification number, the identification number may be relied upon as the proper identification of the financial institution. Therefore, it is important that the Buyer Representative takes such steps as it deems prudent to ensure that there are no such inconsistencies in the funds transfer instructions it sends to the Escrow Agent.

Part I

Name, Title, Telephone Number, Electronic Mail ("e-mail") Address, and Specimen Signature for person(s) designated to provide direction, including but not limited to funds transfer instructions, and to otherwise act on behalf of the Buyer Representative

Name	Title	Telephone Number	E-mail Address	Specimen Signature

[list more if desired]

Part II

Name, Title, Telephone Number and E-mail Address for person(s) designated to confirm funds transfer instructions

Name	Title	Telephone Number	E-mail Address

[list more if desired]

Part III

Means for delivery of instructions and/or confirmations

The security procedure to be used with respect to funds transfer instructions is checked below:

☐ *Option 1. Confirmation by telephone call-back*. The Escrow Agent shall confirm funds transfer instructions by telephone call-back to a person at the telephone number designated on Part II above. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-1.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by telephone call-back, the Escrow Agent may, at its discretion, confirm by e-mail, as described in Option 2.

☐ *Option 2. Confirmation by e-mail*. The Escrow Agent shall confirm funds transfer instructions by e-mail to a person at the e-mail address specified for such person in Part II of this Exhibit G-1. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-1. The Buyer Representative understands the risks associated with communicating sensitive matters, including time sensitive matters, by e-mail. The Buyer Representative further acknowledges that instructions and data sent by e-mail may be less confidential or secure than instructions or data transmitted by other methods. The Escrow Agent shall not be liable for any loss of the confidentiality of instructions and data prior to receipt by the Escrow Agent.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by e-mail, the Escrow Agent may, at its discretion, confirm by telephone call-back, as described in Option 1.

☐ **Option 3. Delivery of funds transfer instructions by password protected file transfer system only - no confirmation*. The Escrow Agent offers the option to deliver funds transfer instructions through a password protected file transfer system. If the Buyer Representative wishes to use the password protected file transfer system, further instructions will be provided by the Escrow Agent. If the Buyer Representative chooses this Option 3, they agree that no further confirmation of funds transfer instructions will be performed by the Escrow Agent.

☐ **Option 4. Delivery of funds transfer instructions by password protected file transfer system with confirmation*. Same as Option 3 above, but the Escrow Agent shall confirm funds transfer instructions by ☐ telephone call-back or ☐ e-mail (must check at least one, may check both) to a person at the telephone number or e-mail address designated on Part II above. By checking a box in the prior sentence, the party shall be deemed to have agreed to the terms of such confirmation option as more fully described in Option 1 and Option 2 above.

**The password protected file system has a password that expires every 60 days. If you anticipate having infrequent activity on this account, please consult with your Escrow Agent before selecting this option.*

Dated this ____ day of _____, 2017.

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

EXHIBIT G-2

Seller Representative Security Agreement

The Seller Representative certifies that the names, titles, telephone numbers, e-mail addresses and specimen signatures set forth in Parts I and II of this Exhibit G-2 identify the persons authorized to provide direction and initiate or confirm transactions, including funds transfer instructions, on behalf of the Seller Representative, and that the option checked in Part III of this Exhibit G-2 is the security procedure selected by the Seller Representative for use in verifying that a funds transfer instruction received by the Escrow Agent is that of the Seller Representative.

The Seller Representative has reviewed each of the security procedures and has determined that the option checked in Part III of this Exhibit G-2 best meets its requirements given the size, type, and frequency of the instructions it will issue to the Escrow Agent. By selecting the security procedure specified in Part III of this Exhibit G-2, the Seller Representative acknowledges that it has elected to not use the other security procedures described and agrees to be bound by any funds transfer instruction, whether or not authorized, issued in its name and accepted by the Escrow Agent in compliance with the particular security procedure chosen by the Seller Representative.

NOTICE: The security procedure selected by the Seller Representative will not be used to detect errors in the funds transfer instructions given by the Seller Representative. If a funds transfer instruction describes the beneficiary of the payment inconsistently by name and account number, payment may be made on the basis of the account number even if it identifies a person different from the named beneficiary. If a funds transfer instruction describes a participating financial institution inconsistently by name and identification number, the identification number may be relied upon as the proper identification of the financial institution. Therefore, it is important that the Seller Representative takes such steps as it deems prudent to ensure that there are no such inconsistencies in the funds transfer instructions it sends to the Escrow Agent.

Part I

Name, Title, Telephone Number, Electronic Mail ("e-mail") Address, and Specimen Signature for person(s) designated to provide direction, including but not limited to funds transfer instructions, and to otherwise act on behalf of the Seller Representative

Name	Title	Telephone Number	E-mail Address	Specimen Signature

Part II

Name, Title, Telephone Number, and E-mail Address for person(s) designated to confirm funds transfer instructions

Name	Title	Telephone Number	E-mail Address

Part III

Means for delivery of instructions and/or confirmations

The security procedure to be used with respect to funds transfer instructions is checked below:

☐ *Option 1. Confirmation by telephone call-back.* The Escrow Agent shall confirm funds transfer instructions by telephone call-back to a person at the telephone number designated on Part II above. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-2.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by telephone call-back, the Escrow Agent may, at its discretion, confirm by e-mail, as described in Option 2.

☐ *Option 2. Confirmation by e-mail.* The Escrow Agent shall confirm funds transfer instructions by e-mail to a person at the e-mail address specified for such person in Part II of this Exhibit G-2. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-2. The Seller Representative understands the risks associated with communicating sensitive matters, including time sensitive matters, by e-mail. The Seller Representative further acknowledges that instructions and data sent by e-mail may be less confidential or secure than instructions or data transmitted by other methods. The Escrow Agent shall not be liable for any loss of the confidentiality of instructions and data prior to receipt by the Escrow Agent.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by e-mail, the Escrow Agent may, at its discretion, confirm by telephone call-back, as described in Option 1.

☐ **Option 3. Delivery of funds transfer instructions by password protected file transfer system only - no confirmation.* The Escrow Agent offers the option to deliver funds transfer instructions through a password protected file transfer system. If the Seller Representative wishes to use the password protected file transfer system, further instructions will be provided by the Escrow Agent. If the Seller Representative chooses this Option 3, it agrees that no further confirmation of funds transfer instructions will be performed by the Escrow Agent.

☐ **Option 4. Delivery of funds transfer instructions by password protected file transfer system with confirmation.* Same as Option 3 above, but the Escrow Agent shall confirm funds transfer instructions by ☐ telephone call-back or ☐ e-mail (must check at least one, may check both) to a person at the telephone number or e-mail address designated on Part II above. By checking a box in the prior sentence, the party shall be deemed to have agreed to the terms of such confirmation option as more fully described in Option 1 and Option 2 above.

**The password protected file system has a password that expires every 60 days. If you anticipate having infrequent activity on this account, please consult with your Escrow Agent before selecting this option.*

Dated this ____ day of _____, 2017.

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name:_____
Title:_____

SCHEDULE I

Wire Transfer Instructions

Buyer Representative

Bank Name:

Bank Address:

Beneficiary:

Beneficiary ABA #

Beneficiary Account #

Seller Representative

Beneficiary Company:

Beneficiary Bank:

Beneficiary ABA #

Beneficiary Account #

Swift Code =

EXHIBIT C

BILL OF SALE

This Bill of Sale (this "**Bill of Sale**") is executed and delivered as of _____, 2017 by Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**") and Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**" and with Sharon, RHA and TSWS, each individually a "**Seller**" and collectively, the "**Sellers**"), pursuant to that certain Asset Purchase Agreement dated September __, 2016 (the "**Asset Purchase Agreement**") by and among Sellers, Health Quest Systems, Inc., a New York non-profit corporation ("**Health Quest**") and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("**VHC**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**"), solely for the purposes of Sections 13.32 and 13.33 of the Asset Purchase Agreement.

1. Defined Terms. Capitalized terms used but not defined herein shall have the meanings set forth in the Asset Purchase Agreement.

2. Transfer of Assets. For the consideration set forth in the Asset Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Sellers do hereby grant, bargain, sell, transfer, assign, convey, and deliver to Buyer and its successors and assigns, forever, effective as of the Closing, all of Sellers' right, title, and interest in, to, and under the Assets.

3. Further Assurances; Successors and Assigns. From and after the Closing Date, Sellers will execute, acknowledge, and deliver such other instruments of conveyance and transfer and perform such other acts as may be reasonably required effectively to transfer to, and vest in, Buyer and its successors and assigns, all of Sellers' right, title, and interest in, to, and under the Assets. This instrument shall be binding on Sellers and their successors and assigns, and the covenants and agreements of the Sellers set forth herein shall inure to the benefit of Buyer and its successors and assigns.

4. Conflict with Asset Purchase Agreement. The terms of this Bill of Sale are subject to the terms, provisions, conditions, and limitations set forth in the Asset Purchase Agreement, and this Bill of Sale is not intended to alter the obligations of the parties to the Asset Purchase Agreement. In the event the terms of this Bill of Sale conflict with the terms of the Asset Purchase Agreement, the terms of the Asset Purchase Agreement shall govern.

5. Governing Law. This Bill of Sale and the transactions contemplated hereby shall be governed by and construed and enforced in accordance with the internal laws of the State of New York without regard to the conflict of law provisions thereof.

[Signature Page Follows]

IN WITNESS WHEREOF, Sellers have executed this Bill of Sale as of the date first written above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

REGIONAL HEALTHCARE ASSOCIATES, LLC,

By:_____

Name:_____

Title:_____

HEALTH QUEST SYSTEMS, INC.

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____

Name:_____

Title:_____

TRI STATE WOMEN'S SERVICES, LLC

By:_____

Name:_____

Title:_____

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

EXHIBIT D

ASSIGNMENT AND ASSUMPTION AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION AGREEMENT (this "**Agreement**") is made and entered into as of _____, 2017, by and among Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**"), and Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**" and with Sharon, RHA, and TSWS, each individually a "**Seller**" and collectively, the "**Sellers**"), Health Quest Systems, Inc., a New York non-profit corporation ("**Health Quest**"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("**VHC**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**").

WHEREAS, pursuant to that certain Asset Purchase Agreement dated September __, 2016 (the "**Asset Purchase Agreement**") by and among Buyer, Sellers, and RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**"), solely for the purposes of Sections 13.32 and 13.33 of the Asset Purchase Agreement, Buyer has agreed to purchase the Assets (as defined in the Asset Purchase Agreement); and

WHEREAS, pursuant to the Asset Purchase Agreement, Sellers have agreed to assign certain rights and agreements to Buyer, and Buyer has agreed to assume certain obligations of Sellers, as set forth herein, and this Agreement is contemplated by Sections 3.2(c) and 3.3(b) of the Asset Purchase Agreement.

NOW, THEREFORE, for the consideration set forth in the Asset Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Capitalized Terms. Capitalized terms used but not defined herein shall have the meanings set forth in the Asset Purchase Agreement.

2. Assignment. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Closing, Sharon and/or SHHC, as applicable, hereby assigns to Buyer all of Sellers' right, title, benefit, privileges, and interest in, to and under the Assumed Contracts, the Tenant Leases, and the Seller Leases (collectively, the "**Seller Agreements**").

3. Assumption. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Closing, Buyer hereby accepts the assignment set forth in Section 2 above and assumes and agrees to keep, perform, and fulfill all of the terms, covenants, conditions, and obligations required to be kept, performed, or fulfilled by either Seller under the Seller Agreements. Additionally, subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Closing Date, Buyer hereby assumes and agrees to pay, perform, and discharge on a timely basis, in accordance with their terms, the Assumed Liabilities. Notwithstanding anything herein to the contrary, Buyer does not hereby assume, and shall not be liable or otherwise responsible for, any Excluded Liabilities.

4. Appointment. Sellers hereby appoint Buyer as Sellers' true and lawful attorney, with full power of substitution by, on behalf of, and for the benefit of Buyer and its successors and assigns, to enforce any right, title or interest hereby sold, conveyed, assigned, transferred, and delivered. The foregoing powers are coupled with an interest and shall be irrevocable by Sellers for any reason whatsoever.

5. Terms of the Asset Purchase Agreement. The terms of the Asset Purchase Agreement are incorporated herein by this reference. Except as provided in Sections 2 and 3 above, the representations, warranties, covenants, and agreements contained in the Asset Purchase Agreement shall not be superseded hereby but shall remain in full force and effect to the full extent provided therein. In the event of any conflict between the terms of this Agreement and the Asset Purchase Agreement, but specifically excluding Section 2 and Section 3 of this Agreement, the terms of the Asset Purchase Agreement shall govern.

6. Further Actions. From and after the Closing Date, each party hereto (a "**Party**") will execute, acknowledge and deliver such other instruments of transfer, assignment and assumption and perform such other acts as may be reasonably required effectively to consummate the assignments and assumptions contemplated by this Agreement.

7. Governing Law. This Agreement and the transactions contemplated hereby shall be governed by and construed and enforced in accordance with the internal laws of the State of New York without regard to the conflict of law provisions thereof.

8. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

9. Counterparts. This Agreement may be executed in one or more counterparts, any one of which need not contain the signatures of more than one Party, but all such counterparts taken together will constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or other means of electronic transmission shall be as effective as delivery of a manually executed counterpart.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

REGIONAL HEALTHCARE ASSOCIATES, LLC

By:_____

Name:_____

Title:_____

HEALTH QUEST SYSTEMS, INC.

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____

Name:_____

Title:_____

TRI STATE WOMEN'S SERVICES, LLC

By:_____

Name:_____

Title:_____

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

Exhibit E

List of Liens to be Released at Closing

Sharon Hospital Holding Company

Sharon Hospital Holding Company is currently a guarantor under RegionalCare Hospital Partners Holdings, Inc.'s asset-backed revolving facility and senior secured notes. The secured parties listed below have liens against Sharon Hospital Holding Company that will be released by the Sellers prior to Closing.

1. Royal Bank of Canada, as collateral agent (DE lien no. 20162614020)
2. Wilmington Trust National Association, as collateral agent (De lien no. 20162615209)

Essent Healthcare of Connecticut, Inc.

1. Master Lease Agreement (Quasi) by and between Essent Healthcare of Connecticut, Inc. and General Electric Capital Corporation, dated January 29, 2013, including all related schedules (capital lease for Toshiba/Aquilion 64 CT Scanner) (CT lien no. 0002918904).

EXHIBIT F

Limited Power of Attorney for Use of DEA and Other Registration Numbers, and Controlled Substances Order Forms

Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut stock corporation ("Registrant"), owns and operates a hospital ("Hospital") and hospital pharmacy located at 50 Hospital Hill Road, Sharon, Connecticut (DEA registration number BE7740562), is authorized to sign the current applications for registration and licensure as the registrant under the Controlled Substances Act (21 U.S.C. § 801 *et seq.*) or Controlled Substances Import and Export Act of the United States (21 U.S.C. § 951 *et seq.*), and is licensed to operate such pharmacy under the laws of the State of Connecticut.

Pursuant to that certain Asset Purchase Agreement dated as of September __, 2016, (the "Purchase Agreement") by and among Registrant, Regional Healthcare Associates, LLC, a Connecticut limited liability company ("RHA"), Tri State Women's Services, LLC, a Connecticut limited liability company ("TSWS"), and Sharon Hospital Holding Company, a Delaware corporation ("SHHC" and together with Registrant, RHA, and TSWS, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest"), Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("NewCo" and together with Health Quest, the "Buyer"), and RegionalCare Hospital Partners, Inc., a Delaware corporation ("RCHP"), solely for the purposes of Sections 13.32 and 13.33 of the Purchase Agreement, Registrant will transfer to NewCo substantially all of the assets, properties and rights relating to its provision of hospital services at the Hospital as of the Closing Date (as defined in the Purchase Agreement).

In recognition of the need to continue to make available controlled substances for treatment of the Hospital's patients and to continue to operate the Hospital's existing pharmacy during the period from the Closing Date until approval of NewCo's DEA application and Controlled Substances Ordering System ("CSOS") registration, Registrant has, effective as of the Closing Date, made, constituted and appointed, and by these presents does make, constitute, and appoint, NewCo as Registrant's agent and attorney-in-fact for the limited purpose of utilizing Registrant's DEA registration and any other registrations required under the laws of the State of Connecticut to continue pharmacy operations at the pharmacy facility located at the address set forth above (hereinafter "Pharmacy") and listed on **Exhibit A** attached hereto. NewCo may act in this capacity until such time as NewCo receives notice of the DEA's approval of NewCo's registration application (the "DEA Notice") and notice that NewCo is established in the DEA's CSOS, but in no event shall this limited power of attorney continue for more than one hundred twenty (120) days after the Closing Date (unless otherwise extended by mutual agreement of NewCo and Registrant).

Registrant further grants this limited power of attorney to NewCo to act, effective as of the Closing Date, as the true and lawful agent and attorney-in-fact of Registrant, and to act in the name, place, and stead of Registrant, to execute applications for books of official order forms and to sign such order forms in requisition for Schedules II, III, IV and V controlled substances, whether these orders be on Form 222, other forms as may be required under the laws of the State of Connecticut, or electronic in accordance with Section 308 of the Controlled Substances Act

(21 U.S.C. § 828) and part 1305 of Title 21 of the Code of Federal Regulations, as is necessary for the treatment of the Hospital's patients.

Registrant recognizes that it is legally responsible for the DEA and other registrations. Therefore, Registrant grants this limited power of attorney based upon the following covenants and warranties of NewCo: (a) that NewCo shall follow and abide by all federal, state and local laws governing the regulation of controlled substances and pharmacy practice at all times while this limited power of attorney is in effect; and (b) that NewCo shall diligently pursue and use its commercially reasonable efforts to obtain its own DEA and other registrations which are required for the distribution of pharmaceuticals, including, but not limited to, controlled substances at the Pharmacy, as soon as practicable after the Closing Date under the Purchase Agreement.

NewCo shall indemnify and hold harmless Registrant for all losses, liabilities, costs, expenses (including reasonable attorneys' fees) and penalties incurred, paid or required under penalty of law to be paid by Registrant related, in whole or in part, to NewCo's use of the pharmacy license, DEA, and other registrations of Registrant from and after the Closing Date. Indemnification claims shall be made and processed in accordance with the applicable provisions of Article 12 of the Purchase Agreement.

NewCo agrees to notify Registrant in writing within five (5) business days after receipt of the DEA Notice and within five (5) business days after receiving confirmation that NewCo is established in CSOS. Registrant agrees that it shall not take any action to deactivate any current DEA registration or CSOS registration until NewCo makes such notification to Registrant.

Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Purchase Agreement.

[*Signatures on following page.*]

IN WITNESS WHEREOF, Registrant and NewCo have executed this Limited Power of Attorney for Use of DEA and Other Registration Numbers and DEA Order Forms on this ____ day of _____, 2017.

NewCo:

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Its: _____

Witness:

_____

Registrant:

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name:
Its:

Witness:

_____

EXHIBIT A
Licenses and Registrations
Covered by Limited Power of Attorney

Federal:

1. United States Department of Justice Drug Enforcement Administration, Controlled Substance Registration Certificate BE7740562; Registrant: Essent Healthcare of Connecticut, Inc.; Issue Date: August 12, 2013; Expiration Date: August 31, 2016.

State:

1. State of Connecticut, Department of Consumer Protection, Controlled Substances Registration for Hospitals, Registration Number CSP.0000875-HOSP; Registrant: Essent Healthcare of Connecticut, Inc.; Effective Date: March 1, 2015; Expiration Date: February 28, 2017.

Pharmacy Facility Address:

50 Hospital Hill Road
Sharon, CT 06069-2092

EXHIBIT G
FORM OF MANAGEMENT AGREEMENT

(Not attached - See Tab II)

EXHIBIT H

FORM OF TENANT ESTOPPEL

TENANT ESTOPPEL CERTIFICATE

To: _____
_____
_____
_____

Re: Lease Pertaining to _____

1. The undersigned, as tenant ("Tenant") of approximately _____ square feet of space (the "Premises") under a certain lease dated _____, _____, as amended by amendments dated _____, _____ (as so amended, the "Lease") made with Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut stock corporation ("Landlord"), covering space in Landlord's building commonly known as _____ (the "Building"), hereby certifies as follows:

(a) That the Lease is in full force and effect and has not been modified, supplemented or amended in any way except as described above. The interest of Tenant in the Lease has not been assigned or encumbered nor has Tenant entered into any sublease, license or other occupancy or use agreement with respect to the Premises;

(b) That the Lease represents the entire agreement between the parties as to said leasing, and that there are no other agreements, written or oral, which affect the occupancy of the Premises by Tenant;

(c) That the commencement date of the term of the Lease was _____, _____;

(d) That the expiration date of the term of the Lease is _____, _____, including any presently exercised option or renewal term, and that Tenant has no rights to renew, extend or cancel the Lease or to lease additional space in the Premises or the Building, except as expressly set forth in the Lease;

(e) That Tenant has no option or preferential right to purchase all or any part of the Premises (or the land or Building of which the Premises are a part), and has no right or interest with respect to the Premises or the Building;

(f) That all conditions of the Lease to be performed by Landlord and necessary to the enforceability of the Lease have been satisfied. On this date there are no existing defenses, offsets, claims or credits which Tenant has against the enforcement of the Lease except for prepaid rent through _____ (not to exceed one month);

(g) That all contributions required by the Lease to be paid by Landlord to date for improvements to the Premises have been paid in full. All improvements or work required under the Lease to be made by Landlord to date, if any, have been completed to the satisfaction of Tenant. Charges for all labor and materials used or furnished in connection with improvements and/or alterations made for the account of Tenant in the Premises have been paid in full. Tenant has accepted the Premises, subject to no conditions other than those set forth in the Lease. Tenant has entered into occupancy of the Premises;

(h) That the annual minimum rent currently payable under the Lease is $_____ and has been paid through _____;

(i) That additional monthly rent for estimated taxes, insurance and CAM charges is $_____ per month and has been paid through _____;

(j) That there are no current defaults by Tenant or Landlord under the Lease, and, to Tenant's knowledge, no event has occurred or situation exists that would, with the giving of notice or passage of time or both, constitute a default under the Lease. There are currently no disputes between Tenant and Landlord concerning the Lease (including, without limitation, the computation of rent payable under the Lease), the Premises or the improvements thereon;

(k) That Tenant has paid to Landlord a security deposit in the amount of $_____;

(l) That there are no concessions, bonuses, free month's rent, rent rebates or other matters effecting the rentals, and no rent has been paid more than thirty (30) days in advance of its due date;

(m) That Tenant has all governmental permits, licenses and consents required for the activities and operations being conducted or to be conducted by it in or around the Building; and

(n) That as of this date there are no actions, whether voluntary or otherwise, pending against Tenant or any guarantor of the Lease under the bankruptcy or insolvency laws of the United States or any state thereof.

2. Tenant acknowledges the right of Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("Buyer"), and its affiliates, subsidiaries, successors and assigns to rely upon the certifications and agreements in this Certificate in acquiring the Building.

3. Tenant represents and warrants to Buyer that the person signing this certificate on behalf of Tenant has the full authority and legal capacity to execute and deliver this certificate and bind Tenant hereto.

EXECUTED this _____ day of _____, 2016.

TENANT:

_____,
a _____

By:_____
Name:_____
Its:_____

EXHIBIT I

FORM OF LANDLORD ESTOPPEL

LANDLORD ESTOPPEL CERTIFICATE

THIS LANDLORD ESTOPPEL (this "Estoppel") is made as of _____, 2016 by [_____] ("Landlord"), to and for the benefit of Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut stock corporation ("Tenant"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("Buyer").

W I T N E S S E T H:

WHEREAS, Landlord, as landlord, and Tenant, as tenant, are parties to the lease agreement dated as of _____, 20__, [as amended, [_____, 20__,] (the "Lease"), with respect to the real property known as _____ (the "Premises");

WHEREAS, Buyer has agreed to purchase certain assets of Tenant, including the assumption of Tenant's rights under the Lease, pursuant to a certain Asset Purchase Agreement (the "Transaction"); and

WHEREAS, in connection with the Transaction, Tenant and Buyer desire to obtain an estoppel certificate containing the statements, confirmations, and assurances of Landlord as set forth herein.

NOW, THEREFORE, for and in consideration of good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and for the purpose of providing Buyer and Tenant with the assurances set forth herein, Landlord hereby acknowledges, certifies, represents, and warrants the following to Buyer and Tenant as of the date hereof:

1. Pursuant to the Lease, Landlord currently leases to Tenant the Premises, as more particularly described therein, which Premises consists of approximately [_____] rentable square feet.

2. Landlord is the sole owner and holder of the Landlord's interest under the Lease, and Landlord has good right and lawful authority to execute and deliver this Estoppel without the necessity of the consent or joinder of any other person or entity.

3. The Lease is in full force and effect and constitutes the complete and accurate agreement by which Landlord leases the Premises to Tenant. There are no amendments or modifications to the Lease (except as noted above), written or oral, or any other agreements to which Landlord is a party which are binding upon Landlord and relate to the leasing of the Premises by Tenant.

4. Landlord has not commenced any action or given or received any notice for the purpose of terminating the Lease or declaring default under or breach of the Lease. To Landlord's knowledge, no uncured breaches or defaults under the Lease exist and no facts or circumstances exist which with the giving of notice or the passage of time, or both, would constitute a breach or default on the part of Landlord or Tenant under the Lease.

5. The term of the Lease commenced on [_____], and the Lease will expire by its terms on [_____], subject to any extension or renewal options as may be expressly set forth in the Lease.

6. As of the date hereof, base rent, additional rent, and all other sums due and payable by Tenant under the Lease have been paid in full as and when required under the Lease through the end of the current calendar month. The current monthly base rent payable to Landlord by Tenant under the Lease is $_____, which has been paid through and including the current calendar month. The current monthly installment of additional rent under the Lease is $_____, which has been paid through and including the current calendar month.

7. Tenant has not prepaid to Landlord, and Landlord has not accepted from Tenant, any base rent, additional rent, or other charges under the Lease more than 30 days in advance or as otherwise specifically provided and referred to in the Lease.

8. Landlord is holding in accordance with the Lease a security deposit on account of Tenant under the Lease in the amount of $_____.

9. This Estoppel shall inure to the benefit of Buyer and Tenant and each of their respective successors and assigns and shall be binding upon Landlord, its successors and assigns.

[signature page follows]

IN WITNESS WHEREOF, Landlord has executed and delivered this Estoppel as of the date first above written.

LANDLORD:

[_____
_____]

By:_____

Name:_____

Its:_____

ASSET PURCHASE AGREEMENT

AMONG

HEALTH QUEST SYSTEMS, INC.,

VASSAR HEALTH CONNECTICUT, INC.,

ESSENT HEALTHCARE OF CONNECTICUT, INC.,

SHARON HOSPITAL HOLDING COMPANY.

REGIONAL HEALTHCARE ASSOCIATES, LLC,

TRI STATE WOMEN'S SERVICES, LLC

AND

REGIONALCARE HOSPITAL PARTNERS, INC.,

(solely for the limited purpose of Section 13.32 and 13.33 therein)

September 13, 2016

Attached to and forming a part of that certain Asset Purchase Agreement dated as of September 13, 2016 (the "Agreement"), by and among Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("Sharon" or the "Hospital"), Sharon Hospital Holding Company, a Delaware corporation ("SHHC"), Regional Healthcare Associates, LLC, a Delaware limited liability company ("RHA"), Tri State Women's Services, LLC, a Delaware limited liability company ("TSWS" and collectively with Sharon, SHHC, and RHA, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("VHC" and, collectively with Health Quest, the "Buyer") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("RCHP"), solely for the purposes of Sections 13.32 and 13.33 therein, are these Schedules. The Schedules shall be organized to correspond to the section numbers used for the Sellers' representations and warranties in the Agreement, and disclosures contained therein shall provide the information contemplated by, or otherwise qualify, the representations and warranties of the Sellers set forth in the corresponding section or subsection of the Agreement; provided that, any exception or qualification set forth in the Schedules with respect to a particular representation or warranty contained in the Agreement shall be deemed to be an exception or qualification with respect to all other applicable representations and warranties contained in the Agreement to the extent the relevance of such disclosure to such other representations and warranties is reasonably apparent on its face. Nothing in the Schedules shall broaden the scope of any representation or

warranty contained in this Agreement or create any covenant. Matters reflected in the Schedules do not represent a determination that such matters are material or establish a standard of materiality, do not and shall not represent a determination that any such matters did not arise in the ordinary course of business, and shall not constitute, or be deemed to be, an admission to any third party concerning such matter or an admission of default or breach under any agreement or document.

SCHEDULES

#	Title
2.1(a)	Owned Real Property
2.1(b)	Leased Real Property
2.1(c)	Personal Property
2.1(h)	Tenant Leases
2.1(i)	Seller Leases
2.1(k)	Pending Approvals
2.2	Excluded Assets
2.2(e)	Excluded Contracts
2.2(i)	Amounts Due to Sellers
2.3(c)	Accrued PTO
2.4(c)	Excluded Liabilities
4.2(b)	Sellers' Required Consents
4.4(a)	Financial Statements; GAAP Exceptions
4.5	Certain Post-Balance Sheet Results
4.6	Licenses
4.7	Applications
4.8	Medicare Participation; Accreditation
4.9	Regulatory Compliance
4.10	Equipment
4.11	Permitted Encumbrances
4.11(a)	Property Violations
4.11(b)	Zoning
4.11(d)	Real Property Actions
4.11(g)	Rent Roll
4.11(h)	Notice of Modifications
4.11(i)	Encroachments
4.11(j)	Third Party Rights
4.11(k)	Construction
4.11(l)	Tenant Improvement
4.12	Condition of the Assets
4.13(a)	Benefit Plans
4.13(c)	ERISA
4.14	Litigation
4.16	Tax Returns
4.16(a)	Tax Extensions
4.16(b)	Tax Audits
4.16(c)	Tax Partnerships
4.17(a)	Employees
4.17(b)	Employment Claims
4.17(c)(i)	Employment Contracts
4.17(c)(ii)	Employment Loss
4.18	Material Contracts

#	Title
4.19(d)	Assumed Contract Consents
4.19(e)	Assignment Penalties
4.21	Insurance
4.22	Cost Reports
4.23	Medical Staff Matters
4.25	Compliance Program
4.26	Environmental Matters
4.26(f)(i)	Underground Storage Tanks
4.26(g)	Environmental Proceedings
4.26(j)	Connecticut Transfer Act
4.27(a)	Owned Intellectual Property
4.27(b)	Other Intellectual Property
4.27(d)	Patents, Copyrights and Trademarks
4.29	Sellers' Brokers
4.30	Knowledge Parties
5.2(b)	Buyer Required Consents
5.5	Buyer Brokers
6.4(j)	Sellers' Negative Covenants
8.1	Governmental Approvals
8.6	Material Contract Consents

Schedule 2.1(a)
Owned Real Property

Tract I - 48 & 50 Hospital Hill Road
Assessor Map 28
Lot 7-1

All that certain piece or parcel of land, together with the buildings and improvements thereon, situated in the Town of Sharon, County of Litchfield and State of Connecticut and shown on a map entitled: "Site Plan Prepared for Sharon Hospital, Inc. Hospital Hill Road & King Hill Road Sharon, Connecticut Scale 1" = 50' July 22, 1991 Total Area = 16.133 ± Acres Perer A. Lamb R.L.S. #7764 Sharon, Connecticut From the Office of: Lamb-Kiefer Land Surveyors, Sharon, Connecticut", and more particularly bounded and described as follows:

Beginning at a point in the southerly street line of King Hill Road which point marks the northeast corner of the herein described parcel and the northwest corner of land now or formerly of Richard Debrowsky & Melanie Aakjar; thence running S 06° 13' 00" W a distance of 185.30 feet along land now or formerly of Richard Debrowsky & Melanie Aakjar to a point; thence running S 84° 08' 00" E a distance of 271.50 feet to an iron pipe; thence S 06° 17' 00" W a distance of 109.85 feet to a point; the last two courses and distances being along land now or formerly of Richard Debrowsky and Melanie Aakjar and August Prause and St. Bernard's Roman Catholic Church, Inc., in part by each; thence running N 84° 14' 00" W a distance of 39.25 feet to a point; thence S 06° 34' 03" W a distance of 110.00 feet to an iron pipe; the last two courses and distances being along land now or formerly of Thomas A. & Violet E. Cunningham; thence N 84° 14' 00" W a distance of 302.21 feet to an iron pipe along land now or formerly of Florence C. Gobillot and Eugene B. & Florence C. Gobillot, in part by each; thence running S 05° 54' 00" W a distance of 149.20 feet to a point; thence S 84° 06' 00" E a distance of 65.20 feet to an iron pipe, the last two courses and distances being along land now or formerly of Eugene B. & Florence C. Gobillot; thence S 06° 32' 00" W a distance of 321.87 feet along land now or formerly of Alma & Gertrude King to a point on the northerly street line of Hospital Hill Road; thence N 82° 38' 00" W a distance of 353.533 feet to a point; thence along the arc of a curve to the right having a radius of 150.00 feet, a delta of 48° 22' 00", a tangent of 673.602 feet and a length of 126.623 feet to a point; thence N 34° 06' 00" W a distance of 723.598 feet to an iron pipe the last three courses and distances being along Hospital Hill Road; thence N 60° 20' 00" E a distance of 81.90 feet along land now or formerly of Patricia A. Lynehan to an iron pipe; thence N 10° 52' 00" W a distance of 239.30 feet along land now or formerly of Patricia A. Lynehan and Barbara Heili, in part by each, to a point on the southerly street line of King Hill Road; thence S 83° 10' 55" E a distance of 944.824 feet along King Hill Road to the point or place of beginning.

Tract II - 1 Low Road

Assessor Map 29
Lot 7

PARCEL TWO: All that certain tract or parcel of land with all buildings thereon standing and all appurtenances thereto belonging, lying northerly of Route #41, so-called, in the Town of Sharon, County of Litchfield, and State of Connecticut, bounded and described as follows:

NORTHERLY	by lands now or formerly of Patricia Gillette and lands now or formerly of Mabel Hotaling, each in part;
EASTERLY	by Low Street, so-called, by lands now or formerly of Mabel Hotaling, by lands now or formerly of Kenneth L. and Margaret Bartram, and by lands now or formerly of Iva N. Stine, each in part;
SOUTHERLY	by highway leading from Sharon to Lakeville (Route #41); and
WESTERLY	by lands now or formerly of Arthur W. Lamb and by lands now or formerly of L. H. Bartram, each in part.

Tract III - 25 Hospital Hill Road

Assessor Map 26
Lot 40-2

All that certain piece or parcel of land, with all improvements thereon situated on the southerly side of the highway leading from Sharon Town Street to Sharon Valley in the Town of Sharon, County of Litchfield and State of Connecticut, bounded and described as follows: viz:

BEGINNING at an iron pipe in the southerly line of said highway at the northwest corner of land of I. Harry Bartram and being the northeast corner of the parcel herein conveyed; thence along the westerly line of land of said Bartram S. 18° 48' W. 259.1 feet to an iron pipe in line of other lands owned by Laura R. Hamlin; thence along line of other land of said Laura R. Hamlin N. 70° 38' W. 132.0 feet to an iron pipe, being the southeast corner of land now or formerly of Pete, Ida and Louise Hansen; thence along said Hansen land N. 18° 48' E. 261.1 feet to an iron pipe in the southerly line of said highway; thence along the southerly line of said highway S. 69° 48' E. 132.0 feet to the iron pipe and place of beginning. Containing .787 of an acre, more or less.

Tract IV - 29 Hospital Hill Road & 40 Amenia Road
Assessor Map 26
Lot 40-3

All that certain piece or parcel of land with all improvements thereon, situated on the northerly side of the highway leading from Sharon, Connecticut to Amenia, New York, in the Town of Sharon, County of Litchfield, State of Connecticut, bounded and described as follows:

BEGINNING at an iron pin in the southwesterly corner of the piece herein described and running the following courses and distances North 20° 49' East 10.8 feet to an iron pin; North 8° 23' East 521.6 feet to an iron pin; North 4° 26' East 390.6 feet to an iron pin; thence running South 70° 26' East 132.2 feet to an iron pin; thence running South 17° 36' West 97.5 feet to an iron pin; then running the following courses and distances: South 70° 38' East 133.65 feet to an iron pin; South 70° 38' East 132.0 feet to an iron pin; South 70° 38' East 253.85 feet to an iron pin; thence running South 20° 52' West 239.2 feet to an iron pin; thence running North 72° 37' West 131.4 feet to an iron pin; thence running the following courses and distances: South 15° 08' East 266.6 feet to an iron pin; South 7° 47' East 77.6 feet to an iron pin; South 1° 11' West 79.95 feet to an iron pin; South 4° 04' West 186.1 feet to an iron pin; thence running the following courses and distances: North 70° 53' West 99.6 feet to a Connecticut Highway Department monument; North 70° 53' West 159.0 feet to an iron pin; thence running North 15° 10' East 200.3 feet to an iron pin; thence running North 70° 53' West 180.0 feet to an iron pin; thence running South 15° 10' West 200.3 feet to an iron pin; thence running along the northerly line of the Sharon, Connecticut to Amenia, New York highway the following courses and distances: North 70° 53' West 102.9 feet to a Connecticut Highway Department monument; North 88° 30' West 38.21 feet to an iron pin which marks the point and place of beginning.

Containing 9.35 acres, more or less.

Reference is made to a map entitled "Map Showing Property of Laura Hamlin in the Town of Sharon, Conn. Scale 1 inch = 40 feet, by H. Knickerbocker, Land Surveyor, Salisbury, Conn., dated March 10, 1958.

LESS AND EXCEPTING that certain parcel conveyed to United Methodist Home of Sharon, Inc. by Warranty Deed dated May 31, 2001 and recorded on June 1, 2001 in Volume 141 at Page 256 of the Sharon Land Records.

Excepting from the above-described parcel the property described in the following deeds:

(a) Quit Claim Deed dated April 30, 1990 from West Sharon Corporation to Sharon Corporation recorded in Volume 113, Page 331 of the Sharon Land Records; however, the property referenced in the Quit Claim Deed dated September 1, 1991 from Sharon Corporation to West Sharon Corporation recorded in Volume 115, Page 495 is not excepted from the above described Parcel 4. Reference is made to Map 1611 and Map 1640.

(b) Warranty Deed dated August 21, 1992 from West Sharon Corporation to Sharon Medical Office Building Limited Partnership recorded in Volume 117, Page 708 of the Sharon Land Records. Reference is made to Map 1657.

(c) Statutory Form Warranty Deed dated May 31, 2001 from Sharon Health Care, Inc. to United Methodist Home of Sharon, Inc. recorded in Volume 115, Page 729 of the Sharon Land Records. Reference is further made to a Quit Claim Deed dated September 30, 1991 from West Sharon Corporation to Sharon Corporation recorded in Volume 115, Page 491 of the Sharon Land Records. Reference is made to Map 1693.

(d) Warranty Deed dated May 1, 2014 from Essent Healthcare of Connecticut, Inc. to Jean C. Hodouin recorded in Volume 195, Page 201 of the Sharon Land Records. Reference is made to Map 2129.

Tract V - 33 Hospital Hill Road
Assessor Map 26
Lot 40-1

All that certain piece or parcel of land, situated in the Town of Sharon, County of Litchfield and State of Connecticut more particularly bounded and described as follows: Beginning at the Northeast corner of the property herein described; thence in line of West Main Street, westerly four rods to a corner bound; thence south 18 degrees 56 minutes 05 seconds west, 262.054 feet to an iron pipe; thence easterly about four rods to an iron pipe; thence northerly along land now or formerly of Clarence Bassett to the place of beginning. Shown as 0.398 more or less acre on a map entitled Map Prepared for Sharon Hospital, Inc., Hospital Hill Road, Sharon, Connecticut dated May 5, 1985, prepared by Peter A. Lamb and on file in the Office of the Town Clerk of Sharon as Map No. 1429.

Schedule 2.1(b)
Leased Real Property

TENANT	LANDLORD	ADDRESS/ LOCATION
Essent Healthcare of Connecticut, Inc.	Anu Properties Corp.	17 Hospital Hill Road (Residential Unit) Sharon, CT
Regional Healthcare Associates, LLC	Robert J. Orlandi	2 Old Park Lane (1st Floor) New Milford, CT
Regional Healthcare Associates, LLC	Robert J. Orlandi	2 Old Park Lane (2nd Floor) New Milford, CT
Tri State Women's Services, LLC	Bruce Janelli, M.D.	75 Church St. Canaan, CT
Tri State Women's Services, LLC	Orlito Trias, M.D.	9 Aspetuck Ave. New Milford, CT
Tri State Women's Services LLC	Winsted Health Center, Inc.	115 Spencer St. Winsted, CT
Regional Healthcare Associates, LLC	Kenmil Realty, LLC	64 Maple St. Kent, CT
Tri State Women's Services LLC	Sharon Medical Office Building LLC	50 Amenia Rd. Sharon, CT
Regional Healthcare Associates, LLC	Candlewood Properties, LLC	120 Park Lane Road, New Milford, CT
Regional Healthcare Associates, LLC	Anu Properties, LLC	17 Hospital Hill Road (Office Space) Sharon, CT

Schedule 2.1(c)
Personal Property

See attached.

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
1	Cisco WAN interface	0.00	0.00	0.00	030.1470.10000	030.1570.10000
2	Cisco 2901 WAN router & license	0.00	0.00	0.00	030.1470.10000	030.1570.10000
3	Microsoft Licenses (from audit)	48.38	241.88	290.26	030.1470.10000	030.1570.10000
4	Wound Care Archtect and contruction	0.00	0.00	0.00	030.1450.10000	030.1550.10000
5	New Roof- Quality PO 57603 Inv 938, Securitis	0.00	0.00	0.00	030.1420.10000	030.1520.10000
6	New Roof- Quality PO 57603 Inv 938, Securitis	0.00	0.00	0.00	030.1420.10000	030.1520.10000
7	Carpet:ing: Pottenburgh, Ped office	0.00	0.00	0.00	0	0
8	CarpetFlooring 3 B Inv 10312	0.00	0.00	0.00	0	0
9	New Door SBH	0.00	0.00	0.00	030.1420.10000	030.1520.10000
10	Wound Care Computers	175.00	875.00	1,050.00	030.1470.10000	030.1570.10000
11	Computers - 5 Dell Marketing Inv XFFJ1J195	0.00	0.00	0.00	030.1470.10000	030.1570.10000
12	Computers 20- Dell Marketing Inv XFJNNPX93,	279.16	1,395.83	1,675.00	030.1470.10000	030.1570.10000
13	Mac Computer	0.00	0.00	0.00	030.1470.10000	030.1570.10000
14	Computer:Dell 7 Laptops	87.50	437.50	525.00	030.1470.10000	030.1570.10000
15	CDW Cinv C9333343 PO 58053, Network	0.00	0.00	0.00	030.1470.10000	030.1570.10000
16	Paragon Imaging Software, CDW Inv D213774,	0.00	0.00	0.00	030.1470.10000	030.1570.10000
17	Computers, CDW F180861 & F261842, PO	175.00	875.00	1,050.00	030.1470.10000	030.1570.10000
18	Computers - 20 Dell/ CDW	350.00	1,750.00	2,100.00	030.1470.10000	030.1570.10000
19	Microsoft Office Update	0.00	0.00	0.00	030.1450.10000	030.1550.10000
20	Dragon Software, Nuance 10039055, po 60403	26.88	134.38	161.26	030.1470.10000	030.1570.10000
21	Microsoft Office Update - Acct, CDW K606006	0.00	0.00	0.00	030.1450.10000	030.1550.10000
22	CD Burner- Sorna, Inv 19904 & BPO 59785	44.79	223.96	268.75	030.1450.10000	030.1550.10000
23	Lap Tops, CDW P621686, pO 6082	0.00	0.00	0.00	030.1470.10000	030.1570.10000
24	Sprinkler System in Morgue Hartford Spinkler	0.00	0.00	0.00	030.1450.10000	030.1550.10000
25	7 Carts for Laptops CDW C976194 PO 57555	104.16	520.83	625.00	030.1470.10000	030.1570.10000
26	Wound Care Equipmt Medical	687.50	3,437.50	4,125.00	030.1450.10000	030.1550.10000
27	PACS : Dell, Merge Healthcare	2,220.84	11,104.17	13,325.00	030.1450.10000	030.1550.10000
28	Ultrasound console: GE 5212284,5212282,	21.43	107.14	128.57	030.1450.10000	030.1550.10000
29	Travel and Traing on Powerscribe:Nuance	0.00	0.00	0.00	030.1450.10000	030.1550.10000
30	Wound Care Equipmt Medical	248.61	1,243.05	1,491.66	030.1450.10000	030.1550.10000
31	Immuno Analyzer: Fisher	41.21	206.04	247.25	030.1450.10000	030.1550.10000
32	Disk Array Enclosure - PACs	0.00	0.00	0.00	030.1450.10000	030.1550.10000
33	Medical Equipment, peds	33.34	166.67	200.00	030.1450.10000	030.1550.10000
34	Stretchers for TelestrokeHill Rom Inv 23572371	26.39	131.95	158.34	030.1450.10000	030.1550.10000
35	Beds - 7 Hill Rom Inv 23580845	273.59	1,367.92	1,641.50	030.1450.10000	030.1550.10000
36	Cad Stream Server, Merge Inv II32799, PO	43.75	218.75	262.50	030.1450.10000	030.1550.10000
37	C-Arm Model 9900, GE 70375 PO 58385	1,736.11	8,680.55	10,416.66	030.1450.10000	030.1550.10000
38	Blinds, Peds office, Window coverup	0.00	0.00	0.00	030.1480.10000	030.1580.10000
39	Medical Equipment, peds	22.22	111.11	133.33	030.1450.10000	030.1550.10000
40	Welch/Allyn Wall Mount Diagnostic Set-Ped	30.56	152.78	183.34	030.1450.10000	030.1550.10000
41	Treatment Tables3 -PT, Universal Hospital Inv	15.28	76.39	91.67	030.1450.10000	030.1550.10000
42	Dishwashing Machine, Kittredge Inv H267008,	158.90	794.51	953.41	030.1450.10000	030.1550.10000

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
1	Cisco WAN interface	0.00	0.00	0.00	030.1470.10000	030.1570.10000
2	Cisco 2901 WAN router & license	0.00	0.00	0.00	030.1470.10000	030.1570.10000
3	Microsoft Licenses (from audit)	48.38	241.88	290.26	030.1470.10000	030.1570.10000
4	Wound Care Archtect and contruction	0.00	0.00	0.00	030.1450.10000	030.1550.10000
5	New Roof- Quality PO 57603 Inv 938, Securitis	0.00	0.00	0.00	030.1420.10000	030.1520.10000
6	New Roof- Quality PO 57603 Inv 938, Securitis	0.00	0.00	0.00	030.1420.10000	030.1520.10000
7	Carpet:ing: Pottenburgh, Ped office	0.00	0.00	0.00	0	0
8	CarpetFlooring 3 B Inv 10312	0.00	0.00	0.00	0	0
9	New Door SBH	0.00	0.00	0.00	030.1420.10000	030.1520.10000
10	Wound Care Computers	175.00	875.00	1,050.00	030.1470.10000	030.1570.10000
11	Computers - 5 Dell Marketing Inv XFFJ1J195	0.00	0.00	0.00	030.1470.10000	030.1570.10000
12	Computers 20- Dell Marketing Inv XFJNNPX93,	279.16	1,395.83	1,675.00	030.1470.10000	030.1570.10000
13	Mac Computer	0.00	0.00	0.00	030.1470.10000	030.1570.10000
14	Computer:Dell 7 Laptops	87.50	437.50	525.00	030.1470.10000	030.1570.10000
15	CDW Cinv C9333343 PO 58053, Network	0.00	0.00	0.00	030.1470.10000	030.1570.10000
16	Paragon Imaging Software, CDW Inv D213774,	0.00	0.00	0.00	030.1470.10000	030.1570.10000
17	Computers, CDW F180861 & F261842, PO	175.00	875.00	1,050.00	030.1470.10000	030.1570.10000
18	Computers - 20 Dell/ CDW	350.00	1,750.00	2,100.00	030.1470.10000	030.1570.10000
19	Microsoft Office Update	0.00	0.00	0.00	030.1450.10000	030.1550.10000
20	Dragon Software, Nuance 10039055, po 60403	26.88	134.38	161.26	030.1470.10000	030.1570.10000
21	Microsoft Office Update - Acct, CDW K606006	0.00	0.00	0.00	030.1450.10000	030.1550.10000
22	CD Burner- Sorna, Inv 19904 & BPO 59785	44.79	223.96	268.75	030.1450.10000	030.1550.10000
23	Lap Tops, CDW P621686, pO 6082	0.00	0.00	0.00	030.1470.10000	030.1570.10000
24	Sprinkler System in Morgue Hartford Spinkler	0.00	0.00	0.00	030.1450.10000	030.1550.10000
25	7 Carts for Laptops CDW C976194 PO 57555	104.16	520.83	625.00	030.1470.10000	030.1570.10000
26	Wound Care Equipmt Medical	687.50	3,437.50	4,125.00	030.1450.10000	030.1550.10000
27	PACS : Dell, Merge Healthcare	2,220.84	11,104.17	13,325.00	030.1450.10000	030.1550.10000
28	Ultrasound console: GE 5212284,5212282,	21.43	107.14	128.57	030.1450.10000	030.1550.10000
29	Travel and Traing on Powerscribe:Nuance	0.00	0.00	0.00	030.1450.10000	030.1550.10000
30	Wound Care Equipmt Medical	248.61	1,243.05	1,491.66	030.1450.10000	030.1550.10000
31	Immuno Analyzer: Fisher	41.21	206.04	247.25	030.1450.10000	030.1550.10000
32	Disk Array Enclosure - PACs	0.00	0.00	0.00	030.1450.10000	030.1550.10000
33	Medical Equipment, peds	33.34	166.67	200.00	030.1450.10000	030.1550.10000
34	Stretchers for TelestrokeHill Rom Inv 23572371	26.39	131.95	158.34	030.1450.10000	030.1550.10000
35	Beds - 7 Hill Rom Inv 23580845	273.59	1,367.92	1,641.50	030.1450.10000	030.1550.10000
36	Cad Stream Server, Merge Inv II32799, PO	43.75	218.75	262.50	030.1450.10000	030.1550.10000
37	C-Arm Model 9900, GE 70375 PO 58385	1,736.11	8,680.55	10,416.66	030.1450.10000	030.1550.10000
38	Blinds, Peds office, Window coverup	0.00	0.00	0.00	030.1480.10000	030.1580.10000
39	Medical Equipment, peds	22.22	111.11	133.33	030.1450.10000	030.1550.10000
40	Welch/Allyn Wall Mount Diagnostic Set-Ped	30.56	152.78	183.34	030.1450.10000	030.1550.10000
41	Treatment Tables3 -PT, Universal Hospital Inv	15.28	76.39	91.67	030.1450.10000	030.1550.10000
42	Dishwashing Machine, Kittredge Inv H267008,	158.90	794.51	953.41	030.1450.10000	030.1550.10000

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
43	Ultra sound, GE Inv 520391673 PO	251.39	1,256.95	1,508.34	030.1450.10000	030.1550.10000
44	Stretchers, Heritage Med Inv 16028, PO 58963	59.72	298.61	358.33	030.1450.10000	030.1550.10000
45	Update Viewing Stations - Hudson, CDW PO	155.95	779.76	935.71	030.1450.10000	030.1550.10000
46	Replacement Centrifuge, Helmer Inv 144330	0.00	0.00	0.00	030.1450.10000	030.1550.10000
47	Lesion Generator, Neurotherm Inv 80849 PO	146.43	732.14	878.57	030.1450.10000	030.1550.10000
48	Steris Replacement, Olympus PO	300.00	1,500.00	1,800.00	030.1450.10000	030.1550.10000
49	Privacy Glass, PT Ducillo Inv 4410	27.38	136.90	164.28	030.1450.10000	030.1550.10000
50	Alarm Panel, Simplex Inv 40460212, PO 59743	67.86	339.29	407.15	030.1450.10000	030.1550.10000
51	Storz Image 1 P3 Camera, Total Repair Inv	17.86	89.29	107.15	030.1450.10000	030.1550.10000
52	Ultra sound, Phy for Women - Tri-State	400.00	2,000.00	2,400.00	030.1450.10000	030.1550.10000
53	Crypblation, Phy for Women - Tri-State	88.10	440.48	528.58	030.1450.10000	030.1550.10000
54	Affirm Micro, Phy for Women Tri-State	32.15	160.72	192.86	030.1450.10000	030.1550.10000
55	Ikon Copier - Tri-State	0.00	0.00	0.00	030.1450.10000	030.1550.10000
56	Server Transfer from ECHO Corporate	0.00	0.00	0.00	030.1470.10000	030.1570.10000
57	Buildings - Sharon Hospital - Main Hospital	0.00	0.00	0.00	030.1420.10000	030.1520.10000
58	Buildings - Medical Arts Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
59	Land - Sharon Hospital - Main Hospital	0.00	0.00	0.00	030.1400.10000	0
60	MRI System	1,912.50	9,562.50	11,475.00	030.1450.10000	030.1550.10000
61	Site Improvements - Sharon Hospital - Main	0.00	0.00	0.00	030.1420.10000	030.1520.10000
62	PACS	1,139.78	5,698.89	6,838.67	030.1450.10000	030.1550.10000
63	Site Improvements - Medical Arts Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
64	Land - Community Health Building	0.00	0.00	0.00	030.1400.10000	0
65	Land - Medical Arts Building	0.00	0.00	0.00	030.1400.10000	0
66	Buildings - Community Health Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
67	Mammography System	763.89	3,819.45	4,583.34	030.1450.10000	030.1550.10000
68	Radiographic/Fluoroscopic System	563.89	2,819.45	3,383.34	030.1450.10000	030.1550.10000
69	Dictation System	344.09	1,720.42	2,064.50	030.1450.10000	030.1550.10000
70	Buildings - Bargain Barn	0.00	0.00	0.00	030.1420.10000	030.1520.10000
71	Buildings - House - Corporate Apartments	0.00	0.00	0.00	030.1420.10000	030.1520.10000
72	Land - Hansen House - On-Call Apartment	0.00	0.00	0.00	030.1400.10000	0
73	Table, Surgical	40.61	203.05	243.66	030.1450.10000	030.1550.10000
74	Phones Lease	238.34	1,191.67	1,430.00	030.1450.10000	030.1550.10000
75	Land - Cottage C - Empty	0.00	0.00	0.00	030.1400.10000	0
76	Land - House - Corporate Apartments	0.00	0.00	0.00	030.1400.10000	0
77	Walk in Freezer	170.25	851.25	1,021.50	030.1450.10000	030.1550.10000
78	PACS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
79	Dell Marketing	375.00	1,875.00	2,250.00	030.1450.10000	030.1550.10000
80	Insight Phone System	130.84	654.17	785.00	030.1450.10000	030.1550.10000
81	Buildings - Hansen House - On-Call Apartment	0.00	0.00	0.00	030.1420.10000	030.1520.10000
82	Buildings - Maintenance Barns (2)	0.00	0.00	0.00	030.1420.10000	030.1520.10000
83	CT Scanner	186.11	930.55	1,116.66	030.1450.10000	030.1550.10000
84	Analyzer, Coagulation	125.46	627.29	752.75	030.1450.10000	030.1550.10000

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
85	Analyzer, Coagulation	125.46	627.29	752.75	030.1450.10000	030.1550.10000
86	Radiographic System	166.66	833.33	1,000.00	030.1450.10000	030.1550.10000
87	Gamma Camera	166.66	833.33	1,000.00	030.1450.10000	030.1550.10000
88	Mobile C-Arm	347.22	1,736.11	2,083.33	030.1450.10000	030.1550.10000
89	CORE SWITCHES	127.84	639.17	767.00	030.1450.10000	030.1550.10000
90	Mobile C-Arm	277.78	1,388.89	1,666.67	030.1450.10000	030.1550.10000
91	Monitor, Central	140.28	701.39	841.67	030.1470.10000	030.1570.10000
92	STROKE CART	129.16	645.83	775.00	030.1450.10000	030.1550.10000
93	Ultrasound, Diagnostic	118.06	590.28	708.34	030.1450.10000	030.1550.10000
94	Radiographic System	112.50	562.50	675.00	030.1450.10000	030.1550.10000
95	Meditech Nursing Module	113.89	569.45	683.34	030.1450.10000	030.1550.10000
96	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
97	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
98	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
99	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
100	Surveillance Cameras	0.00	0.00	0.00	030.1450.10000	030.1550.10000
101	Computers	179.16	895.83	1,075.00	030.1470.10000	030.1570.10000
102	CR Reader	101.39	506.95	608.34	030.1450.10000	030.1550.10000
103	CR Reader	101.39	506.95	608.34	030.1450.10000	030.1550.10000
104	Video Tower	95.84	479.17	575.00	030.1450.10000	030.1550.10000
105	PACS Expansion	92.00	460.00	552.00	030.1450.10000	030.1550.10000
106	CAD - MRI	88.89	444.45	533.34	030.1450.10000	030.1550.10000
107	Ultrasound, Diagnostic	86.11	430.55	516.66	030.1450.10000	030.1550.10000
108	COMPUTERS -HOSPITAL	154.16	770.83	925.00	030.1470.10000	030.1570.10000
109	Refrigerator/Freezer, Walk-in	59.14	295.70	354.84	030.1450.10000	030.1550.10000
110	Cryostat	84.72	423.61	508.33	030.1450.10000	030.1550.10000
111	Dell Marketing	150.00	750.00	900.00	030.1450.10000	030.1550.10000
112	Bone Densitometer	80.56	402.78	483.34	030.1450.10000	030.1550.10000
113	Monitor, Central	77.78	388.89	466.67	030.1470.10000	030.1570.10000
114	Portable Radiographic	70.84	354.17	425.00	030.1450.10000	030.1550.10000
115	Tissue Processor	75.00	375.00	450.00	030.1450.10000	030.1550.10000
116	NURSE CALL SYSTEM	44.79	223.96	268.75	030.1450.10000	030.1550.10000
117	Ultrasound, Diagnostic	66.66	333.33	400.00	030.1450.10000	030.1550.10000
118	Ultrasound, Diagnostic	66.66	333.33	400.00	030.1450.10000	030.1550.10000
119	Sterilizer	69.44	347.22	416.67	030.1450.10000	030.1550.10000
120	Sterilizer	69.44	347.22	416.67	030.1450.10000	030.1550.10000
121	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
122	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
123	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
124	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
125	Utility Boom	47.19	235.97	283.17	030.1450.10000	030.1550.10000
126	Breast Biopsy System	59.72	298.61	358.33	030.1450.10000	030.1550.10000

SH000211
11/03/2016

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
127	Biopsy System	59.72	298.61	358.33	030.1450.10000	030.1550.10000
128	Dell Marketing	95.84	479.17	575.00	030.1450.10000	030.1550.10000
129	Laser Imager	51.39	256.95	308.34	030.1470.10000	030.1570.10000
130	Buildings - Cottage C - Empty	0.00	0.00	0.00	030.1420.10000	030.1520.10000
131	Kronos	50.00	250.00	300.00	030.1450.10000	030.1550.10000
132	COMPUTERS	87.50	437.50	525.00	030.1470.10000	030.1570.10000
133	Table, Surgical	48.97	244.86	293.83	030.1450.10000	030.1550.10000
134	POINT OF SERVICE	56.94	284.72	341.67	030.1450.10000	030.1550.10000
135	Ablation Device	47.22	236.11	283.33	030.1450.10000	030.1550.10000
136	MRI Expansion	34.65	173.26	207.91	030.1450.10000	030.1550.10000
137	Slit Lamp	47.22	236.11	283.33	030.1450.10000	030.1550.10000
138	Dell Marketing	83.34	416.67	500.00	030.1450.10000	030.1550.10000
139	Ulralinq Echo Storage	45.84	229.17	275.00	030.1450.10000	030.1550.10000
140	Injector, Angiographic	41.66	208.33	250.00	030.1450.10000	030.1550.10000
141	Washer/Disinfector	44.44	222.22	266.67	030.1450.10000	030.1550.10000
142	Pulmonary Function System	44.44	222.22	266.67	030.1450.10000	030.1550.10000
143	Handpiece	44.44	222.22	266.67	030.1450.10000	030.1550.10000
144	Forceps-Arthroscopy equip	41.81	209.03	250.84	030.1450.10000	030.1550.10000
145	Chairs/Drapes for Boardroom	31.07	155.35	186.42	030.1480.10000	030.1580.10000
146	Rad Room #4 Renovations (C&H Electric) From	31.07	155.35	186.42	030.1450.10000	030.1550.10000
147	Analyzer, Blood Culture	26.88	134.38	161.26	030.1450.10000	030.1550.10000
148	Analyzer, Blood Culture	26.88	134.38	161.26	030.1450.10000	030.1550.10000
149	Table, Surgical	40.61	203.05	243.66	030.1450.10000	030.1550.10000
150	5 COMPUTERS	70.84	354.17	425.00	030.1470.10000	030.1570.10000
151	Sleep Study System	40.28	201.39	241.67	030.1450.10000	030.1550.10000
152	DOCUMENT SCANNER	45.84	229.17	275.00	030.1470.10000	030.1570.10000
153	ANTI VIRUS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
154	Injector, MRI	36.11	180.55	216.66	030.1450.10000	030.1550.10000
155	CDW Computer Centers Inc	66.66	333.33	400.00	030.1450.10000	030.1550.10000
156	Furnishing for Corp Apartmt	28.07	140.35	168.42	030.1480.10000	030.1580.10000
157	COMPUTERS	62.50	312.50	375.00	030.1470.10000	030.1570.10000
158	Table, Surgical	33.44	167.22	200.67	030.1450.10000	030.1550.10000
159	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
160	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
161	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
162	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
163	Hot Food Steam Table	33.34	166.67	200.00	030.1450.10000	030.1550.10000
164	Bladder Scanner	37.50	187.50	225.00	030.1450.10000	030.1550.10000
165	Sterilizer	31.94	159.72	191.67	030.1450.10000	030.1550.10000
166	Monitor, Telemetry	20.90	104.51	125.41	030.1470.10000	030.1570.10000
167	Steamer	30.56	152.78	183.34	030.1450.10000	030.1550.10000
168	Plate Warmer	30.56	152.78	183.34	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
169	Dell Marketing	54.16	270.83	325.00	030.1450.10000	030.1550.10000
170	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
171	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
172	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
173	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
174	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
175	Vascular System	29.16	145.83	175.00	030.1450.10000	030.1550.10000
176	Stretcher (6)	29.16	145.83	175.00	030.1450.10000	030.1550.10000
177	Anesthesia Machine	27.78	138.89	166.67	030.1450.10000	030.1550.10000
178	LARYNGOSCOPE BLADES	19.71	98.54	118.25	030.1450.10000	030.1550.10000
179	Micro Saw and Drill	27.78	138.89	166.67	030.1450.10000	030.1550.10000
180	Sterilizer	27.78	138.89	166.67	030.1450.10000	030.1550.10000
181	Holter Monitor System	27.78	138.89	166.67	030.1450.10000	030.1550.10000
182	Water Separator	27.78	138.89	166.67	030.1450.10000	030.1550.10000
183	COMPUTERS LATITUDE E6400	45.84	229.17	275.00	030.1470.10000	030.1570.10000
184	Incubator, Infant	26.39	131.95	158.34	030.1450.10000	030.1550.10000
185	Dell Marketing	45.84	229.17	275.00	030.1450.10000	030.1550.10000
186	Defibrillator	25.00	125.00	150.00	030.1450.10000	030.1550.10000
187	Stretcher (5)	25.00	125.00	150.00	030.1450.10000	030.1550.10000
188	Stretcher (7)	25.00	125.00	150.00	030.1450.10000	030.1550.10000
189	Beds	25.09	125.42	150.50	030.1450.10000	030.1550.10000
190	Heat Pump	25.00	125.00	150.00	030.1450.10000	030.1550.10000
191	Prep Station	23.61	118.05	141.66	030.1450.10000	030.1550.10000
192	Argon Beam Coagulator	23.61	118.05	141.66	030.1450.10000	030.1550.10000
193	Argon Beam Coagulator	23.61	118.05	141.66	030.1450.10000	030.1550.10000
194	EKG	23.61	118.05	141.66	030.1450.10000	030.1550.10000
195	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
196	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
197	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
198	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
199	PACS SERVER	22.91	114.58	137.50	030.1450.10000	030.1550.10000
200	Gero Psych Low Beds	23.89	119.45	143.34	030.1450.10000	030.1550.10000
201	WATER SOFTNER	22.22	111.11	133.33	030.1450.10000	030.1550.10000
202	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
203	Fuel Tank monitoring and Leak Detection Syste	16.13	80.63	96.76	030.1450.10000	030.1550.10000
204	Digitizer, Film	20.84	104.17	125.00	030.1450.10000	030.1550.10000
205	Defibrillator	22.22	111.11	133.33	030.1450.10000	030.1550.10000
206	Freezer	22.22	111.11	133.33	030.1450.10000	030.1550.10000
207	Microscope (6)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
208	UPS for CT Scan	20.84	104.17	125.00	030.1450.10000	030.1550.10000
209	Mobile Treatment Recliners	22.22	111.11	133.33	030.1450.10000	030.1550.10000
210	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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211	Monitor, MRI	20.84	104.17	125.00	030.1470.10000	030.1570.10000
212	Portable Radiographic	19.44	97.22	116.67	030.1450.10000	030.1550.10000
213	Microscope, Surgical	20.31	101.53	121.84	030.1450.10000	030.1550.10000
214	Defibrillator	20.84	104.17	125.00	030.1450.10000	030.1550.10000
215	EMC Corp	20.84	104.17	125.00	030.1450.10000	030.1550.10000
216	Microscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
217	Microscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
218	Stress Test System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
219	Bone Forcepts	19.11	95.55	114.66	030.1450.10000	030.1550.10000
220	5100 Radio Pager System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
221	In house paging System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
222	DELL COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
223	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
224	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
225	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
226	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
227	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
228	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
229	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
230	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
231	Light, Surgical	19.11	95.55	114.66	030.1480.10000	030.1580.10000
232	Light, Surgical	19.11	95.55	114.66	030.1480.10000	030.1580.10000
233	Pump, IV (19)	18.06	90.28	108.34	030.1450.10000	030.1550.10000
234	PACS Expansion	18.06	90.28	108.34	030.1450.10000	030.1550.10000
235	ICU Ice Machine	18.06	90.28	108.34	030.1450.10000	030.1550.10000
236	Computers	0.00	0.00	0.00	030.1470.10000	030.1570.10000
237	Pro-Med Computer Upgrade	0.00	0.00	0.00	030.1470.10000	030.1570.10000
238	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
239	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
240	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
241	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
242	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
243	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
244	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
245	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
246	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
247	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
248	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
249	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
250	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
251	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
252	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000

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253	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
254	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
255	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
256	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
257	Endoscope, Flexible (5)	16.66	83.33	100.00	030.1450.10000	030.1550.10000
258	Cataract Tray	18.06	90.28	108.34	030.1450.10000	030.1550.10000
259	Phototherapy Lights	18.06	90.28	108.34	030.1450.10000	030.1550.10000
260	SALT SPREADER	18.06	90.28	108.34	030.1450.10000	030.1550.10000
261	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
262	Dietary Chairs	12.54	62.71	75.25	030.1450.10000	030.1550.10000
263	Gazebo Furniture	12.54	62.71	75.25	030.1480.10000	030.1580.10000
264	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
265	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
266	CDW	0.00	0.00	0.00	030.1470.10000	030.1570.10000
267	Computer Backup System	0.00	0.00	0.00	030.1470.10000	030.1570.10000
268	ON-LINE CREDIT CARD PROCESSING	0.00	0.00	0.00	030.1470.10000	030.1570.10000
269	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
270	Defibrillator	15.28	76.39	91.67	030.1450.10000	030.1550.10000
271	Eye Wash Station	15.28	76.39	91.67	030.1450.10000	030.1550.10000
272	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
273	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
274	EYE HANDPIECE	15.28	76.39	91.67	030.1450.10000	030.1550.10000
275	Lumbar and Spine Instruments	15.28	76.39	91.67	030.1450.10000	030.1550.10000
276	Meat Slicer	15.28	76.39	91.67	030.1450.10000	030.1550.10000
277	Oven	15.28	76.39	91.67	030.1450.10000	030.1550.10000
278	Nortel WLAN Access Port	0.00	0.00	0.00	030.1470.10000	030.1570.10000
279	Monitor, Telemetry	8.96	44.79	53.75	030.1470.10000	030.1570.10000
280	Monitor, Patient	0.00	0.00	0.00	030.1470.10000	030.1570.10000
281	Monitor, Bedside	14.34	71.67	86.00	030.1470.10000	030.1570.10000
282	ELLIPTICAL CROSSTRAINER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
283	BARIATRIC RECLINER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
284	LOW BEDS	14.34	71.67	86.00	030.1450.10000	030.1550.10000
285	LOW BEDS	14.34	71.67	86.00	030.1450.10000	030.1550.10000
286	COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
287	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
288	Gazebo Furniture	9.56	47.78	57.34	030.1480.10000	030.1580.10000
289	Hartford Fine Art & Framing	9.56	47.78	57.34	030.1480.10000	030.1580.10000
290	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
291	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
292	PHONES	0.00	0.00	0.00	030.1450.10000	030.1550.10000
293	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
294	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000

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295	Microtome	0.00	0.00	0.00	030.1450.10000	030.1550.10000
296	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
297	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
298	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
299	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
300	Hardware to support Meditide	0.00	0.00	0.00	030.1470.10000	030.1570.10000
301	CAD System	0.00	0.00	0.00	030.1450.10000	030.1550.10000
302	Integra Lifesciences Corp (instruments)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
303	Hartford Fine Art & Framing	8.96	44.79	53.75	030.1480.10000	030.1580.10000
304	Lobby Furniture Upholstery	8.96	44.79	53.75	030.1480.10000	030.1580.10000
305	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
306	Owens & Minor	0.00	0.00	0.00	030.1450.10000	030.1550.10000
307	Refrigerator, Walk-in	7.76	38.82	46.58	030.1450.10000	030.1550.10000
308	Thyroid Uptake	0.00	0.00	0.00	030.1450.10000	030.1550.10000
309	Cell Washer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
310	Freezer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
311	Light, Exam	0.00	0.00	0.00	030.1480.10000	030.1580.10000
312	Electrosurgical Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
313	File Cabinet & Shelf	8.36	41.80	50.16	030.1480.10000	030.1580.10000
314	LOCK SYSTEM	8.36	41.80	50.16	030.1450.10000	030.1550.10000
315	Centrifuge	0.00	0.00	0.00	030.1450.10000	030.1550.10000
316	Defibrillator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
317	Defibrillator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
318	Treatment Tables	0.00	0.00	0.00	030.1450.10000	030.1550.10000
319	Treatment Tables	0.00	0.00	0.00	030.1450.10000	030.1550.10000
320	GK Electric LLC	0.00	0.00	0.00	030.1450.10000	030.1550.10000
321	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
322	Trash Recepticles	8.36	41.80	50.16	030.1480.10000	030.1580.10000
323	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
324	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
325	DIGITAL VITALS MACHINE	0.00	0.00	0.00	030.1450.10000	030.1550.10000
326	Temp Pacemaker	0.00	0.00	0.00	030.1450.10000	030.1550.10000
327	Telemetry Units	7.16	35.83	43.00	030.1450.10000	030.1550.10000
328	Ultra Shoulder Positioner	0.00	0.00	0.00	030.1450.10000	030.1550.10000
329	Sink /Facet	7.76	38.82	46.58	030.1450.10000	030.1550.10000
330	Athena Travel invoice	0.00	0.00	0.00	030.1470.10000	030.1570.10000
331	Hydrocollator Mobile Heatg Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
332	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
333	SERVERS-COMPUTER	0.00	0.00	0.00	030.1470.10000	030.1570.10000
334	FOOD WARMER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
335	Athena	0.00	0.00	0.00	030.1470.10000	030.1570.10000
336	DOCUMENT SCANNERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000

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337	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
338	Pathology Dictation Equipmt	0.00	0.00	0.00	030.1470.10000	030.1570.10000
339	Electrocardiograph	0.00	0.00	0.00	030.1450.10000	030.1550.10000
340	Electrocardiograph	0.00	0.00	0.00	030.1450.10000	030.1550.10000
341	Microscope, Surgical	0.00	0.00	0.00	030.1450.10000	030.1550.10000
342	Performa bobath	0.00	0.00	0.00	030.1450.10000	030.1550.10000
343	Stirrups for OB Cased	0.00	0.00	0.00	030.1450.10000	030.1550.10000
344	SERVER-COMPUTER	0.00	0.00	0.00	030.1470.10000	030.1570.10000
345	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
346	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
347	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
348	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
349	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
350	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
351	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
352	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
353	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
354	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
355	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
356	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
357	Incubator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
358	Hood , Biomedical	0.00	0.00	0.00	030.1450.10000	030.1550.10000
359	Light, Exam (6)	0.00	0.00	0.00	030.1480.10000	030.1580.10000
360	Endoscope, Flexible (6)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
361	Monitor, Fetal (3)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
362	Laparascopic Gallbladder Instrument Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
363	Computer Optiplex 760	0.00	0.00	0.00	030.1470.10000	030.1570.10000
364	Suction Regulators-Med Surg	0.00	0.00	0.00	030.1450.10000	030.1550.10000
365	Sona Speech Machine	0.00	0.00	0.00	030.1470.10000	030.1570.10000
366	Bed, Patient (7)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
367	Bed, Patient (8)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
368	Radiology Record Shelving	0.00	0.00	0.00	030.1450.10000	030.1550.10000
369	Stretcher (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
370	Beds	0.00	0.00	0.00	030.1450.10000	030.1550.10000
371	Fisher Healthcare	0.00	0.00	0.00	030.1450.10000	030.1550.10000
372	Hill rom	0.00	0.00	0.00	030.1450.10000	030.1550.10000
373	Network Switch Replacement	0.00	0.00	0.00	030.1470.10000	030.1570.10000
374	Power Vault Stoage for CMS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
375	Driver Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
376	ER Chairs	0.00	0.00	0.00	030.1480.10000	030.1580.10000
377	Harmonic Scalpel	0.00	0.00	0.00	030.1450.10000	030.1550.10000
378	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000

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Depreciation Expense Report
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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
379	Total Gym 200030.9100.10.0.0	0.00	0.00	0.00	030.1450.10000	030.1550.10000
380	TREATMENT TABLE	0.00	0.00	0.00	030.1450.10000	030.1550.10000
381	OXICLIP ADULT FINGER SENSOR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
382	Oven	0.00	0.00	0.00	030.1450.10000	030.1550.10000
383	Garbage Disposal	0.00	0.00	0.00	030.1450.10000	030.1550.10000
384	Auscultation Trainer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
385	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
386	AC UNIT-MEDICAL ARTS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
387	Carts	0.00	0.00	0.00	030.1450.10000	030.1550.10000
388	Sink for OR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
389	Portable AC Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
390	EMC Corp	0.00	0.00	0.00	030.1450.10000	030.1550.10000
391	Formfast check Printing Software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
392	Knee Positioner	0.00	0.00	0.00	030.1450.10000	030.1550.10000
393	Raintech Sound & Comm Inc	0.00	0.00	0.00	030.1450.10000	030.1550.10000
394	Grossing Station	0.00	0.00	0.00	030.1450.10000	030.1550.10000
395	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
396	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
397	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
398	Phlebotomy Chair	0.00	0.00	0.00	030.1480.10000	030.1580.10000
399	Monitor, NIBP (4)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
400	Mannequin	0.00	0.00	0.00	030.1450.10000	030.1550.10000
401	Meditech Equipmt Loan/Swap	0.00	0.00	0.00	030.1450.10000	030.1550.10000
402	Router-Wireless Project	0.00	0.00	0.00	030.1470.10000	030.1570.10000
403	Staples Advantage	0.00	0.00	0.00	030.1450.10000	030.1550.10000
404	TVs 5	0.00	0.00	0.00	030.1470.10000	030.1570.10000
405	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
406	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
407	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
408	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
409	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
410	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
411	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
412	Injector, CT	0.00	0.00	0.00	030.1450.10000	030.1550.10000
413	Cryostat	0.00	0.00	0.00	030.1450.10000	030.1550.10000
414	Table, Imaging	0.00	0.00	0.00	030.1450.10000	030.1550.10000
415	Wall Mount Diagnost Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
416	Endoscope, Flexible (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
417	Light, Surgical (2)	0.00	0.00	0.00	030.1480.10000	030.1580.10000
418	Warmer, Infant (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
419	Storage System	0.00	0.00	0.00	030.1450.10000	030.1550.10000
420	Wheelchairs	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
421	TimeClock 2N	0.00	0.00	0.00	030.1450.10000	030.1550.10000
422	HDTV 1080P SONY	0.00	0.00	0.00	030.1470.10000	030.1570.10000
423	(2) Dave's TV	0.00	0.00	0.00	030.1470.10000	030.1570.10000
424	Chairs for Lab Office	0.00	0.00	0.00	030.1480.10000	030.1580.10000
425	Computer Software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
426	Containers	0.00	0.00	0.00	030.1450.10000	030.1550.10000
427	ED Meditech Module	0.00	0.00	0.00	030.1450.10000	030.1550.10000
428	Used Furniture	0.00	0.00	0.00	030.1480.10000	030.1580.10000
429	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
430	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
431	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
432	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
433	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
434	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
435	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
436	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
437	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
438	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
439	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
440	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
441	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
442	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
443	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
444	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
445	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
446	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
447	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
448	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
449	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
450	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
451	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
452	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
453	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
454	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
455	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
456	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
457	Refrigerator, Blood Bank	0.00	0.00	0.00	030.1450.10000	030.1550.10000
458	Table, Autopsy	0.00	0.00	0.00	030.1450.10000	030.1550.10000
459	Phacoemulsifier	0.00	0.00	0.00	030.1450.10000	030.1550.10000
460	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
461	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
462	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
463	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
464	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
465	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
466	Bed, Patient	0.00	0.00	0.00	030.1450.10000	030.1550.10000
467	Bed, Patient	0.00	0.00	0.00	030.1450.10000	030.1550.10000
468	Refrigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
469	Med Fridge	0.00	0.00	0.00	030.1450.10000	030.1550.10000
470	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
471	Meehan & Goodin	0.00	0.00	0.00	030.1450.10000	030.1550.10000
472	Outdoor Tables	0.00	0.00	0.00	030.1480.10000	030.1580.10000
473	Owens	0.00	0.00	0.00	030.1450.10000	030.1550.10000
474	PACS Expansion	0.00	0.00	0.00	030.1450.10000	030.1550.10000
475	Abbott Lab	0.00	0.00	0.00	030.1450.10000	030.1550.10000
476	licensing for 3M system (2)	23.04	115.18	138.22	030.1450.10000	030.1550.10000
477	Cart Intelect XT & Transport	0.00	0.00	0.00	030.1450.10000	030.1550.10000
478	N600 Pulse OX, 1 yr, adk kit	10.75	53.75	64.50	030.1450.10000	030.1550.10000
479	High Definition Eyecup camera head	781.87	3,909.35	4,691.22	030.1450.10000	030.1550.10000
480	High Definition Urology Camera Head	36.87	184.35	221.22	030.1450.10000	030.1550.10000
481	(2each) HD camera, control, etc.	175.12	875.60	1,050.72	030.1450.10000	030.1550.10000
482	Certegra Workstation	172.56	862.80	1,035.36	030.1450.10000	030.1550.10000
483	Video carts (2)	46.60	232.98	279.58	030.1450.10000	030.1550.10000
484	Colpac Unit C-5 w/6 std & 6 half sz coldpac	7.68	38.39	46.07	030.1450.10000	030.1550.10000
485	Hypothermia Machine	0.00	0.00	0.00	030.1450.10000	030.1550.10000
486	Hypothermia Machine	19.96	99.82	119.79	030.1450.10000	030.1550.10000
487	NIBP MONITORSCareScape printers,	105.95	529.76	635.71	030.1450.10000	030.1550.10000
488	Mettler Balance 120G/41G X 0.1 MG/0.01M	18.43	92.14	110.57	030.1450.10000	030.1550.10000
489	IM4123 High Definition 3ccd Urology Camera	36.87	184.35	221.22	030.1450.10000	030.1550.10000
490	2013 Chevy Silverado	98.31	491.55	589.86	030.1450.10000	030.1550.10000
491	Infiltration Pump	9.72	48.63	58.36	030.1450.10000	030.1550.10000
492	ms-SQL 3M Conversion software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
493	Intelect Legend XT 4 channel combp w/5 cm	11.26	56.31	67.57	030.1450.10000	030.1550.10000
494	10 desktops	108.34	541.67	650.00	030.1470.10000	030.1570.10000
495	Medlux GPI Ceiling Graphics CT Project	0.00	0.00	0.00	030.1450.10000	030.1550.10000
496	Laptops HP SB 8470P (4)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
497	4 LAPTOPS FOR MEDICAL EDUCATION	0.00	0.00	0.00	030.1470.10000	030.1570.10000
498	Ice MachinesDispenser 12# Air Cooled	19.45	97.26	116.71	030.1450.10000	030.1550.10000
499	Treatment recliner (3)	26.63	133.15	159.78	030.1450.10000	030.1550.10000
500	DASH4-FEAG-XAXB-XAAX	46.60	232.98	279.58	030.1450.10000	030.1550.10000
501	Bike upright nautilus 10 series w/7" touch	12.80	63.99	76.79	030.1450.10000	030.1550.10000
502	Cable Crossover - Free standing	14.34	71.67	86.00	030.1450.10000	030.1550.10000
503	QD head coil	57.35	286.73	344.08	030.1450.10000	030.1550.10000
504	Removal of Asb. Floor tile, mastic, etc from CT	0.00	0.00	0.00	0	0

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
505	Re-install all curtains CT SCAN	0.00	0.00	0.00	030.1450.10000	030.1550.10000
506	Kangaroo Epump (5)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
507	Preparation & painting of interior of Dr. Smith's	20.47	102.38	122.86	030.1450.10000	030.1550.10000
508	Monitor, ABP (2)	22.01	110.06	132.07	030.1470.10000	030.1570.10000
509	6 Channel TeleRehab versaCare - Single	150.02	750.12	900.14	030.1450.10000	030.1550.10000
510	Guest Wireless	6.15	30.72	36.86	030.1470.10000	030.1570.10000
511	4 LAPTOPS FOR MEDICAL EDUCATION	0.00	0.00	0.00	030.1470.10000	030.1570.10000
512	Histology Strainer	100.87	504.35	605.22	030.1450.10000	030.1550.10000
513	Anesthisia machine	31.24	156.19	187.43	030.1450.10000	030.1550.10000
514	MOB Wireless	97.29	486.43	583.72	030.1470.10000	030.1570.10000
515	MOB Wireless	54.79	273.93	328.72	030.1470.10000	030.1570.10000
516	MOB Wireless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
517	Ground penetrating Radar ct PROJECT	0.00	0.00	0.00	030.1450.10000	030.1550.10000
518	Dr Smiths office painting and interior	19.45	97.26	116.71	030.1480.10000	030.1580.10000
519	Network Cabling	6.66	33.28	39.94	030.1470.10000	030.1570.10000
520	Network Cabling	6.66	33.28	39.94	030.1470.10000	030.1570.10000
521	Dragon Medical Practice Edition	0.00	0.00	0.00	030.1470.10000	030.1570.10000
522	Fabricate and install the pan	0.00	0.00	0.00	030.1450.10000	030.1550.10000
523	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
524	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
525	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
526	Dr. Astrauskas	26.12	130.60	156.72	030.1450.10000	030.1550.10000
527	ICU Telemetry	11.77	58.87	70.64	030.1450.10000	030.1550.10000
528	CT Lung Software	231.19	1,155.94	1,387.13	030.1450.10000	030.1550.10000
529	Dr. Astrauskas	0.00	0.00	0.00	030.1450.10000	030.1550.10000
530	Sleep Room Comfort Control	8.19	40.95	49.14	030.1450.10000	030.1550.10000
531	Laptops for Dr. Sussman's office	0.00	0.00	0.00	030.1470.10000	030.1570.10000
532	Laptops Dr. Sussman	0.00	0.00	0.00	030.1470.10000	030.1570.10000
533	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
534	Quality Control Data Analyizer	53.75	268.75	322.50	030.1450.10000	030.1550.10000
535	TV REMOVAL	0.00	0.00	0.00	030.1470.10000	030.1570.10000
536	Stryker Stretcher Chair	17.91	89.58	107.50	030.1480.10000	030.1580.10000
537	Guest Wireless	13.44	67.19	80.63	030.1470.10000	030.1570.10000
538	CT Scan Room Rennovations	0.00	0.00	0.00	0	0
539	Mamography reporting system	23.30	116.51	139.81	030.1450.10000	030.1550.10000
540	Registration area	19.71	98.54	118.25	030.1450.10000	030.1550.10000
541	SONY IPELA CAMERA REMOTE INSTALLED	0.00	0.00	0.00	030.1470.10000	030.1570.10000
542	RHA Think Pads (2)	25.09	125.47	150.56	030.1450.10000	030.1550.10000
543	Chiller Tower Media Replacement	24.20	120.99	145.19	030.1450.10000	030.1550.10000
544	Registration area	6.27	31.35	37.62	030.1450.10000	030.1550.10000
545	Registration area	23.30	116.51	139.81	030.1450.10000	030.1550.10000
546	Optical through cutting Biopsy focep	4.93	24.64	29.57	030.1450.10000	030.1550.10000

SH000221
11/03/2016

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
547	Cardiology Move	8.96	44.79	53.75	030.1450.10000	030.1550.10000
548	Autoscrubber T3	22.85	114.27	137.13	030.1450.10000	030.1550.10000
549	Weil Mclain WTGO5 Gold Boiler	30.47	152.35	182.82	030.1450.10000	030.1550.10000
550	MOB Roof	0.00	0.00	0.00	030.1420.10000	030.1520.10000
551	10 laptops and software	86.11	430.55	516.66	030.1470.10000	030.1570.10000
552	10 laptops and software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
553	10 laptops and software	194.44	972.22	1,166.67	030.1470.10000	030.1570.10000
554	Carpeting various locations	0.00	0.00	0.00	0	0
555	Carpeting various locations	0.00	0.00	0.00	0	0
556	Carpeting various locations	0.00	0.00	0.00	0	0
557	DOOR HINGE REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
558	DOOR HINGE REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
559	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
560	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
561	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
562	Software licensing	26.88	134.38	161.26	030.1470.10000	030.1570.10000
563	MOB WIRELESS	187.50	937.50	1,125.00	030.1470.10000	030.1570.10000
564	6 ft coaxile for MOB wirless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
565	26" TV SAMSUNG (32)	113.10	565.48	678.58	030.1470.10000	030.1570.10000
566	Carpeting various locations	0.00	0.00	0.00	0	0
567	(22) 26" TV'S REPLACEMENT	38.10	190.48	228.58	030.1470.10000	030.1570.10000
568	6 ft coaxile for MOB wirless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
569	GEN 4 DIGITAL TV NURSE CALL	25.09	125.42	150.50	030.1470.10000	030.1570.10000
570	COLLIMATOR REPLACEMENT RAD ROOM 4	65.47	327.38	392.86	030.1450.10000	030.1550.10000
571	LOCKING REFRIGERATOR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
572	UTILITY CART	0.00	0.00	0.00	030.1450.10000	030.1550.10000
573	BABY SCALE DIGITAL	0.00	0.00	0.00	030.1450.10000	030.1550.10000
574	TREATMENT TABLE SUITE 1600	0.00	0.00	0.00	030.1450.10000	030.1550.10000
575	TREATMENT TABLE SUITE 1600	0.00	0.00	0.00	030.1450.10000	030.1550.10000
576	RNNOVATIONS	0.00	0.00	0.00	0	0
577	RNNOVATIONS	0.00	0.00	0.00	0	0
578	WELCH ALLYN 767 WALL SYSTEM	29.76	148.81	178.57	030.1450.10000	030.1550.10000
579	RNNOVATIONS	0.00	0.00	0.00	0	0
580	INTERFACE FOR VITROS 5600	29.76	148.81	178.57	030.1450.10000	030.1550.10000
581	Selenia tungsten base system service	253.57	1,267.86	1,521.43	030.1450.10000	030.1550.10000
582	STRAP TOGGLE 1/4"	0.00	0.00	0.00	030.1450.10000	030.1550.10000
583	TOSHIBA AMERICA MEDICAL SYSTEMS	298.81	1,494.05	1,792.86	030.1450.10000	030.1550.10000
584	Wireless	175.63	878.13	1,053.76	030.1470.10000	030.1570.10000
585	Ob rennovations painting	8.96	44.79	53.75	030.1450.10000	030.1550.10000
586	Registration waiting area	6.27	31.35	37.62	030.1450.10000	030.1550.10000
587	Glass Enclosures	23.30	116.51	139.81	030.1450.10000	030.1550.10000
588	TJ's Custom Floors	4.93	24.64	29.57	030.1450.10000	030.1550.10000

Sharon Hospital
Depreciation Expense Report
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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
589	Recliner Caremore (3)	7.62	38.08	45.70	030.1450.10000	030.1550.10000
590	TJ's Custom Floors	17.91	89.58	107.50	030.1450.10000	030.1550.10000
591	Anesthsia Machine	99.01	495.05	594.06	030.1450.10000	030.1550.10000
592	Guarmarx Specimen Boxes	12.54	62.71	75.25	030.1450.10000	030.1550.10000
593	Wiring for automated doors wound care	0.00	0.00	0.00	030.1450.10000	030.1550.10000
594	Pemkp Hinges Installed	39.43	197.14	236.57	030.1450.10000	030.1550.10000
595	Drop Arm Commodes	11.65	58.23	69.88	030.1450.10000	030.1550.10000
596	12 Lazy Boy Florin Guest Chairs	28.68	143.39	172.07	030.1480.10000	030.1580.10000
597	Bariatric transported	18.81	94.06	112.87	030.1450.10000	030.1550.10000
598	MOB Roof work	47.04	235.21	282.25	030.1450.10000	030.1550.10000
599	26" NDS Monitors	38.53	192.66	231.19	030.1470.10000	030.1570.10000
600	MVS Ultrasound	30.47	152.35	182.82	030.1450.10000	030.1550.10000
601	Sytemm 777 Opthalmoscope & otoscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
602	vENTILATOR	37.19	185.94	223.13	030.1450.10000	030.1550.10000
603	CANOPY LOADING DOCK	13.44	67.19	80.63	030.1450.10000	030.1550.10000
604	(2) TREATMENT TABLES	10.30	51.51	61.81	030.1450.10000	030.1550.10000
605	Ventilator	5.38	26.88	32.26	030.1450.10000	030.1550.10000
606	Cardio Pacs	13.82	69.11	82.93	030.1450.10000	030.1550.10000
607	enovate latop cart	4.93	24.64	29.57	030.1450.10000	030.1550.10000
608	LAPTOP CART	0.00	0.00	0.00	030.1470.10000	030.1570.10000
609	INSTALLATION OF DOOR	9.85	49.27	59.13	030.1450.10000	030.1550.10000
610	OR SONIC IRRAGATOR	101.25	506.25	607.50	030.1450.10000	030.1550.10000
611	OR humidity control	39.43	197.14	236.57	030.1450.10000	030.1550.10000
612	Purchase of Dr. Sussman's practice	0.00	0.00	0.00	030.1420.10000	030.1520.10000
613	Pacs system	537.63	2,688.13	3,225.76	030.1450.10000	030.1550.10000
614	chemistry analyzer lease	2,627.25	13,136.25	15,763.50	030.1450.10000	030.1550.10000
615	Enovate Laptop Cart	0.00	0.00	0.00	030.1470.10000	030.1570.10000
616	Replacement of Carpet	7.16	35.83	43.00	030.1450.10000	030.1550.10000
617	High definition Urology Camera	37.90	189.47	227.36	030.1450.10000	030.1550.10000
618	Wireless network	13.31	66.55	79.86	030.1470.10000	030.1570.10000
619	Guarmarx Specimen Boxes	28.23	141.15	169.38	030.1450.10000	030.1550.10000
620	Ge Soloar 8000i ECG NIBP	39.43	197.14	236.57	030.1450.10000	030.1550.10000
621	Low Beds (4)	128.31	641.58	769.90	030.1450.10000	030.1550.10000
622	BIG WHEEL STRETCHERS (2)	44.35	221.77	266.13	030.1450.10000	030.1550.10000
623	trade in on steris from 2012	0.00	0.00	0.00	030.1450.10000	030.1550.10000
624	HOER LIFT	23.75	118.75	142.50	030.1450.10000	030.1550.10000
625	ct ELECTRICAL RENNOVATION	0.00	0.00	0.00	0	0
626	GERI CHAIR	9.85	49.27	59.13	030.1450.10000	030.1550.10000
627	TABLET	11.65	58.23	69.88	030.1470.10000	030.1570.10000
628	Treadmill	30.10	150.50	180.60	030.1450.10000	030.1550.10000
629	COLPOSCOPE	84.84	424.17	509.00	030.1450.10000	030.1550.10000
630	3 DESK PRO COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000

Sharon Hospital
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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
631	CARD READER	32.25	161.25	193.50	030.1450.10000	030.1550.10000
632	CARDIOLOGY [ACS	16.13	80.63	96.76	030.1450.10000	030.1550.10000
633	CARDIOLOGY [ACS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
634	Food Thermiliazer replacement	9.40	47.03	56.44	030.1450.10000	030.1550.10000
635	TrabsAir3 PFT system	101.70	508.49	610.19	030.1450.10000	030.1550.10000
636	Expansion Feasibility	24.65	123.23	147.88	030.1450.10000	030.1550.10000
637	SCALE FOR ED	7.16	35.83	43.00	030.1450.10000	030.1550.10000
638	PANDA WARMER	52.97	264.82	317.78	030.1450.10000	030.1550.10000
639	COLOPSCOPE	33.15	165.73	198.88	030.1450.10000	030.1550.10000
640	ORTHOPEDIC PEGBOARD	11.54	57.73	69.28	030.1450.10000	030.1550.10000
641	ICE MAKER	12.74	63.70	76.44	030.1450.10000	030.1550.10000
642	CENTRIFUGE 24C	12.34	61.71	74.05	030.1450.10000	030.1550.10000
643	LAB CHEMISTRY 180	47.50	237.50	285.00	030.1450.10000	030.1550.10000
644	DRAGON SOFTWARE	59.75	298.75	358.50	030.1470.10000	030.1570.10000
645	MICROSCOPE BX 43 THREE	148.75	743.75	892.50	030.1450.10000	030.1550.10000
646	GARBAGE DISPOSAL	7.97	39.82	47.78	030.1450.10000	030.1550.10000
647	ACMEWARE SOFTWARE LICENSE	311.84	1,559.17	1,871.00	030.1470.10000	030.1570.10000
648	PHARMACY ONE SOURCE LICENSE	331.90	1,659.50	1,991.40	030.1470.10000	030.1570.10000
649	HEATEK 300 SLIDE STAINER	39.03	195.14	234.17	030.1450.10000	030.1550.10000
650	VERSACARE BED MODEL =3200	36.44	182.22	218.67	030.1450.10000	030.1550.10000
651	ICE APEXPREO TELEMETRY TRANSMITTER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
652	MEDICAL ARMS	18.32	91.58	109.90	030.1450.10000	030.1550.10000
653	MEDICAL ARTS WATER HEATER	9.56	47.78	57.34	030.1450.10000	030.1550.10000
654	OVERBED TABLES (40)	103.94	519.72	623.67	030.1450.10000	030.1550.10000
655	Ortho surgical	151.74	758.68	910.42	030.1450.10000	030.1550.10000
656	Ortho surgical	21.50	107.50	129.00	030.1450.10000	030.1550.10000
657	CARDIOLOGY PACS SYSTEM	1,417.56	7,087.78	8,505.34	030.1450.10000	030.1550.10000
658	Venue 40 Demo Ultrasound	87.61	438.05	525.66	030.1450.10000	030.1550.10000
659	CDIS Infrastructure	16.72	83.61	100.33	030.1450.10000	030.1550.10000
660	SUBRAU COUURIER CAR 2011	65.32	326.58	391.90	030.1450.10000	030.1550.10000
661	ROOFING REPAIR MAINT BLGDS	88.01	440.05	528.06	030.1450.10000	030.1550.10000
662	MRI MONITOR	186.78	933.89	1,120.67	030.1450.10000	030.1550.10000
663	HELO PAD WORK	36.64	183.20	219.84	030.1450.10000	030.1550.10000
664	ACU-DOSE SYSTEM	20.32	101.58	121.90	030.1450.10000	030.1550.10000
665	NUCLEAR MED PACS	141.78	708.89	850.67	030.1450.10000	030.1550.10000
666	CISCO FROM CORPORATE	29.76	148.81	178.57	030.1470.10000	030.1570.10000
667	CISCO FROM CORPORATE	97.62	488.10	585.72	030.1470.10000	030.1570.10000
668	Carpet rplacement Dr. Kirsh	14.34	71.67	86.00	030.1480.10000	030.1580.10000
669	CT Scanner Capital Leae	1,914.87	9,574.33	11,489.20	030.1450.10000	030.1550.10000
670	Laproscopic instruments	10.35	51.76	62.11	030.1450.10000	030.1550.10000
671	12 channel uretero renoscope	92.29	461.46	553.75	030.1450.10000	030.1550.10000
672	ENDOCSOPY INSTRUMENTS	21.51	107.55	129.06	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
673	TISSUE TEC 5 SYSTEM	46.59	232.96	279.55	030.1450.10000	030.1550.10000
674	COMPUTERS / LAPTOPS	89.59	447.92	537.50	030.1470.10000	030.1570.10000
675	Segami Dell server	0.00	0.00	0.00	030.1470.10000	030.1570.10000
676	Segami Dell server	14.29	71.43	85.72	030.1470.10000	030.1570.10000
677	Chairs (35)	39.43	197.13	236.56	030.1480.10000	030.1580.10000
678	LD304 BedMaternityMM	205.50	1,027.50	1,233.00	030.1450.10000	030.1550.10000
679	GLIDE SCOPE AV;	136.21	681.04	817.25	030.1450.10000	030.1550.10000
680	12 lead ECG	30.27	151.34	181.61	030.1450.10000	030.1550.10000
681	5 ECG Holter Monitors	326.57	1,632.83	1,959.40	030.1470.10000	030.1570.10000
682	Corp Meaningful use	1,861.50	9,307.50	11,169.00	030.1450.10000	030.1550.10000
683	Unit Combo Intelect	13.54	67.69	81.23	030.1450.10000	030.1550.10000
684	Biodex Biostep	17.52	87.59	105.11	030.1450.10000	030.1550.10000
685	Medical Air Dryer	15.93	79.63	95.56	030.1450.10000	030.1550.10000
686	Patient Recliners and guest chairs	132.22	661.11	793.33	030.1450.10000	030.1550.10000
687	Naunce Software	69.31	346.53	415.84	030.1470.10000	030.1570.10000
688	Panda Warmer	58.15	290.74	348.89	030.1450.10000	030.1550.10000
689	Telemtry	9.95	49.77	59.72	030.1450.10000	030.1550.10000
690	Airfit Cycle	8.76	43.80	52.56	030.1450.10000	030.1550.10000
691	Roof Replacement Medical Bldg	0.00	0.00	0.00	030.1420.10000	030.1520.10000
692	Refrigerator and Chilling cart	54.56	272.78	327.34	030.1450.10000	030.1550.10000
693	PC equipment purchase	92.00	460.00	552.00	030.1470.10000	030.1570.10000
694	Patient Controlled Analgesia	164.88	824.38	989.26	030.1450.10000	030.1550.10000
695	Surgical Exam Light	9.56	47.78	57.34	030.1450.10000	030.1550.10000
696	Motorized Micotome	58.94	294.72	353.67	030.1450.10000	030.1550.10000
697	Sound Wizards	6.37	31.85	38.22	030.1450.10000	030.1550.10000
698	Cardio PACS	70.34	351.72	422.06	030.1450.10000	030.1550.10000
699	Cardio PACS Modules	135.41	677.04	812.45	030.1450.10000	030.1550.10000
700	Bedside Cabinets	142.35	711.73	854.08	030.1480.10000	030.1580.10000
701	Eliptical	15.76	78.83	94.60	030.1450.10000	030.1550.10000
702	Ped Renovation	0.00	0.00	0.00	0	0
703	Column Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
704	Shoulder Arthroscopy	9.31	46.58	55.90	030.1450.10000	030.1550.10000
705	Refrigerator and Chiller	57.35	286.75	344.10	030.1450.10000	030.1550.10000
706	Sleeper Chairs	35.49	177.42	212.90	030.1480.10000	030.1580.10000
707	Pxyis Meditech Interface	80.40	401.97	482.36	030.1470.10000	030.1570.10000
708	Warming Cabinet	13.98	69.88	83.86	030.1450.10000	030.1550.10000
709	GUS Probe	9.68	48.38	58.06	030.1450.10000	030.1550.10000
710	Waiting Chairs	26.16	130.83	157.00	030.1480.10000	030.1580.10000
711	Chimney Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
712	Door Frame Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
713	Waiting Chairs	15.41	77.04	92.45	030.1480.10000	030.1580.10000
714	Waiting Chairs	15.41	77.04	92.45	030.1480.10000	030.1580.10000

SH000225
11/03/2016

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
715	Window Sills	0.00	0.00	0.00	030.1420.10000	030.1520.10000
716	Patient Beds	362.52	1,812.62	2,175.14	030.1450.10000	030.1550.10000
717	CT Scanner Battery	27.60	138.00	165.60	030.1450.10000	030.1550.10000
718	Ortho Power Tools	246.59	1,232.96	1,479.55	030.1450.10000	030.1550.10000
719	Microfiche Cabinets	15.05	75.25	90.30	030.1450.10000	030.1550.10000
720	Bi-Polar Terp	63.44	317.21	380.65	030.1450.10000	030.1550.10000
721	Patient Lift	18.64	93.21	111.85	030.1450.10000	030.1550.10000
722	Ramp Replacement Oncall House	0.00	0.00	0.00	0	0
723	Bedside Monitor	37.90	189.47	227.36	030.1470.10000	030.1570.10000
724	Exam Table	29.19	145.95	175.14	030.1450.10000	030.1550.10000
725	Centrifuge	16.13	80.63	96.76	030.1450.10000	030.1550.10000
726	EEG Machine	66.66	333.33	400.00	030.1450.10000	030.1550.10000
727	Portable CO2	7.89	39.42	47.30	030.1450.10000	030.1550.10000
728	Stair Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
729	Meditech Interfaces	17.91	89.58	107.50	030.1470.10000	030.1570.10000
730	Meditech Interfaces	92.68	463.39	556.07	030.1470.10000	030.1570.10000
731	Boiler Replacement Oncall House	0.00	0.00	0.00	030.1450.10000	030.1550.10000
732	SBH Unit Reno	0.00	0.00	0.00	030.1450.10000	030.1550.10000
733	Roof - CT Scan	0.00	0.00	0.00	030.1420.10000	030.1520.10000
734	equipment	10.04	50.17	60.20	030.1450.10000	030.1550.10000
735	Stretcher	21.86	109.33	131.20	030.1450.10000	030.1550.10000
736	Anethesia Glidescope	128.31	641.58	769.90	030.1450.10000	030.1550.10000
737	OBIX Refresh	84.23	421.15	505.38	030.1450.10000	030.1550.10000
738	Pyxis Interface	17.91	89.58	107.50	030.1470.10000	030.1570.10000
739	Ventilator	47.79	238.94	286.73	030.1450.10000	030.1550.10000
740	CareFusion	5.18	25.88	31.06	030.1450.10000	030.1550.10000
741		0.00	0.00	0.00	#N/A	#N/A
742	Blood Culture	101.79	508.96	610.75	030.1450.10000	030.1550.10000
743	Pxyis Cabinet	10.39	51.96	62.35	030.1450.10000	030.1550.10000
744	Tables / Chairs	32.98	164.88	197.86	030.1480.10000	030.1580.10000
745	Stess Test	77.41	387.08	464.50	030.1450.10000	030.1550.10000
746	Cardiac Cycle	15.76	78.83	94.60	030.1450.10000	030.1550.10000
747	Bargain Barn	333.34	1,666.67	2,000.00	030.1420.10000	030.1520.10000
748	CDW - PO 71085 OBIX HW - Equpipment	22.22	111.11	133.33	030.1470.10000	030.1570.10000
749	Community Health Building	416.66	2,083.33	2,500.00	030.1420.10000	030.1520.10000
750	Community Health Campus	0.00	0.00	0.00	030.1400.10000	0
751	Corporate Apartment Land	0.00	0.00	0.00	030.1400.10000	0
752	Hansen House	250.00	1,250.00	1,500.00	030.1420.10000	030.1520.10000
753	Hansen House Land	0.00	0.00	0.00	030.1400.10000	0
754	House - Corporate Apartments	161.29	806.46	967.75	030.1420.10000	030.1520.10000
755	Main Campus	0.00	0.00	0.00	030.1400.10000	0
756	Main Campus	2,568.69	12,843.47	15,412.17	030.1410.10000	030.1510.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
757	Maintenance Barn 1	83.34	416.67	500.00	030.1420.10000	030.1520.10000
758	Maintenance Barn 2	83.34	416.67	500.00	030.1420.10000	030.1520.10000
759	Medical Arts Building	1,720.43	8,602.13	10,322.56	030.1420.10000	030.1520.10000
760	Medical Arts Campus	0.00	0.00	0.00	030.1400.10000	0
761	Medical Arts Campus	716.84	3,584.22	4,301.06	030.1410.10000	030.1510.10000
762	MRI Monitors	276.50	1,382.50	1,659.00	030.1470.10000	030.1570.10000
763	Patient Curtains SBH Unit Reno	107.14	535.67	642.80	030.1450.10000	030.1550.10000
764	Philips Healthcare PO 69121 MRI Monitor -	22.22	111.11	133.33	030.1470.10000	030.1570.10000
765	RX Renovations Not in Production - Equipment	70.37	351.85	422.22	030.1450.10000	030.1550.10000
766	SBH/EMR	212.97	1,064.86	1,277.83	030.1450.10000	030.1550.10000
767	Sharon Hospital	46,487.30	232,436.50	278,923.80	030.1420.10000	030.1520.10000
768	Workstation Replacement	212.97	1,064.86	1,277.83	030.1470.10000	030.1570.10000
769	Workstation Replacement	212.99	1,064.93	1,277.92	030.1470.10000	030.1570.10000
770	Loading Dock Door	116.81	584.08	584.08	030.1420.10000	030.1520.10000
771	RX Renovations PH2	490.84	2,454.17	2,454.17	030.1420.10000	030.1520.10000
772	MOB Sink Replacement	64.95	194.84	194.84	030.1420.10000	030.1520.10000
773	RX Renovations PH2	772.92	3,091.67	3,091.67	030.1420.10000	030.1520.10000
774	Ultrasound	394.17	1,182.50	1,182.50	030.1450.10000	030.1550.10000
775	TSW EMR	539.58	2,158.33	2,158.33	030.1470.10000	030.1570.10000
776	OB Door Locks	99.48	298.43	298.43	030.1420.10000	030.1520.10000
777	MRI Monitors	265.83	797.50	797.50	030.1470.10000	030.1570.10000
778	Registration Tablet	61.11	122.22	122.22	030.1470.10000	030.1570.10000
779	On Call House Reno	164.41	328.83	328.83	030.1420.10000	030.1520.10000
780	ED Mag Locks	66.31	132.61	132.61	030.1420.10000	030.1520.10000
781	2N Light Replacement	76.21	152.42	152.42	030.1420.10000	030.1520.10000
782	On Call House Reno	96.62	96.62	96.62	030.1420.10000	030.1520.10000
783	Atrium Window Repair	128.50	128.50	128.50	030.1420.10000	030.1520.10000
784	SBH Renovations	0.00	0.00	0.00	030.1420.10000	030.1520.10000
785	Light Replacement 2N	36.85	36.85	36.85	030.1420.10000	030.1520.10000
786	Atrium Window Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
787	Patient Curtains SDS	120.88	120.88	120.88	030.1450.10000	030.1550.10000
788	Exam Table	31.66	31.66	31.66	030.1450.10000	030.1550.10000
789	Biological Cabinet	90.11	90.11	90.11	030.1450.10000	030.1550.10000
790	Biological Cabinet Install	27.64	27.64	27.64	030.1450.10000	030.1550.10000
791	Fixed Asset Purchase - Roth	0.00	0.00	0.00	030.1450.10000	030.1550.10000
792	Screw Replace System	0.00	0.00	0.00	030.1450.10000	030.1550.10000

SH000227
11/03/2016

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
43	Ultra sound, GE Inv 520391673 PO	251.39	1,256.95	1,508.34	030.1450.10000	030.1550.10000
44	Stretchers, Heritage Med Inv 16028, PO 58963	59.72	298.61	358.33	030.1450.10000	030.1550.10000
45	Update Viewing Stations - Hudson, CDW PO	155.95	779.76	935.71	030.1450.10000	030.1550.10000
46	Replacement Centrifuge, Helmer Inv 144330	0.00	0.00	0.00	030.1450.10000	030.1550.10000
47	Lesion Generator, Neurotherm Inv 80849 PO	146.43	732.14	878.57	030.1450.10000	030.1550.10000
48	Steris Replacement, Olympus PO	300.00	1,500.00	1,800.00	030.1450.10000	030.1550.10000
49	Privacy Glass, PT Ducillo Inv 4410	27.38	136.90	164.28	030.1450.10000	030.1550.10000
50	Alarm Panel, Simplex Inv 40460212, PO 59743	67.86	339.29	407.15	030.1450.10000	030.1550.10000
51	Storz Image 1 P3 Camera, Total Repair Inv	17.86	89.29	107.15	030.1450.10000	030.1550.10000
52	Ultra sound, Phy for Women - Tri-State	400.00	2,000.00	2,400.00	030.1450.10000	030.1550.10000
53	Crypblation, Phy for Women - Tri-State	88.10	440.48	528.58	030.1450.10000	030.1550.10000
54	Affirm Micro, Phy for Women Tri-State	32.15	160.72	192.86	030.1450.10000	030.1550.10000
55	Ikon Copier - Tri-State	0.00	0.00	0.00	030.1450.10000	030.1550.10000
56	Server Transfer from ECHO Corporate	0.00	0.00	0.00	030.1470.10000	030.1570.10000
57	Buildings - Sharon Hospital - Main Hospital	0.00	0.00	0.00	030.1420.10000	030.1520.10000
58	Buildings - Medical Arts Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
59	Land - Sharon Hospital - Main Hospital	0.00	0.00	0.00	030.1400.10000	0
60	MRI System	1,912.50	9,562.50	11,475.00	030.1450.10000	030.1550.10000
61	Site Improvements - Sharon Hospital - Main	0.00	0.00	0.00	030.1420.10000	030.1520.10000
62	PACS	1,139.78	5,698.89	6,838.67	030.1450.10000	030.1550.10000
63	Site Improvements - Medical Arts Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
64	Land - Community Health Building	0.00	0.00	0.00	030.1400.10000	0
65	Land - Medical Arts Building	0.00	0.00	0.00	030.1400.10000	0
66	Buildings - Community Health Building	0.00	0.00	0.00	030.1420.10000	030.1520.10000
67	Mammography System	763.89	3,819.45	4,583.34	030.1450.10000	030.1550.10000
68	Radiographic/Fluoroscopic System	563.89	2,819.45	3,383.34	030.1450.10000	030.1550.10000
69	Dictation System	344.09	1,720.42	2,064.50	030.1450.10000	030.1550.10000
70	Buildings - Bargain Barn	0.00	0.00	0.00	030.1420.10000	030.1520.10000
71	Buildings - House - Corporate Apartments	0.00	0.00	0.00	030.1420.10000	030.1520.10000
72	Land - Hansen House - On-Call Apartment	0.00	0.00	0.00	030.1400.10000	0
73	Table, Surgical	40.61	203.05	243.66	030.1450.10000	030.1550.10000
74	Phones Lease	238.34	1,191.67	1,430.00	030.1450.10000	030.1550.10000
75	Land - Cottage C - Empty	0.00	0.00	0.00	030.1400.10000	0
76	Land - House - Corporate Apartments	0.00	0.00	0.00	030.1400.10000	0
77	Walk in Freezer	170.25	851.25	1,021.50	030.1450.10000	030.1550.10000
78	PACS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
79	Dell Marketing	375.00	1,875.00	2,250.00	030.1450.10000	030.1550.10000
80	Insight Phone System	130.84	654.17	785.00	030.1450.10000	030.1550.10000
81	Buildings - Hansen House - On-Call Apartment	0.00	0.00	0.00	030.1420.10000	030.1520.10000
82	Buildings - Maintenance Barns (2)	0.00	0.00	0.00	030.1420.10000	030.1520.10000
83	CT Scanner	186.11	930.55	1,116.66	030.1450.10000	030.1550.10000
84	Analyzer, Coagulation	125.46	627.29	752.75	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
85	Analyzer, Coagulation	125.46	627.29	752.75	030.1450.10000	030.1550.10000
86	Radiographic System	166.66	833.33	1,000.00	030.1450.10000	030.1550.10000
87	Gamma Camera	166.66	833.33	1,000.00	030.1450.10000	030.1550.10000
88	Mobile C-Arm	347.22	1,736.11	2,083.33	030.1450.10000	030.1550.10000
89	CORE SWITCHES	127.84	639.17	767.00	030.1450.10000	030.1550.10000
90	Mobile C-Arm	277.78	1,388.89	1,666.67	030.1450.10000	030.1550.10000
91	Monitor, Central	140.28	701.39	841.67	030.1470.10000	030.1570.10000
92	STROKE CART	129.16	645.83	775.00	030.1450.10000	030.1550.10000
93	Ultrasound, Diagnostic	118.06	590.28	708.34	030.1450.10000	030.1550.10000
94	Radiographic System	112.50	562.50	675.00	030.1450.10000	030.1550.10000
95	Meditech Nursing Module	113.89	569.45	683.34	030.1450.10000	030.1550.10000
96	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
97	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
98	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
99	Anesthesia Machine	250.00	1,250.00	1,500.00	030.1450.10000	030.1550.10000
100	Surveillance Cameras	0.00	0.00	0.00	030.1450.10000	030.1550.10000
101	Computers	179.16	895.83	1,075.00	030.1470.10000	030.1570.10000
102	CR Reader	101.39	506.95	608.34	030.1450.10000	030.1550.10000
103	CR Reader	101.39	506.95	608.34	030.1450.10000	030.1550.10000
104	Video Tower	95.84	479.17	575.00	030.1450.10000	030.1550.10000
105	PACS Expansion	92.00	460.00	552.00	030.1450.10000	030.1550.10000
106	CAD - MRI	88.89	444.45	533.34	030.1450.10000	030.1550.10000
107	Ultrasound, Diagnostic	86.11	430.55	516.66	030.1450.10000	030.1550.10000
108	COMPUTERS -HOSPITAL	154.16	770.83	925.00	030.1470.10000	030.1570.10000
109	Refrigerator/Freezer, Walk-in	59.14	295.70	354.84	030.1450.10000	030.1550.10000
110	Cryostat	84.72	423.61	508.33	030.1450.10000	030.1550.10000
111	Dell Marketing	150.00	750.00	900.00	030.1450.10000	030.1550.10000
112	Bone Densitometer	80.56	402.78	483.34	030.1450.10000	030.1550.10000
113	Monitor, Central	77.78	388.89	466.67	030.1470.10000	030.1570.10000
114	Portable Radiographic	70.84	354.17	425.00	030.1450.10000	030.1550.10000
115	Tissue Processor	75.00	375.00	450.00	030.1450.10000	030.1550.10000
116	NURSE CALL SYSTEM	44.79	223.96	268.75	030.1450.10000	030.1550.10000
117	Ultrasound, Diagnostic	66.66	333.33	400.00	030.1450.10000	030.1550.10000
118	Ultrasound, Diagnostic	66.66	333.33	400.00	030.1450.10000	030.1550.10000
119	Sterilizer	69.44	347.22	416.67	030.1450.10000	030.1550.10000
120	Sterilizer	69.44	347.22	416.67	030.1450.10000	030.1550.10000
121	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
122	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
123	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
124	Monitor, Fetal	68.06	340.28	408.34	030.1470.10000	030.1570.10000
125	Utility Boom	47.19	235.97	283.17	030.1450.10000	030.1550.10000
126	Breast Biopsy System	59.72	298.61	358.33	030.1450.10000	030.1550.10000

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127	Biopsy System	59.72	298.61	358.33	030.1450.10000	030.1550.10000
128	Dell Marketing	95.84	479.17	575.00	030.1450.10000	030.1550.10000
129	Laser Imager	51.39	256.95	308.34	030.1470.10000	030.1570.10000
130	Buildings - Cottage C - Empty	0.00	0.00	0.00	030.1420.10000	030.1520.10000
131	Kronos	50.00	250.00	300.00	030.1450.10000	030.1550.10000
132	COMPUTERS	87.50	437.50	525.00	030.1470.10000	030.1570.10000
133	Table, Surgical	48.97	244.86	293.83	030.1450.10000	030.1550.10000
134	POINT OF SERVICE	56.94	284.72	341.67	030.1450.10000	030.1550.10000
135	Ablation Device	47.22	236.11	283.33	030.1450.10000	030.1550.10000
136	MRI Expansion	34.65	173.26	207.91	030.1450.10000	030.1550.10000
137	Slit Lamp	47.22	236.11	283.33	030.1450.10000	030.1550.10000
138	Dell Marketing	83.34	416.67	500.00	030.1450.10000	030.1550.10000
139	Ulralinq Echo Storage	45.84	229.17	275.00	030.1450.10000	030.1550.10000
140	Injector, Angiographic	41.66	208.33	250.00	030.1450.10000	030.1550.10000
141	Washer/Disinfector	44.44	222.22	266.67	030.1450.10000	030.1550.10000
142	Pulmonary Function System	44.44	222.22	266.67	030.1450.10000	030.1550.10000
143	Handpiece	44.44	222.22	266.67	030.1450.10000	030.1550.10000
144	Forceps-Arthroscopy equip	41.81	209.03	250.84	030.1450.10000	030.1550.10000
145	Chairs/Drapes for Boardroom	31.07	155.35	186.42	030.1480.10000	030.1580.10000
146	Rad Room #4 Renovations (C&H Electric) From	31.07	155.35	186.42	030.1450.10000	030.1550.10000
147	Analyzer, Blood Culture	26.88	134.38	161.26	030.1450.10000	030.1550.10000
148	Analyzer, Blood Culture	26.88	134.38	161.26	030.1450.10000	030.1550.10000
149	Table, Surgical	40.61	203.05	243.66	030.1450.10000	030.1550.10000
150	5 COMPUTERS	70.84	354.17	425.00	030.1470.10000	030.1570.10000
151	Sleep Study System	40.28	201.39	241.67	030.1450.10000	030.1550.10000
152	DOCUMENT SCANNER	45.84	229.17	275.00	030.1470.10000	030.1570.10000
153	ANTI VIRUS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
154	Injector, MRI	36.11	180.55	216.66	030.1450.10000	030.1550.10000
155	CDW Computer Centers Inc	66.66	333.33	400.00	030.1450.10000	030.1550.10000
156	Furnishing for Corp Apartmt	28.07	140.35	168.42	030.1480.10000	030.1580.10000
157	COMPUTERS	62.50	312.50	375.00	030.1470.10000	030.1570.10000
158	Table, Surgical	33.44	167.22	200.67	030.1450.10000	030.1550.10000
159	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
160	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
161	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
162	Monitor, Bedside	34.64	173.20	207.84	030.1470.10000	030.1570.10000
163	Hot Food Steam Table	33.34	166.67	200.00	030.1450.10000	030.1550.10000
164	Bladder Scanner	37.50	187.50	225.00	030.1450.10000	030.1550.10000
165	Sterilizer	31.94	159.72	191.67	030.1450.10000	030.1550.10000
166	Monitor, Telemetry	20.90	104.51	125.41	030.1470.10000	030.1570.10000
167	Steamer	30.56	152.78	183.34	030.1450.10000	030.1550.10000
168	Plate Warmer	30.56	152.78	183.34	030.1450.10000	030.1550.10000

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169	Dell Marketing	54.16	270.83	325.00	030.1450.10000	030.1550.10000
170	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
171	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
172	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
173	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
174	Light, Birthing	30.56	152.78	183.34	030.1480.10000	030.1580.10000
175	Vascular System	29.16	145.83	175.00	030.1450.10000	030.1550.10000
176	Stretcher (6)	29.16	145.83	175.00	030.1450.10000	030.1550.10000
177	Anesthesia Machine	27.78	138.89	166.67	030.1450.10000	030.1550.10000
178	LARYNGOSCOPE BLADES	19.71	98.54	118.25	030.1450.10000	030.1550.10000
179	Micro Saw and Drill	27.78	138.89	166.67	030.1450.10000	030.1550.10000
180	Sterilizer	27.78	138.89	166.67	030.1450.10000	030.1550.10000
181	Holter Monitor System	27.78	138.89	166.67	030.1450.10000	030.1550.10000
182	Water Separator	27.78	138.89	166.67	030.1450.10000	030.1550.10000
183	COMPUTERS LATITUDE E6400	45.84	229.17	275.00	030.1470.10000	030.1570.10000
184	Incubator, Infant	26.39	131.95	158.34	030.1450.10000	030.1550.10000
185	Dell Marketing	45.84	229.17	275.00	030.1450.10000	030.1550.10000
186	Defibrillator	25.00	125.00	150.00	030.1450.10000	030.1550.10000
187	Stretcher (5)	25.00	125.00	150.00	030.1450.10000	030.1550.10000
188	Stretcher (7)	25.00	125.00	150.00	030.1450.10000	030.1550.10000
189	Beds	25.09	125.42	150.50	030.1450.10000	030.1550.10000
190	Heat Pump	25.00	125.00	150.00	030.1450.10000	030.1550.10000
191	Prep Station	23.61	118.05	141.66	030.1450.10000	030.1550.10000
192	Argon Beam Coagulator	23.61	118.05	141.66	030.1450.10000	030.1550.10000
193	Argon Beam Coagulator	23.61	118.05	141.66	030.1450.10000	030.1550.10000
194	EKG	23.61	118.05	141.66	030.1450.10000	030.1550.10000
195	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
196	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
197	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
198	Tourniquet	23.61	118.05	141.66	030.1450.10000	030.1550.10000
199	PACS SERVER	22.91	114.58	137.50	030.1450.10000	030.1550.10000
200	Gero Psych Low Beds	23.89	119.45	143.34	030.1450.10000	030.1550.10000
201	WATER SOFTNER	22.22	111.11	133.33	030.1450.10000	030.1550.10000
202	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
203	Fuel Tank monitoring and Leak Detection Syste	16.13	80.63	96.76	030.1450.10000	030.1550.10000
204	Digitizer, Film	20.84	104.17	125.00	030.1450.10000	030.1550.10000
205	Defibrillator	22.22	111.11	133.33	030.1450.10000	030.1550.10000
206	Freezer	22.22	111.11	133.33	030.1450.10000	030.1550.10000
207	Microscope (6)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
208	UPS for CT Scan	20.84	104.17	125.00	030.1450.10000	030.1550.10000
209	Mobile Treatment Recliners	22.22	111.11	133.33	030.1450.10000	030.1550.10000
210	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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211	Monitor, MRI	20.84	104.17	125.00	030.1470.10000	030.1570.10000
212	Portable Radiographic	19.44	97.22	116.67	030.1450.10000	030.1550.10000
213	Microscope, Surgical	20.31	101.53	121.84	030.1450.10000	030.1550.10000
214	Defibrillator	20.84	104.17	125.00	030.1450.10000	030.1550.10000
215	EMC Corp	20.84	104.17	125.00	030.1450.10000	030.1550.10000
216	Microscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
217	Microscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
218	Stress Test System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
219	Bone Forcepts	19.11	95.55	114.66	030.1450.10000	030.1550.10000
220	5100 Radio Pager System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
221	In house paging System	19.44	97.22	116.67	030.1450.10000	030.1550.10000
222	DELL COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
223	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
224	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
225	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
226	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
227	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
228	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
229	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
230	Monitor, Bedside	20.31	101.53	121.84	030.1470.10000	030.1570.10000
231	Light, Surgical	19.11	95.55	114.66	030.1480.10000	030.1580.10000
232	Light, Surgical	19.11	95.55	114.66	030.1480.10000	030.1580.10000
233	Pump, IV (19)	18.06	90.28	108.34	030.1450.10000	030.1550.10000
234	PACS Expansion	18.06	90.28	108.34	030.1450.10000	030.1550.10000
235	ICU Ice Machine	18.06	90.28	108.34	030.1450.10000	030.1550.10000
236	Computers	0.00	0.00	0.00	030.1470.10000	030.1570.10000
237	Pro-Med Computer Upgrade	0.00	0.00	0.00	030.1470.10000	030.1570.10000
238	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
239	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
240	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
241	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
242	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
243	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
244	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
245	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
246	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
247	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
248	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
249	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
250	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
251	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
252	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000

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253	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
254	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
255	Bed, Patient	17.91	89.58	107.50	030.1450.10000	030.1550.10000
256	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
257	Endoscope, Flexible (5)	16.66	83.33	100.00	030.1450.10000	030.1550.10000
258	Cataract Tray	18.06	90.28	108.34	030.1450.10000	030.1550.10000
259	Phototherapy Lights	18.06	90.28	108.34	030.1450.10000	030.1550.10000
260	SALT SPREADER	18.06	90.28	108.34	030.1450.10000	030.1550.10000
261	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
262	Dietary Chairs	12.54	62.71	75.25	030.1450.10000	030.1550.10000
263	Gazebo Furniture	12.54	62.71	75.25	030.1480.10000	030.1580.10000
264	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
265	Defibrillator	18.06	90.28	108.34	030.1450.10000	030.1550.10000
266	CDW	0.00	0.00	0.00	030.1470.10000	030.1570.10000
267	Computer Backup System	0.00	0.00	0.00	030.1470.10000	030.1570.10000
268	ON-LINE CREDIT CARD PROCESSING	0.00	0.00	0.00	030.1470.10000	030.1570.10000
269	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
270	Defibrillator	15.28	76.39	91.67	030.1450.10000	030.1550.10000
271	Eye Wash Station	15.28	76.39	91.67	030.1450.10000	030.1550.10000
272	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
273	Ventilator, Adult	15.28	76.39	91.67	030.1450.10000	030.1550.10000
274	EYE HANDPIECE	15.28	76.39	91.67	030.1450.10000	030.1550.10000
275	Lumbar and Spine Instruments	15.28	76.39	91.67	030.1450.10000	030.1550.10000
276	Meat Slicer	15.28	76.39	91.67	030.1450.10000	030.1550.10000
277	Oven	15.28	76.39	91.67	030.1450.10000	030.1550.10000
278	Nortel WLAN Access Port	0.00	0.00	0.00	030.1470.10000	030.1570.10000
279	Monitor, Telemetry	8.96	44.79	53.75	030.1470.10000	030.1570.10000
280	Monitor, Patient	0.00	0.00	0.00	030.1470.10000	030.1570.10000
281	Monitor, Bedside	14.34	71.67	86.00	030.1470.10000	030.1570.10000
282	ELLIPTICAL CROSSTRAINER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
283	BARIATRIC RECLINER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
284	LOW BEDS	14.34	71.67	86.00	030.1450.10000	030.1550.10000
285	LOW BEDS	14.34	71.67	86.00	030.1450.10000	030.1550.10000
286	COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000
287	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
288	Gazebo Furniture	9.56	47.78	57.34	030.1480.10000	030.1580.10000
289	Hartford Fine Art & Framing	9.56	47.78	57.34	030.1480.10000	030.1580.10000
290	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
291	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
292	PHONES	0.00	0.00	0.00	030.1450.10000	030.1550.10000
293	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
294	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
295	Microtome	0.00	0.00	0.00	030.1450.10000	030.1550.10000
296	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
297	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
298	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
299	Monitor, Bedside	13.14	65.70	78.84	030.1470.10000	030.1570.10000
300	Hardware to support Meditide	0.00	0.00	0.00	030.1470.10000	030.1570.10000
301	CAD System	0.00	0.00	0.00	030.1450.10000	030.1550.10000
302	Integra Lifesciences Corp (instruments)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
303	Hartford Fine Art & Framing	8.96	44.79	53.75	030.1480.10000	030.1580.10000
304	Lobby Furniture Upholstery	8.96	44.79	53.75	030.1480.10000	030.1580.10000
305	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
306	Owens & Minor	0.00	0.00	0.00	030.1450.10000	030.1550.10000
307	Refrigerator, Walk-in	7.76	38.82	46.58	030.1450.10000	030.1550.10000
308	Thyroid Uptake	0.00	0.00	0.00	030.1450.10000	030.1550.10000
309	Cell Washer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
310	Freezer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
311	Light, Exam	0.00	0.00	0.00	030.1480.10000	030.1580.10000
312	Electrosurgical Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
313	File Cabinet & Shelf	8.36	41.80	50.16	030.1480.10000	030.1580.10000
314	LOCK SYSTEM	8.36	41.80	50.16	030.1450.10000	030.1550.10000
315	Centrifuge	0.00	0.00	0.00	030.1450.10000	030.1550.10000
316	Defibrillator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
317	Defibrillator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
318	Treatment Tables	0.00	0.00	0.00	030.1450.10000	030.1550.10000
319	Treatment Tables	0.00	0.00	0.00	030.1450.10000	030.1550.10000
320	GK Electric LLC	0.00	0.00	0.00	030.1450.10000	030.1550.10000
321	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
322	Trash Recepticles	8.36	41.80	50.16	030.1480.10000	030.1580.10000
323	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
324	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
325	DIGITAL VITALS MACHINE	0.00	0.00	0.00	030.1450.10000	030.1550.10000
326	Temp Pacemaker	0.00	0.00	0.00	030.1450.10000	030.1550.10000
327	Telemetry Units	7.16	35.83	43.00	030.1450.10000	030.1550.10000
328	Ultra Shoulder Positioner	0.00	0.00	0.00	030.1450.10000	030.1550.10000
329	Sink /Facet	7.76	38.82	46.58	030.1450.10000	030.1550.10000
330	Athena Travel invoice	0.00	0.00	0.00	030.1470.10000	030.1570.10000
331	Hydrocollator Mobile Heatg Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
332	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
333	SERVERS-COMPUTER	0.00	0.00	0.00	030.1470.10000	030.1570.10000
334	FOOD WARMER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
335	Athena	0.00	0.00	0.00	030.1470.10000	030.1570.10000
336	DOCUMENT SCANNERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000

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337	Optimus Arch	0.00	0.00	0.00	030.1450.10000	030.1550.10000
338	Pathology Dictation Equipmt	0.00	0.00	0.00	030.1470.10000	030.1570.10000
339	Electrocardiograph	0.00	0.00	0.00	030.1450.10000	030.1550.10000
340	Electrocardiograph	0.00	0.00	0.00	030.1450.10000	030.1550.10000
341	Microscope, Surgical	0.00	0.00	0.00	030.1450.10000	030.1550.10000
342	Performa bobath	0.00	0.00	0.00	030.1450.10000	030.1550.10000
343	Stirrups for OB Cased	0.00	0.00	0.00	030.1450.10000	030.1550.10000
344	SERVER-COMPUTER	0.00	0.00	0.00	030.1470.10000	030.1570.10000
345	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
346	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
347	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
348	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
349	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
350	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
351	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
352	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
353	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
354	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
355	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
356	Monitor, Bedside	0.00	0.00	0.00	030.1470.10000	030.1570.10000
357	Incubator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
358	Hood , Biomedical	0.00	0.00	0.00	030.1450.10000	030.1550.10000
359	Light, Exam (6)	0.00	0.00	0.00	030.1480.10000	030.1580.10000
360	Endoscope, Flexible (6)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
361	Monitor, Fetal (3)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
362	Laparascopic Gallbladder Instrument Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
363	Computer Optiplex 760	0.00	0.00	0.00	030.1470.10000	030.1570.10000
364	Suction Regulators-Med Surg	0.00	0.00	0.00	030.1450.10000	030.1550.10000
365	Sona Speech Machine	0.00	0.00	0.00	030.1470.10000	030.1570.10000
366	Bed, Patient (7)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
367	Bed, Patient (8)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
368	Radiology Record Shelving	0.00	0.00	0.00	030.1450.10000	030.1550.10000
369	Stretcher (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
370	Beds	0.00	0.00	0.00	030.1450.10000	030.1550.10000
371	Fisher Healthcare	0.00	0.00	0.00	030.1450.10000	030.1550.10000
372	Hill rom	0.00	0.00	0.00	030.1450.10000	030.1550.10000
373	Network Switch Replacement	0.00	0.00	0.00	030.1470.10000	030.1570.10000
374	Power Vault Stoage for CMS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
375	Driver Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
376	ER Chairs	0.00	0.00	0.00	030.1480.10000	030.1580.10000
377	Harmonic Scalpel	0.00	0.00	0.00	030.1450.10000	030.1550.10000
378	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000

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379	Total Gym 200030.9100.10.0.0	0.00	0.00	0.00	030.1450.10000	030.1550.10000
380	TREATMENT TABLE	0.00	0.00	0.00	030.1450.10000	030.1550.10000
381	OXICLIP ADULT FINGER SENSOR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
382	Oven	0.00	0.00	0.00	030.1450.10000	030.1550.10000
383	Garbage Disposal	0.00	0.00	0.00	030.1450.10000	030.1550.10000
384	Auscultation Trainer	0.00	0.00	0.00	030.1450.10000	030.1550.10000
385	Treadmill	0.00	0.00	0.00	030.1450.10000	030.1550.10000
386	AC UNIT-MEDICAL ARTS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
387	Carts	0.00	0.00	0.00	030.1450.10000	030.1550.10000
388	Sink for OR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
389	Portable AC Unit	0.00	0.00	0.00	030.1450.10000	030.1550.10000
390	EMC Corp	0.00	0.00	0.00	030.1450.10000	030.1550.10000
391	Formfast check Printing Software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
392	Knee Positioner	0.00	0.00	0.00	030.1450.10000	030.1550.10000
393	Raintech Sound & Comm Inc	0.00	0.00	0.00	030.1450.10000	030.1550.10000
394	Grossing Station	0.00	0.00	0.00	030.1450.10000	030.1550.10000
395	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
396	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
397	Refigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
398	Phlebotomy Chair	0.00	0.00	0.00	030.1480.10000	030.1580.10000
399	Monitor, NIBP (4)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
400	Mannequin	0.00	0.00	0.00	030.1450.10000	030.1550.10000
401	Meditech Equipmt Loan/Swap	0.00	0.00	0.00	030.1450.10000	030.1550.10000
402	Router-Wireless Project	0.00	0.00	0.00	030.1470.10000	030.1570.10000
403	Staples Advantage	0.00	0.00	0.00	030.1450.10000	030.1550.10000
404	TVs 5	0.00	0.00	0.00	030.1470.10000	030.1570.10000
405	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
406	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
407	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
408	Bed, Birthing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
409	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
410	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
411	Cabinet, Warming	0.00	0.00	0.00	030.1450.10000	030.1550.10000
412	Injector, CT	0.00	0.00	0.00	030.1450.10000	030.1550.10000
413	Cryostat	0.00	0.00	0.00	030.1450.10000	030.1550.10000
414	Table, Imaging	0.00	0.00	0.00	030.1450.10000	030.1550.10000
415	Wall Mount Diagnost Set	0.00	0.00	0.00	030.1450.10000	030.1550.10000
416	Endoscope, Flexible (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
417	Light, Surgical (2)	0.00	0.00	0.00	030.1480.10000	030.1580.10000
418	Warmer, Infant (2)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
419	Storage System	0.00	0.00	0.00	030.1450.10000	030.1550.10000
420	Wheelchairs	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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421	TimeClock 2N	0.00	0.00	0.00	030.1450.10000	030.1550.10000
422	HDTV 1080P SONY	0.00	0.00	0.00	030.1470.10000	030.1570.10000
423	(2) Dave's TV	0.00	0.00	0.00	030.1470.10000	030.1570.10000
424	Chairs for Lab Office	0.00	0.00	0.00	030.1480.10000	030.1580.10000
425	Computer Software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
426	Containers	0.00	0.00	0.00	030.1450.10000	030.1550.10000
427	ED Meditech Module	0.00	0.00	0.00	030.1450.10000	030.1550.10000
428	Used Furniture	0.00	0.00	0.00	030.1480.10000	030.1580.10000
429	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
430	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
431	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
432	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
433	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
434	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
435	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
436	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
437	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
438	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
439	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
440	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
441	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
442	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
443	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
444	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
445	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
446	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
447	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
448	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
449	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
450	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
451	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
452	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
453	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
454	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
455	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
456	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
457	Refrigerator, Blood Bank	0.00	0.00	0.00	030.1450.10000	030.1550.10000
458	Table, Autopsy	0.00	0.00	0.00	030.1450.10000	030.1550.10000
459	Phacoemulsifier	0.00	0.00	0.00	030.1450.10000	030.1550.10000
460	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
461	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000
462	Pump, IV	0.00	0.00	0.00	030.1450.10000	030.1550.10000

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463	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
464	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
465	Monitor, NIBP	0.00	0.00	0.00	030.1470.10000	030.1570.10000
466	Bed, Patient	0.00	0.00	0.00	030.1450.10000	030.1550.10000
467	Bed, Patient	0.00	0.00	0.00	030.1450.10000	030.1550.10000
468	Refrigerator	0.00	0.00	0.00	030.1450.10000	030.1550.10000
469	Med Fridge	0.00	0.00	0.00	030.1450.10000	030.1550.10000
470	Dell Marketing	0.00	0.00	0.00	030.1450.10000	030.1550.10000
471	Meehan & Goodin	0.00	0.00	0.00	030.1450.10000	030.1550.10000
472	Outdoor Tables	0.00	0.00	0.00	030.1480.10000	030.1580.10000
473	Owens	0.00	0.00	0.00	030.1450.10000	030.1550.10000
474	PACS Expansion	0.00	0.00	0.00	030.1450.10000	030.1550.10000
475	Abbott Lab	0.00	0.00	0.00	030.1450.10000	030.1550.10000
476	licensing for 3M system (2)	23.04	115.18	138.22	030.1450.10000	030.1550.10000
477	Cart Intelect XT & Transport	0.00	0.00	0.00	030.1450.10000	030.1550.10000
478	N600 Pulse OX, 1 yr, adk kit	10.75	53.75	64.50	030.1450.10000	030.1550.10000
479	High Definition Eyecup camera head	781.87	3,909.35	4,691.22	030.1450.10000	030.1550.10000
480	High Definition Urology Camera Head	36.87	184.35	221.22	030.1450.10000	030.1550.10000
481	(2each) HD camera, control, etc.	175.12	875.60	1,050.72	030.1450.10000	030.1550.10000
482	Certegra Workstation	172.56	862.80	1,035.36	030.1450.10000	030.1550.10000
483	Video carts (2)	46.60	232.98	279.58	030.1450.10000	030.1550.10000
484	Colpac Unit C-5 w/6 std & 6 half sz coldpac	7.68	38.39	46.07	030.1450.10000	030.1550.10000
485	Hypothermia Machine	0.00	0.00	0.00	030.1450.10000	030.1550.10000
486	Hypothermia Machine	19.96	99.82	119.79	030.1450.10000	030.1550.10000
487	NIBP MONITORSCareScape printers,	105.95	529.76	635.71	030.1450.10000	030.1550.10000
488	Mettler Balance 120G/41G X 0.1 MG/0.01M	18.43	92.14	110.57	030.1450.10000	030.1550.10000
489	IM4123 High Definition 3ccd Urology Camera	36.87	184.35	221.22	030.1450.10000	030.1550.10000
490	2013 Chevy Silverado	98.31	491.55	589.86	030.1450.10000	030.1550.10000
491	Infiltration Pump	9.72	48.63	58.36	030.1450.10000	030.1550.10000
492	ms-SQL 3M Conversion software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
493	Intelect Legend XT 4 channel combp w/5 cm	11.26	56.31	67.57	030.1450.10000	030.1550.10000
494	10 desktops	108.34	541.67	650.00	030.1470.10000	030.1570.10000
495	Medlux GPI Ceiling Graphics CT Project	0.00	0.00	0.00	030.1450.10000	030.1550.10000
496	Laptops HP SB 8470P (4)	0.00	0.00	0.00	030.1470.10000	030.1570.10000
497	4 LAPTOPS FOR MEDICAL EDUCATION	0.00	0.00	0.00	030.1470.10000	030.1570.10000
498	Ice MachinesDispenser 12# Air Cooled	19.45	97.26	116.71	030.1450.10000	030.1550.10000
499	Treatment recliner (3)	26.63	133.15	159.78	030.1450.10000	030.1550.10000
500	DASH4-FEAG-XAXB-XAAX	46.60	232.98	279.58	030.1450.10000	030.1550.10000
501	Bike upright nautilus 10 series w/7" touch	12.80	63.99	76.79	030.1450.10000	030.1550.10000
502	Cable Crossover - Free standing	14.34	71.67	86.00	030.1450.10000	030.1550.10000
503	QD head coil	57.35	286.73	344.08	030.1450.10000	030.1550.10000
504	Removal of Asb. Floor tile, mastic, etc from CT	0.00	0.00	0.00	0	0

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
505	Re-install all curtains CT SCAN	0.00	0.00	0.00	030.1450.10000	030.1550.10000
506	Kangaroo Epump (5)	0.00	0.00	0.00	030.1450.10000	030.1550.10000
507	Preparation & painting of interior of Dr. Smith's	20.47	102.38	122.86	030.1450.10000	030.1550.10000
508	Monitor, ABP (2)	22.01	110.06	132.07	030.1470.10000	030.1570.10000
509	6 Channel TeleRehab versaCare - Single	150.02	750.12	900.14	030.1450.10000	030.1550.10000
510	Guest Wireless	6.15	30.72	36.86	030.1470.10000	030.1570.10000
511	4 LAPTOPS FOR MEDICAL EDUCATION	0.00	0.00	0.00	030.1470.10000	030.1570.10000
512	Histology Strainer	100.87	504.35	605.22	030.1450.10000	030.1550.10000
513	Anesthisia machine	31.24	156.19	187.43	030.1450.10000	030.1550.10000
514	MOB Wireless	97.29	486.43	583.72	030.1470.10000	030.1570.10000
515	MOB Wireless	54.79	273.93	328.72	030.1470.10000	030.1570.10000
516	MOB Wireless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
517	Ground penetrating Radar ct PROJECT	0.00	0.00	0.00	030.1450.10000	030.1550.10000
518	Dr Smiths office painting and interior	19.45	97.26	116.71	030.1480.10000	030.1580.10000
519	Network Cabling	6.66	33.28	39.94	030.1470.10000	030.1570.10000
520	Network Cabling	6.66	33.28	39.94	030.1470.10000	030.1570.10000
521	Dragon Medical Practice Edition	0.00	0.00	0.00	030.1470.10000	030.1570.10000
522	Fabricate and install the pan	0.00	0.00	0.00	030.1450.10000	030.1550.10000
523	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
524	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
525	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
526	Dr. Astrauskas	26.12	130.60	156.72	030.1450.10000	030.1550.10000
527	ICU Telemetry	11.77	58.87	70.64	030.1450.10000	030.1550.10000
528	CT Lung Software	231.19	1,155.94	1,387.13	030.1450.10000	030.1550.10000
529	Dr. Astrauskas	0.00	0.00	0.00	030.1450.10000	030.1550.10000
530	Sleep Room Comfort Control	8.19	40.95	49.14	030.1450.10000	030.1550.10000
531	Laptops for Dr. Sussman's office	0.00	0.00	0.00	030.1470.10000	030.1570.10000
532	Laptops Dr. Sussman	0.00	0.00	0.00	030.1470.10000	030.1570.10000
533	Dr. Astraskus move	0.00	0.00	0.00	030.1450.10000	030.1550.10000
534	Quality Control Data Analyizer	53.75	268.75	322.50	030.1450.10000	030.1550.10000
535	TV REMOVAL	0.00	0.00	0.00	030.1470.10000	030.1570.10000
536	Stryker Stretcher Chair	17.91	89.58	107.50	030.1480.10000	030.1580.10000
537	Guest Wireless	13.44	67.19	80.63	030.1470.10000	030.1570.10000
538	CT Scan Room Rennovations	0.00	0.00	0.00	0	0
539	Mamography reporting system	23.30	116.51	139.81	030.1450.10000	030.1550.10000
540	Registration area	19.71	98.54	118.25	030.1450.10000	030.1550.10000
541	SONY IPELA CAMERA REMOTE INSTALLED	0.00	0.00	0.00	030.1470.10000	030.1570.10000
542	RHA Think Pads (2)	25.09	125.47	150.56	030.1450.10000	030.1550.10000
543	Chiller Tower Media Replacement	24.20	120.99	145.19	030.1450.10000	030.1550.10000
544	Registration area	6.27	31.35	37.62	030.1450.10000	030.1550.10000
545	Registration area	23.30	116.51	139.81	030.1450.10000	030.1550.10000
546	Optical through cutting Biopsy focep	4.93	24.64	29.57	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
547	Cardiology Move	8.96	44.79	53.75	030.1450.10000	030.1550.10000
548	Autoscrubber T3	22.85	114.27	137.13	030.1450.10000	030.1550.10000
549	Weil Mclain WTGO5 Gold Boiler	30.47	152.35	182.82	030.1450.10000	030.1550.10000
550	MOB Roof	0.00	0.00	0.00	030.1420.10000	030.1520.10000
551	10 laptops and software	86.11	430.55	516.66	030.1470.10000	030.1570.10000
552	10 laptops and software	0.00	0.00	0.00	030.1470.10000	030.1570.10000
553	10 laptops and software	194.44	972.22	1,166.67	030.1470.10000	030.1570.10000
554	Carpeting various locations	0.00	0.00	0.00	0	0
555	Carpeting various locations	0.00	0.00	0.00	0	0
556	Carpeting various locations	0.00	0.00	0.00	0	0
557	DOOR HINGE REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
558	DOOR HINGE REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
559	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
560	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
561	ROOF REPLACEMENT	0.00	0.00	0.00	030.1420.10000	030.1520.10000
562	Software licensing	26.88	134.38	161.26	030.1470.10000	030.1570.10000
563	MOB WIRELESS	187.50	937.50	1,125.00	030.1470.10000	030.1570.10000
564	6 ft coaxile for MOB wirless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
565	26" TV SAMSUNG (32)	113.10	565.48	678.58	030.1470.10000	030.1570.10000
566	Carpeting various locations	0.00	0.00	0.00	0	0
567	(22) 26" TV'S REPLACEMENT	38.10	190.48	228.58	030.1470.10000	030.1570.10000
568	6 ft coaxile for MOB wirless	0.00	0.00	0.00	030.1470.10000	030.1570.10000
569	GEN 4 DIGITAL TV NURSE CALL	25.09	125.42	150.50	030.1470.10000	030.1570.10000
570	COLLIMATOR REPLACEMENT RAD ROOM 4	65.47	327.38	392.86	030.1450.10000	030.1550.10000
571	LOCKING REFRIGERATOR	0.00	0.00	0.00	030.1450.10000	030.1550.10000
572	UTILITY CART	0.00	0.00	0.00	030.1450.10000	030.1550.10000
573	BABY SCALE DIGITAL	0.00	0.00	0.00	030.1450.10000	030.1550.10000
574	TREATMENT TABLE SUITE 1600	0.00	0.00	0.00	030.1450.10000	030.1550.10000
575	TREATMENT TABLE SUITE 1600	0.00	0.00	0.00	030.1450.10000	030.1550.10000
576	RNNOVATIONS	0.00	0.00	0.00	0	0
577	RNNOVATIONS	0.00	0.00	0.00	0	0
578	WELCH ALLYN 767 WALL SYSTEM	29.76	148.81	178.57	030.1450.10000	030.1550.10000
579	RNNOVATIONS	0.00	0.00	0.00	0	0
580	INTERFACE FOR VITROS 5600	29.76	148.81	178.57	030.1450.10000	030.1550.10000
581	Selenia tungsten base system service	253.57	1,267.86	1,521.43	030.1450.10000	030.1550.10000
582	STRAP TOGGLE 1/4"	0.00	0.00	0.00	030.1450.10000	030.1550.10000
583	TOSHIBA AMERICA MEDICAL SYSTEMS	298.81	1,494.05	1,792.86	030.1450.10000	030.1550.10000
584	Wireless	175.63	878.13	1,053.76	030.1470.10000	030.1570.10000
585	Ob rennovations painting	8.96	44.79	53.75	030.1450.10000	030.1550.10000
586	Registration waiting area	6.27	31.35	37.62	030.1450.10000	030.1550.10000
587	Glass Enclosures	23.30	116.51	139.81	030.1450.10000	030.1550.10000
588	TJ's Custom Floors	4.93	24.64	29.57	030.1450.10000	030.1550.10000

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589	Recliner Caremore (3)	7.62	38.08	45.70	030.1450.10000	030.1550.10000
590	TJ's Custom Floors	17.91	89.58	107.50	030.1450.10000	030.1550.10000
591	Anesthsia Machine	99.01	495.05	594.06	030.1450.10000	030.1550.10000
592	Guarmarx Specimen Boxes	12.54	62.71	75.25	030.1450.10000	030.1550.10000
593	Wiring for automated doors wound care	0.00	0.00	0.00	030.1450.10000	030.1550.10000
594	Pemkp Hinges Installed	39.43	197.14	236.57	030.1450.10000	030.1550.10000
595	Drop Arm Commodes	11.65	58.23	69.88	030.1450.10000	030.1550.10000
596	12 Lazy Boy Florin Guest Chairs	28.68	143.39	172.07	030.1480.10000	030.1580.10000
597	Bariatric transported	18.81	94.06	112.87	030.1450.10000	030.1550.10000
598	MOB Roof work	47.04	235.21	282.25	030.1450.10000	030.1550.10000
599	26" NDS Monitors	38.53	192.66	231.19	030.1470.10000	030.1570.10000
600	MVS Ultrasound	30.47	152.35	182.82	030.1450.10000	030.1550.10000
601	Sytemm 777 Opthalmoscope & otoscope	0.00	0.00	0.00	030.1450.10000	030.1550.10000
602	vENTILATOR	37.19	185.94	223.13	030.1450.10000	030.1550.10000
603	CANOPY LOADING DOCK	13.44	67.19	80.63	030.1450.10000	030.1550.10000
604	(2) TREATMENT TABLES	10.30	51.51	61.81	030.1450.10000	030.1550.10000
605	Ventilator	5.38	26.88	32.26	030.1450.10000	030.1550.10000
606	Cardio Pacs	13.82	69.11	82.93	030.1450.10000	030.1550.10000
607	enovate latop cart	4.93	24.64	29.57	030.1450.10000	030.1550.10000
608	LAPTOP CART	0.00	0.00	0.00	030.1470.10000	030.1570.10000
609	INSTALLATION OF DOOR	9.85	49.27	59.13	030.1450.10000	030.1550.10000
610	OR SONIC IRRAGATOR	101.25	506.25	607.50	030.1450.10000	030.1550.10000
611	OR humidity control	39.43	197.14	236.57	030.1450.10000	030.1550.10000
612	Purchase of Dr. Sussman's practice	0.00	0.00	0.00	030.1420.10000	030.1520.10000
613	Pacs system	537.63	2,688.13	3,225.76	030.1450.10000	030.1550.10000
614	chemistry analyzer lease	2,627.25	13,136.25	15,763.50	030.1450.10000	030.1550.10000
615	Enovate Laptop Cart	0.00	0.00	0.00	030.1470.10000	030.1570.10000
616	Replacement of Carpet	7.16	35.83	43.00	030.1450.10000	030.1550.10000
617	High definition Urology Camera	37.90	189.47	227.36	030.1450.10000	030.1550.10000
618	Wireless network	13.31	66.55	79.86	030.1470.10000	030.1570.10000
619	Guarmarx Specimen Boxes	28.23	141.15	169.38	030.1450.10000	030.1550.10000
620	Ge Soloar 8000i ECG NIBP	39.43	197.14	236.57	030.1450.10000	030.1550.10000
621	Low Beds (4)	128.31	641.58	769.90	030.1450.10000	030.1550.10000
622	BIG WHEEL STRETCHERS (2)	44.35	221.77	266.13	030.1450.10000	030.1550.10000
623	trade in on steris from 2012	0.00	0.00	0.00	030.1450.10000	030.1550.10000
624	HOER LIFT	23.75	118.75	142.50	030.1450.10000	030.1550.10000
625	ct ELECTRICAL RENNOVATION	0.00	0.00	0.00	0	0
626	GERI CHAIR	9.85	49.27	59.13	030.1450.10000	030.1550.10000
627	TABLET	11.65	58.23	69.88	030.1470.10000	030.1570.10000
628	Treadmill	30.10	150.50	180.60	030.1450.10000	030.1550.10000
629	COLPOSCOPE	84.84	424.17	509.00	030.1450.10000	030.1550.10000
630	3 DESK PRO COMPUTERS	0.00	0.00	0.00	030.1470.10000	030.1570.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
631	CARD READER	32.25	161.25	193.50	030.1450.10000	030.1550.10000
632	CARDIOLOGY [ACS	16.13	80.63	96.76	030.1450.10000	030.1550.10000
633	CARDIOLOGY [ACS	0.00	0.00	0.00	030.1450.10000	030.1550.10000
634	Food Thermiliazer replacement	9.40	47.03	56.44	030.1450.10000	030.1550.10000
635	TrabsAir3 PFT system	101.70	508.49	610.19	030.1450.10000	030.1550.10000
636	Expansion Feasibility	24.65	123.23	147.88	030.1450.10000	030.1550.10000
637	SCALE FOR ED	7.16	35.83	43.00	030.1450.10000	030.1550.10000
638	PANDA WARMER	52.97	264.82	317.78	030.1450.10000	030.1550.10000
639	COLOPSCOPE	33.15	165.73	198.88	030.1450.10000	030.1550.10000
640	ORTHOPEDIC PEGBOARD	11.54	57.73	69.28	030.1450.10000	030.1550.10000
641	ICE MAKER	12.74	63.70	76.44	030.1450.10000	030.1550.10000
642	CENTRIFUGE 24C	12.34	61.71	74.05	030.1450.10000	030.1550.10000
643	LAB CHEMISTRY 180	47.50	237.50	285.00	030.1450.10000	030.1550.10000
644	DRAGON SOFTWARE	59.75	298.75	358.50	030.1470.10000	030.1570.10000
645	MICROSCOPE BX 43 THREE	148.75	743.75	892.50	030.1450.10000	030.1550.10000
646	GARBAGE DISPOSAL	7.97	39.82	47.78	030.1450.10000	030.1550.10000
647	ACMEWARE SOFTWARE LICENSE	311.84	1,559.17	1,871.00	030.1470.10000	030.1570.10000
648	PHARMACY ONE SOURCE LICENSE	331.90	1,659.50	1,991.40	030.1470.10000	030.1570.10000
649	HEATEK 300 SLIDE STAINER	39.03	195.14	234.17	030.1450.10000	030.1550.10000
650	VERSACARE BED MODEL =3200	36.44	182.22	218.67	030.1450.10000	030.1550.10000
651	ICE APEXPREO TELEMETRY TRANSMITTER	0.00	0.00	0.00	030.1450.10000	030.1550.10000
652	MEDICAL ARMS	18.32	91.58	109.90	030.1450.10000	030.1550.10000
653	MEDICAL ARTS WATER HEATER	9.56	47.78	57.34	030.1450.10000	030.1550.10000
654	OVERBED TABLES (40)	103.94	519.72	623.67	030.1450.10000	030.1550.10000
655	Ortho surgical	151.74	758.68	910.42	030.1450.10000	030.1550.10000
656	Ortho surgical	21.50	107.50	129.00	030.1450.10000	030.1550.10000
657	CARDIOLOGY PACS SYSTEM	1,417.56	7,087.78	8,505.34	030.1450.10000	030.1550.10000
658	Venue 40 Demo Ultrasound	87.61	438.05	525.66	030.1450.10000	030.1550.10000
659	CDIS Infrastructure	16.72	83.61	100.33	030.1450.10000	030.1550.10000
660	SUBRAU COUURIER CAR 2011	65.32	326.58	391.90	030.1450.10000	030.1550.10000
661	ROOFING REPAIR MAINT BLGDS	88.01	440.05	528.06	030.1450.10000	030.1550.10000
662	MRI MONITOR	186.78	933.89	1,120.67	030.1450.10000	030.1550.10000
663	HELO PAD WORK	36.64	183.20	219.84	030.1450.10000	030.1550.10000
664	ACU-DOSE SYSTEM	20.32	101.58	121.90	030.1450.10000	030.1550.10000
665	NUCLEAR MED PACS	141.78	708.89	850.67	030.1450.10000	030.1550.10000
666	CISCO FROM CORPORATE	29.76	148.81	178.57	030.1470.10000	030.1570.10000
667	CISCO FROM CORPORATE	97.62	488.10	585.72	030.1470.10000	030.1570.10000
668	Carpet rplacement Dr. Kirsh	14.34	71.67	86.00	030.1480.10000	030.1580.10000
669	CT Scanner Capital Leae	1,914.87	9,574.33	11,489.20	030.1450.10000	030.1550.10000
670	Laproscopic instruments	10.35	51.76	62.11	030.1450.10000	030.1550.10000
671	12 channel uretero renoscope	92.29	461.46	553.75	030.1450.10000	030.1550.10000
672	ENDOCSOPY INSTRUMENTS	21.51	107.55	129.06	030.1450.10000	030.1550.10000

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	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
673	TISSUE TEC 5 SYSTEM	46.59	232.96	279.55	030.1450.10000	030.1550.10000
674	COMPUTERS / LAPTOPS	89.59	447.92	537.50	030.1470.10000	030.1570.10000
675	Segami Dell server	0.00	0.00	0.00	030.1470.10000	030.1570.10000
676	Segami Dell server	14.29	71.43	85.72	030.1470.10000	030.1570.10000
677	Chairs (35)	39.43	197.13	236.56	030.1480.10000	030.1580.10000
678	LD304 BedMaternityMM	205.50	1,027.50	1,233.00	030.1450.10000	030.1550.10000
679	GLIDE SCOPE AV;	136.21	681.04	817.25	030.1450.10000	030.1550.10000
680	12 lead ECG	30.27	151.34	181.61	030.1450.10000	030.1550.10000
681	5 ECG Holter Monitors	326.57	1,632.83	1,959.40	030.1470.10000	030.1570.10000
682	Corp Meaningful use	1,861.50	9,307.50	11,169.00	030.1450.10000	030.1550.10000
683	Unit Combo Intelect	13.54	67.69	81.23	030.1450.10000	030.1550.10000
684	Biodex Biostep	17.52	87.59	105.11	030.1450.10000	030.1550.10000
685	Medical Air Dryer	15.93	79.63	95.56	030.1450.10000	030.1550.10000
686	Patient Recliners and guest chairs	132.22	661.11	793.33	030.1450.10000	030.1550.10000
687	Naunce Software	69.31	346.53	415.84	030.1470.10000	030.1570.10000
688	Panda Warmer	58.15	290.74	348.89	030.1450.10000	030.1550.10000
689	Telemtry	9.95	49.77	59.72	030.1450.10000	030.1550.10000
690	Airfit Cycle	8.76	43.80	52.56	030.1450.10000	030.1550.10000
691	Roof Replacement Medical Bldg	0.00	0.00	0.00	030.1420.10000	030.1520.10000
692	Refrigerator and Chilling cart	54.56	272.78	327.34	030.1450.10000	030.1550.10000
693	PC equipment purchase	92.00	460.00	552.00	030.1470.10000	030.1570.10000
694	Patient Controlled Analgesia	164.88	824.38	989.26	030.1450.10000	030.1550.10000
695	Surgical Exam Light	9.56	47.78	57.34	030.1450.10000	030.1550.10000
696	Motorized Micotome	58.94	294.72	353.67	030.1450.10000	030.1550.10000
697	Sound Wizards	6.37	31.85	38.22	030.1450.10000	030.1550.10000
698	Cardio PACS	70.34	351.72	422.06	030.1450.10000	030.1550.10000
699	Cardio PACS Modules	135.41	677.04	812.45	030.1450.10000	030.1550.10000
700	Bedside Cabinets	142.35	711.73	854.08	030.1480.10000	030.1580.10000
701	Eliptical	15.76	78.83	94.60	030.1450.10000	030.1550.10000
702	Ped Renovation	0.00	0.00	0.00	0	0
703	Column Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
704	Shoulder Arthroscopy	9.31	46.58	55.90	030.1450.10000	030.1550.10000
705	Refrigerator and Chiller	57.35	286.75	344.10	030.1450.10000	030.1550.10000
706	Sleeper Chairs	35.49	177.42	212.90	030.1480.10000	030.1580.10000
707	Pxyis Meditech Interface	80.40	401.97	482.36	030.1470.10000	030.1570.10000
708	Warming Cabinet	13.98	69.88	83.86	030.1450.10000	030.1550.10000
709	GUS Probe	9.68	48.38	58.06	030.1450.10000	030.1550.10000
710	Waiting Chairs	26.16	130.83	157.00	030.1480.10000	030.1580.10000
711	Chimney Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
712	Door Frame Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
713	Waiting Chairs	15.41	77.04	92.45	030.1480.10000	030.1580.10000
714	Waiting Chairs	15.41	77.04	92.45	030.1480.10000	030.1580.10000

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Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
715	Window Sills	0.00	0.00	0.00	030.1420.10000	030.1520.10000
716	Patient Beds	362.52	1,812.62	2,175.14	030.1450.10000	030.1550.10000
717	CT Scanner Battery	27.60	138.00	165.60	030.1450.10000	030.1550.10000
718	Ortho Power Tools	246.59	1,232.96	1,479.55	030.1450.10000	030.1550.10000
719	Microfiche Cabinets	15.05	75.25	90.30	030.1450.10000	030.1550.10000
720	Bi-Polar Terp	63.44	317.21	380.65	030.1450.10000	030.1550.10000
721	Patient Lift	18.64	93.21	111.85	030.1450.10000	030.1550.10000
722	Ramp Replacement Oncall House	0.00	0.00	0.00	0	0
723	Bedside Monitor	37.90	189.47	227.36	030.1470.10000	030.1570.10000
724	Exam Table	29.19	145.95	175.14	030.1450.10000	030.1550.10000
725	Centrifuge	16.13	80.63	96.76	030.1450.10000	030.1550.10000
726	EEG Machine	66.66	333.33	400.00	030.1450.10000	030.1550.10000
727	Portable CO2	7.89	39.42	47.30	030.1450.10000	030.1550.10000
728	Stair Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
729	Meditech Interfaces	17.91	89.58	107.50	030.1470.10000	030.1570.10000
730	Meditech Interfaces	92.68	463.39	556.07	030.1470.10000	030.1570.10000
731	Boiler Replacement Oncall House	0.00	0.00	0.00	030.1450.10000	030.1550.10000
732	SBH Unit Reno	0.00	0.00	0.00	030.1450.10000	030.1550.10000
733	Roof - CT Scan	0.00	0.00	0.00	030.1420.10000	030.1520.10000
734	equipment	10.04	50.17	60.20	030.1450.10000	030.1550.10000
735	Stretcher	21.86	109.33	131.20	030.1450.10000	030.1550.10000
736	Anethesia Glidescope	128.31	641.58	769.90	030.1450.10000	030.1550.10000
737	OBIX Refresh	84.23	421.15	505.38	030.1450.10000	030.1550.10000
738	Pyxis Interface	17.91	89.58	107.50	030.1470.10000	030.1570.10000
739	Ventilator	47.79	238.94	286.73	030.1450.10000	030.1550.10000
740	CareFusion	5.18	25.88	31.06	030.1450.10000	030.1550.10000
741		0.00	0.00	0.00	#N/A	#N/A
742	Blood Culture	101.79	508.96	610.75	030.1450.10000	030.1550.10000
743	Pxyis Cabinet	10.39	51.96	62.35	030.1450.10000	030.1550.10000
744	Tables / Chairs	32.98	164.88	197.86	030.1480.10000	030.1580.10000
745	Stess Test	77.41	387.08	464.50	030.1450.10000	030.1550.10000
746	Cardiac Cycle	15.76	78.83	94.60	030.1450.10000	030.1550.10000
747	Bargain Barn	333.34	1,666.67	2,000.00	030.1420.10000	030.1520.10000
748	CDW - PO 71085 OBIX HW - Equpipment	22.22	111.11	133.33	030.1470.10000	030.1570.10000
749	Community Health Building	416.66	2,083.33	2,500.00	030.1420.10000	030.1520.10000
750	Community Health Campus	0.00	0.00	0.00	030.1400.10000	0
751	Corporate Apartment Land	0.00	0.00	0.00	030.1400.10000	0
752	Hansen House	250.00	1,250.00	1,500.00	030.1420.10000	030.1520.10000
753	Hansen House Land	0.00	0.00	0.00	030.1400.10000	0
754	House - Corporate Apartments	161.29	806.46	967.75	030.1420.10000	030.1520.10000
755	Main Campus	0.00	0.00	0.00	030.1400.10000	0
756	Main Campus	2,568.69	12,843.47	15,412.17	030.1410.10000	030.1510.10000

Sharon Hospital
Depreciation Expense Report
As of May 31, 2016

	Item	Depreciation	Current YTD	Current Accum	Asset Code	Dep Code
757	Maintenance Barn 1	83.34	416.67	500.00	030.1420.10000	030.1520.10000
758	Maintenance Barn 2	83.34	416.67	500.00	030.1420.10000	030.1520.10000
759	Medical Arts Building	1,720.43	8,602.13	10,322.56	030.1420.10000	030.1520.10000
760	Medical Arts Campus	0.00	0.00	0.00	030.1400.10000	0
761	Medical Arts Campus	716.84	3,584.22	4,301.06	030.1410.10000	030.1510.10000
762	MRI Monitors	276.50	1,382.50	1,659.00	030.1470.10000	030.1570.10000
763	Patient Curtains SBH Unit Reno	107.14	535.67	642.80	030.1450.10000	030.1550.10000
764	Philips Healthcare PO 69121 MRI Monitor -	22.22	111.11	133.33	030.1470.10000	030.1570.10000
765	RX Renovations Not in Production - Equipment	70.37	351.85	422.22	030.1450.10000	030.1550.10000
766	SBH/EMR	212.97	1,064.86	1,277.83	030.1450.10000	030.1550.10000
767	Sharon Hospital	46,487.30	232,436.50	278,923.80	030.1420.10000	030.1520.10000
768	Workstation Replacement	212.97	1,064.86	1,277.83	030.1470.10000	030.1570.10000
769	Workstation Replacement	212.99	1,064.93	1,277.92	030.1470.10000	030.1570.10000
770	Loading Dock Door	116.81	584.08	584.08	030.1420.10000	030.1520.10000
771	RX Renovations PH2	490.84	2,454.17	2,454.17	030.1420.10000	030.1520.10000
772	MOB Sink Replacement	64.95	194.84	194.84	030.1420.10000	030.1520.10000
773	RX Renovations PH2	772.92	3,091.67	3,091.67	030.1420.10000	030.1520.10000
774	Ultrasound	394.17	1,182.50	1,182.50	030.1450.10000	030.1550.10000
775	TSW EMR	539.58	2,158.33	2,158.33	030.1470.10000	030.1570.10000
776	OB Door Locks	99.48	298.43	298.43	030.1420.10000	030.1520.10000
777	MRI Monitors	265.83	797.50	797.50	030.1470.10000	030.1570.10000
778	Registration Tablet	61.11	122.22	122.22	030.1470.10000	030.1570.10000
779	On Call House Reno	164.41	328.83	328.83	030.1420.10000	030.1520.10000
780	ED Mag Locks	66.31	132.61	132.61	030.1420.10000	030.1520.10000
781	2N Light Replacement	76.21	152.42	152.42	030.1420.10000	030.1520.10000
782	On Call House Reno	96.62	96.62	96.62	030.1420.10000	030.1520.10000
783	Atrium Window Repair	128.50	128.50	128.50	030.1420.10000	030.1520.10000
784	SBH Renovations	0.00	0.00	0.00	030.1420.10000	030.1520.10000
785	Light Replacement 2N	36.85	36.85	36.85	030.1420.10000	030.1520.10000
786	Atrium Window Repair	0.00	0.00	0.00	030.1420.10000	030.1520.10000
787	Patient Curtains SDS	120.88	120.88	120.88	030.1450.10000	030.1550.10000
788	Exam Table	31.66	31.66	31.66	030.1450.10000	030.1550.10000
789	Biological Cabinet	90.11	90.11	90.11	030.1450.10000	030.1550.10000
790	Biological Cabinet Install	27.64	27.64	27.64	030.1450.10000	030.1550.10000
791	Fixed Asset Purchase - Roth	0.00	0.00	0.00	030.1450.10000	030.1550.10000
792	Screw Replace System	0.00	0.00	0.00	030.1450.10000	030.1550.10000

Schedule 2.1(h)
Tenant Leases

AGREEMENT	TENANT	LANDLORD	ADDRESS/ LOCATION	EFFECTIVE DATE (current term)
Lease Agreement	David R. Kurish, M.D.	Essent Healthcare of Connecticut, Inc.	Suite 1200 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT.	11/1/15
Medical Office Lease	Torrington Winsted Pediatric Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1600 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	12/7/15
Lease Agreement	Connecticut GI, P.C., successor in interest to Litchfield County Gastroenterology Associates, LLC	Essent Healthcare, Inc.	Suite 1700 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	11/1/15
Physician Space Occupancy Agreement	Arthritis & Allergy Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1800 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	6/1/15
Physician Space Occupancy Agreement	Westwood Ear Nose & Throat, P.C.	Essent Healthcare of Connecticut, Inc.	Certain space in Suite 1900 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	10/1/15
Office Lease Agreement	Saint Francis Medical Group, Inc.	Essent Healthcare of Connecticut, Inc.	Space on 2nd Floor 50 Hospital Hill Rd Sharon, CT	4/8/14
Clinical Space Rental Agreement	Hanger Prosthetics & Orthotics, Inc.	Essent Healthcare of CT, Inc. d/b/a Sharon Hospital	Examination Rooms Nos. 5 and 162 50 Hospital Hill Road Sharon, CT	6/1/16
Retail Thrift Store Lease Agreement	Tri-State Communications, LLC	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	Space on the 1st Floor "Bargain Barn" 3 Low Road Sharon, CT	1/1/16

Schedule 2.1(i)
Seller Leases

AGREEMENT	TENANT	LANDLORD	ADDRESS/ LOCATION	EFFECTIVE DATE (current term)
Connecticut Residential Lease Agreement	Essent Healthcare of Connecticut, Inc.	Anu Properties Corp.	17 Hospital Hill Road (Residential Unit) Sharon, CT	7/15/2016
Lease Agreement	Regional Healthcare Associates, LLC	Robert J. Orlandi	2 Old Park Lane (1st Floor) New Milford, CT	10/1/2013
Lease Agreement	Regional Healthcare Associates, LLC	Robert J. Orlandi	2 Old Park Lane (2nd Floor) New Milford, CT	5/1/2013
Timeshare Lease Agreement	Tri State Women's Services, LLC	Bruce Janelli, M.D.	75 Church St. Canaan, CT	8/1/2012
Physician Space Lease Occupancy Agreement	Tri State Women's Services, LLC	Orlito Trias, M.D.	9 Aspetuck Ave. New Milford, CT	11/1/2015
Lease Agreement	Tri State Women's Services LLC	Winsted Health Center, Inc.	115 Spencer St. Winsted, CT	9/1/2013
Commercial Lease	Regional Healthcare Associates, LLC	Kenmil Realty, LLC	64 Maple St. Kent, CT	8/1/2016
Lease	Tri State Women's Services LLC	Sharon Medical Office Building LLC	50 Amenia Rd. Sharon, CT	5/30/2012
Medical Office Lease Agreement	Regional Healthcare Associates, LLC	Candlewood Properties, LLC	120 Park Lane Road, New Milford, CT	5/5/2016
Medical Office Lease Agreement	Regional Healthcare Associates, LLC	Anu Properties, LLC	17 Hospital Road (Office Space) Sharon, CT	5/5/2016

Schedule 2.1(k)
Pending Approvals

	Program	Provider No.	Comments
1.	NY Medicaid Provider Number (Hospital)	02255392	NY Medicaid is currently processing the hospital's revalidation application filed in October 2015. Still in process per phone call to NY Medicaid on 6/10/16 (218 days in process). Per 8/19/16 phone call to NY Medicaid, the revalidation is still in process and NY Medicaid has no timeline in place for processing revalidations. Tracking ID: 153090248.

Schedule 2.2
Excluded Assets

1. All monies for Medicare and Medicaid MU incentives related to the period prior to Closing.
2. All monies for the period prior to Closing related to CT State Supplemental Payment program
3. All monies for "Sales / Use Tax Refund", as further described in Schedule 4.16(b).
4. Assignment interest in the Sok life insurance contract. The total assignment interest is $544,278.00.
5. Hospital's ownership of Connecticut Hospital Laboratory Network, LLC, including any payments to the Hospital in connection with a potential dissolution.

Schedule 2.2(e)
Excluded Contracts

1. Services Agreement between Essent Healthcare facilities of Southwest Regional Medical Center, Merrimack Valley Hospital, Nashoba Valley Medical Center and Sharon Hospital and Cardon Healthcare Network, Inc., dated January 1, 2011

Schedule 2.2(i)
Amounts Due to the Sellers

All amounts due to the Sellers from Affiliates of the Sellers as of the Closing Date.

Schedule 2.3(c)
Accrued PTO

Accrued PTO

To be provided immediately prior to the Closing Date.

Unrecorded Extended Illness Benefits

483,000

Schedule 2.4(c)
Excluded Liabilities

1. All liabilities relating to the State of Connecticut's audit of the Hospital's Sales and Use Tax, as further described in Schedule 4.16(b).
2. All liabilities of Connecticut Hospital Laboratory Network, LLC that are attributable to the Hospital's ownership interest.
3. All liabilities relating to the assignment interest in the Sok life insurance contract.

Schedule 4.2(b)
Sellers' Required Consents

1. Connecticut Office of Health Care Access
2. CT Hospital License
3. CT Controlled Substance Registration
4. CDPH Lab Registration
5. CDPH Blood Bank Lab Registration
6. NY State Lab Permit
7. PA Lab Registration Letter
8. CDEEP Certificate of Use
9. CDEEP Certificate of Use
10. CDEEP RAM Registration Confirmation
11. CDEEP RAM Registration Confirmation
12. DEA Registration
13. CLIA Certificate of Accreditation
14. CLIA Certificate of Waiver (RHA 17 Hosp Hill Rd)
15. CLIA Certificate of Waiver (RHA 50 Hosp Hill Rd)
16. CLIA Certificate of PPMP (New Milford OB/GYN)
17. CLIA Certificate of PPMP (RHA 29 Hosp Hill Rd, Ste. 1400)
18. CLIA Waiver (RHA 64 Maple St)
19. CLIA Waiver (RHA 120 Park Lane)
20. CAP Accreditation
21. US Nuclear Regulatory Commission Materials License
22. FDA Mammography Facility Certification
23. ACR Accreditation (Mammographic Imaging)
24. ACR Accreditation (Computed Tomography)
25. ACR Accreditation (MRI Services)
26. ACR Accreditation (SBBI Services)
27. ACR Accreditation (Nuclear Medicine)
28. ACR Accreditation (Ultrasound Services)
29. ACR Accreditation (Breast Ultrasound Imaging)
30. ACR Accreditation (Breast MRI)
31. AIUM Accreditation
32. The Joint Commission
33. FCC Radio Station Authorization
34. FCC Radio Station Authorization
35. FCC Radio Station Authorization
36. Connecticut Property Transfer Form

37. CLIA Certificate of Waiver (TSWS 115 Spencer St.)
38. CLIA Waiver (TSWS 76 Church St.)
39. CLIA Certificate of Compliance (TSWS 50 Amenia Rd.)

Schedule 4.4(a)
Seller Financial Statements; GAAP Exceptions

See attached.

GAAP Exceptions:

1. The Financial Statements do not contain year-end notes as would be required for auditing/issuance in accordance with GAAP.
2. The asset related to a key man life insurance policy for James Sok is not recorded on the Balance Sheet as would be required if material in accordance with GAAP.
3. There is no income tax provision prepared or recorded in the Financial Statements.
4. Certain obligations are accounted for on an intercompany basis with RegionalCare Hospital Partners, Inc. (e.g. certain insurance reserves, executive bonuses, etc.)

Schedule 4.5
Certain Post Balance Sheet Results

None.[1]

[1] Note: May be updated prior to Closing, if applicable.

Schedule 4.6
Licenses

	License Issuer	License No.	Expiration Date
1.	State of Connecticut Department of Public Health License	#0071	Expires: 03/31/2018
2.	State of Connecticut Department of Consumer Protection Controlled Substance Registration for Hospitals	CSP.0000875-HOSP (3367)	Expires: 02/28/2017
3.	CDPH Approved Public Health Laboratory	HP-0317	Expires: 03/31/2018
4.	CDPH Registration and Approval Blood Bank Laboratory	BB-1046	Expires: 03/31/2018
5.	NY State Department of Health Clinical Laboratory Permit	3367	Expires: 06/30/2017
6.	PA Department of Health Lab Registration Letter	31767	Expires: ongoing
7.	CDEEP RMI Confirmation of Registration	0302	Expires: 12/31/2016
8.	CDEEP DTX Confirmation of Registration	4480	Expires: 04/30/2018
9.	Sharon Department of Health	Food Establishment License (Gazebo/Café)	Expires: 07/31/2017
10.	Sharon Department of Health	Food Establishment License (Healthcare/Institutional Food Service/Café)	Expires: 7/31/2017
11.	Controlled Substance Registration Certificate United States Department of Justice Drug Enforcement Administration	BE7740562	Expires: 08/31/2016
12.	CLIA Certificate of Accreditation (Hospital)	07D0644532	Expires: 07/19/2017
13.	CLIA Waiver (RHA 64 Maple St)	07D2027246	Expires: 05/26/2017
14.	CLIA Waiver (RHA 50 Hosp Hill Rd)	07D1099947	Expires: 05/26/2017
15.	CLIA PPMP (New Milford OB/GYN)	07D0868377	Expires: 08/31/2016
16.	CLIA PPMP (RHA 29 Hosp Hill Rd, Ste. 1400)	07D1106899	Expires: 09/08/2016
17.	CLIA Waiver (RHA 17 Hosp Hill Rd)	07D0093351	Expires: 01/23/2018

	License Issuer	License No.	Expiration Date
18.	CLIA Waiver (RHA 120 Park Lane)	07D0100407	Expires: 08/29/2016
19.	The College of American Pathologists Accreditation	1185501	Expires: 01/07/2018
20.	United States Nuclear Regulatory Commission	06-08020-02	Expires: 06/30/2025
21.	Food and Drug Administration Certified Mammography Facility	ID: 149658	Expires: 05/13/2017
22.	American College of Radiology Mammographic Imaging	MAP# 00552-05	Expires: 05/13/2017
23.	American College of Radiology Computed Tomography	CTAP# 00311-02	Expires: 03/29/2019
24.	American College of Radiology Magnetic Resonance Imaging Services	MRAP# 01764-03	Expires: 10/29/2016
25.	American College of Radiology Stereotactic Breast Biopsy Imaging Services	SBBAP# 00984-02	Expires: 12/22/2018
26.	American College of Radiology Nuclear Medicine Services	NMAP# 00296-01	Expires: 09/17/2017
27.	American College of Radiology Ultrasound Services	UAP# 02130	Expires: 11/28/2018
28.	American College of Radiology Breast Ultrasound Imaging Services	BUAP# 00083	Expires: 11/01/2016
29.	American College of Radiology Breast Magnetic Resonance Imaging Services	BMRAP# 50771-01	Expires: 02/10/2019
30.	AIUM Accreditation	New Milford OB/GYN	Expires: 10/15/2018
31.	The Joint Commission	5691	Expires: 01/08/2018
32.	Federal Communications Commission Radio Station Authorization	WPDJ523	Expires: 10/06/2018
33.	Federal Communications Commission Radio Station Authorization	WPRG957	Expires: 09/20/2025
34.	Federal Communications Commission Radio Station Authorization	WQUW310	Expires: 10/29/2024
35.	State of Connecticut Division of Construction Services Boiler Operating Certificate	# 014047	Next Inspection Date: 01/08/2018
36.	State of Connecticut Division of Construction Services Boiler Operating Certificate	# 014048	Next Inspection Date: 10/10/2016

	License Issuer	License No.	Expiration Date
37.	State of Connecticut Division of Construction Services Boiler Operating Certificate	# 014049	Next Inspection Date: 11/07/2016
38.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0001	Expires: 02/01/2018
39.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0005	Expires: 07/21/2018
40.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0004	Expires: 07/21/2018
41.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0010	Expires: 03/30/2018
42.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0013	Expires: 05/07/2018
43.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0014	Expires: 05/07/2018
44.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0009	Expires: 03/30/2018
45.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0002	Expires: 07/21/2018
46.	CDEEP Bureau of Air Management	Registration# 162-0007-FPLPE	Expires: 11/08/2020
47.	CDEEP Underground Storage Tank – Notice of Application	Facility ID: 125-2170 Application No.: 2199113	Expires: 10/08/2016
48.	CT Airport Authority	License No. HR171	Expires: 11/15/2016
49.	CLIA Waiver (TSWS 115 Spencer St.)	07D0950433	Expires: 08/24/2018
50.	CLIA Waiver (TSWS 76 Church St.)	07D0950424	Expires: 11/26/2016
51.	CLIA Compliance (TSWS 50 Amenia Rd.)	07D0674765	Expires: 03/10/2017

Schedule 4.7
Applications

Certificate of Need:

State Health Agency	Determination No.	Comments
State of Connecticut Department of Health	Determination # 11-31720-DTR	Certificate of Need not required for merger between Essent Health and RegionalCare Hospital Partners, Inc. 09/09/2011

Schedule 4.8
Medicare Participation; Accreditation

	Program	Provider No.	Comments
1.	Medicare Part A CCN (Hospital)	07-0004	
2.	Medicare Part A CCN (Psych Unit)	07-S004	
3.	Medicare Part B PTAN (Regional Healthcare Associates LLC)	C03779	
4.	Medicare Part B PTAN (Tri State Women's Services LLC)	D100070627	
5.	Railroad Medicare PTAN (Regional Healthcare Associates LLC)	DO7964	
6.	Railroad Medicare PTAN (Tri State Women's Services LLC)	DT3319	
7.	CT Medicaid Provider Number (Hospital)	004221800; 004221818	
8.	CT Medicaid Provider Number (Regional Healthcare Associates LLC)	008024284; 008016129; 008008233; 008024296; 008024286; 008062872; 008064785; 008024424	
9.	CT Medicaid Provider Number (Tri State Women's Services LLC)	1285903526	
10.	NY Medicaid Provider Number (Hospital)	02255392	NY Medicaid is currently processing the hospital's revalidation application filed in October 2015. Still in process per phone call to NY Medicaid on 6/10/16 (218 days in process). Per 8/19/16 phone call to NY Medicaid, the revalidation is still in process and NY Medicaid has no timeline in place for processing revalidations. Tracking ID: 153090248.
11.	NY Medicaid Provider Number (Regional Healthcare Associates LLC)	03597211	
12.	NY Medicaid Provider Number (Tri State Women's Services LLC)	03461832	

	Program	Provider No.	Comments
13.	NPI (Hospital)	1235131442	
14.	NPI (Psych Unit)	1306960596	
15.	NPI (RHA)	1043390156	
16.	NPI (Tri State Women's Services)	1285903526	

Schedule 4.9
Regulatory Compliance

None.

Schedule 4.10
Equipment

See attached.

Schedule 4.11
Permitted Encumbrances

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting certain engineering approvals to finalize the pharmacy renovations.

2. Real estate taxes to Town of Sharon for the year 2016 and subsequent years.

3. As to Parcel 1: Matters shown ALTA/ACSM Land Title Survey; located at Hospital Hill Road and King Hill Road; Sharon, Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and recorded as Map 1860B in the Sharon Town Clerk's office:

   a. Note regarding non-conforming building side yard on easterly property line;
   b. Underground sanitary sewer lines along Hospital Hill Road;
   c. Notes regarding zoning;
   d. Utility poles and lines along King Hill Road;
   e. Telephone line and electric lines along southerly boundary;
   f. Front, rear and sideyard setback lines.

4. As to Parcel 2: Easement dated August 5, 1895 from Albert J. Bostwick to Sharon Water Company recorded in Volume 40, Page 112 of the Sharon Land Records.

5. As to Parcel 2: Rights described in a Warranty Deed dated March 26, 1964 from Ronald B. Wike and Mary Jane Paavola to Iva N. Stine recorded in Volume 76, Page 249 of the Sharon Land Records. Reference is made to Map 628.

6. As to Parcel 2: Release of rights as described in a Quit Claim Deed dated May 27, 1966 from Ronald B. Wike and Mary Jane Paavola to Patricia P. Gillette recorded in Volume 78, Page 478 of the Sharon Land Records.

7. As to Parcel 2: Riparian rights of others in and to Beardsley Park Brook.

8. As to Parcel 2: The following matters shown on a map entitled ALTA/ACSM Land Title Survey; located at Low Road, Lovers Lane, and Gay Street; Sharon Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and on file as Map No. 1861 in the Sharon Town Clerk's Office:

   a. Water Service lines;
   b. Variance between property lines and lines of fencing
   c. Setback lines;
   d. ROW of New Posts over Property Line.

9. As to Parcels 3, 4 and 5: Easement dated July 6, 1966 from Frank Lovallo and Phyllis K. Lovallo to The Hartford Electric Light Company recorded in Volume 78, Page 517 of the Sharon Land Records. Reference is made to Map 691.

10. As to Parcels 3, 4 and 5: Easement dated April 20, 1989 from West Sharon Corporation to Roger W. Elwood and Jane M. Elwood recorded in Volume 111, Page 607 of the Sharon Land Records.

11. As to Parcels 3, 4 and 5: Right of way set forth in a Quit Claim Deed dated April 30, 1990 from West Sharon Corporation to Sharon Corporation recorded in Volume 113, Page 331; as modified, extended and affected by terms set forth in a Statutory Form Warranty Deed dated May 31, 2001 from Sharon Health Care, Inc. to United Methodist Home of Sharon, Inc. recorded in Volume 141, Page 256 of the Sharon Land Records. Reference is made to Map 1611 and Map 1693.

12. As to Parcels 3, 4 and 5: Rights of way as set forth in a Quit Claim Deed dated September 30, 1991 from West Sharon Corporation to Sharon Corporation recorded in Volume 115, Page 491. Reference is made to Map 1640.

13. As to Parcels 3, 4 and 5: Reciprocal Easement Agreement dated as of July 30, 2002 recorded in Volume 148, Page 47 of the Sharon Land Records.

14. As to Parcels 3, 4 and 5: The following matters shown on Sheet 3 of maps entitled ALTA/ACSM Land Title Survey; located at Hospital Hill Road and Amenia Road; Sharon, Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and recorded as Map 1860C in the Sharon Town Clerk's office:

    a. Building setback lines;
    b. Parking Limits over Subdivision Lot Line;
    c. Drainage flow onto east side;
    d. Sanitary sewer line;
    e. Underground electric and telephone lines.

15. As to Parcel 4: A condition set forth in a Warranty Deed dated December 30, 1969 that no part of the (premises) shall be used as a "drive-in" type of restaurant and containing a reversion for any breach of said condition; from Laura Hamlin to Frank Lovallo and Phyllis K. Lovallo recorded in Volume 82, Page 590 of the Sharon Land Records.

16. As to Parcel 4: Easement dated September 29, 1970 from Frank Lovallo and Phyllis K. Lovallo to The Hartford Electric Light Company recorded in Volume 83, Page 493 of the Sharon Land Records. Reference is made to Map 813.

17. As to Parcel 4: Easement dated January 12, 1984 from Frank Lovallo and Phyllis K. Lovallo to The Connecticut Light and Power Company recorded in Volume 101, Page 324 of the Sharon Land Records. Reference is made to Map 1359.

18. As to Parcel 4: Grant of Easement dated September 30, 1991 from West Sharon Corporation to First Church of Christ (Congregational) recorded in Volume 115, Page 496 of the Sharon Land Records. Reference is made to Map 1640.

19. As to Parcel 4: Easement dated August 7, 1992 from West Sharon Corporation to Sharon Medical Office Building Limited Partnership recorded in Volume 117, Page 715 of the Sharon Land Records. Reference is made to Map 1657.

20. As to Parcel 4: Easement dated April 18, 1994 from West Sharon Corporation to Sharon Health Care, Inc. recorded in Volume 122, Page 810 of the Sharon Land Records. Reference is made to Map 1693.

Schedule 4.11(a)
Property Violations

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting certain architectural approvals to finalize the pharmacy renovations. The Hospital's architect met with a State of Connecticut representative the week of August 8, 2016. The State's representative stated that a follow up appointment with T. Bruno from the Connecticut Department of Public Health was necessary for approval. The Hospital is awaiting the scheduling of that appointment from the Connecticut Department of Public Health.

Schedule 4.11(b)
Zoning

None.

Schedule 4.11(d)
Real Property Actions

None.

Schedule 4.11(g)
Rent Roll

TENANT	LANDLORD	PREMISES (ADDRESS)	EFFECTIVE DATE	TERM & RENEWALS	RENT/ CHARGES / SEC DEP	EXPIRES	ARREARS/ PREPD
David R. Kurish, M.D.	Essent Healthcare of Connecticut, Inc.	Suite 1200 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	11/1/15	1 year Automatic 1-year renewal terms	$1,270.00 per month No security deposit	10/31/16	None as of July 26, 2016
Torrington Winsted Pediatric Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1600 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	12/7/15	1 year May renew for one 1-year term	$4,584.67 per month No security deposit	12/31/16	None as of July 26, 2016
Connecticut GI, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1700 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	11/1/15	1 year Automatic 1-year renewal terms	$1,704.56 per month No security deposit	10/31/16	None as of July 26, 2016
Arthritis & Allergy Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1800 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	6/1/15	1 year No renewal options	$541.67 per month No security deposit	5/31/16	None as of July 26, 2016
Westwood Ear Nose & Throat, P.C.	Essent Healthcare of Connecticut, Inc.	Certain space in Suite 1900 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	10/1/15	1 year No renewal options	$1,083.33 per month No security deposit	9/30/16	$6,270.79 balance as of August 15, 2016 consisting of: current and past months' rent and retroactive rent payments still due
Saint Francis Medical Group, Inc.	Essent Healthcare of Connecticut, Inc.	Space on 1st Floor 50 Hospital Hill Rd. Sharon, CT	4/18/14	3 year No renewal options	$5,968.63 per month No security deposit	4/17/17	None as of July 26, 2016
Hanger Prosthetics & Orthotics, Inc.	Essent Healthcare of CT, Inc. d/b/a Sharon Hospital	Examination Rooms Nos. 5 and 162 50 Hospital Hill Road Sharon, CT	6/1/11	1 year Automatic 1 year renewal terms	$263.00 per month No security deposit	6/1/17	None as of July 26, 2016
Tri-State Communicati	Essent Healthcare of	Space on the 1st Floor ("Bargain	1/1/16	3 years	$1,129.06 per month	12/31/18	None as of July 26, 2016

TENANT	LANDLORD	PREMISES (ADDRESS)	EFFECTIVE DATE	TERM & RENEWALS	RENT/ CHARGES / SEC DEP	EXPIRES	ARREARS/ PREPD
ons, LLC	Connecticut, Inc. d/b/a Sharon Hospital	Barn") 3 Low Road Sharon, CT		Tenant has option to renew for 1 additional 3 year term	No security deposit		

Schedule 4.11(h)
Notice of Modification

None.

Schedule 4.11(i)
Encroachments

1. Encroachment of 2 story wood frame building over building setback line on Parcel IV.

2. Encroachment of 1 story wood frame building over building setback line on Parcel I.

3. Encroachment of 1 story masonry building over building setback line on Parcel II.

Schedule 4.11(j)
Third Party Rights

None.

Schedule 4.11(k)
Construction

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting certain architectural approvals to finalize the pharmacy renovations, but the physical construction is substantially complete. The Hospital's architect met with a State of Connecticut representative the week of August 8, 2016. The State's representative stated that a follow up appointment with T. Bruno from the Connecticut Department of Public Health was necessary for approval. The Hospital is awaiting the scheduling of that appointment from the Connecticut Department of Public Health.

Schedule 4.11(l)
Tenant Improvement

None.

Schedule 4.12
Condition of the Assets

1. The 20,000 gallon underground storage tank, as further described in Schedule 4.27(f), is nearing its "end-of-life" and must be replaced by 2018.

Schedule 4.13(a)
Benefit Plans

1. Essent Healthcare Health and Welfare Plan. This particular plan covers the following types of benefits:
    a. Medical and Dental
    b. Life and Accidental Death and Dismemberment Plan
    c. Short-Term Disability Plan
    d. Long-Term Disability Plan
    e. Voluntary Vision
2. RegionalCare Hospital Partners Welfare Benefit Plan. This particular plan covers the following types of benefits:
    a. Medical and Dental
    b. Flexible Benefits (health flexible spending arrangement)
    c. Life and Accidental Death and Dismemberment Plan
    d. Short-Term Disability Plan
    e. Long-Term Disability Plan
    f. Health Reimbursement Account
    g. Health Savings Account
    h. Voluntary Vision
3. RegionalCare Hospital Partners Supplemental Executive Retirement Plan
4. Paid Time Off (Vacation)
5. RegionalCare Hospital Partners Retirement Savings Plan
6. Tuition Reimbursement Program
7. Sharon Hospital Retiree Plan

Schedule 4.13(c)
ERISA

None.

Schedule 4.14
Litigation

Orders

1. Final Decision, Docket No. 01-486-01, by the State of Connecticut Office of the Attorney General, dated November 26, 2001, as amended by the Order, dated January 9, 2002, of the State of Connecticut Office of the Attorney General.

2. Final Decision, Docket No. 01-486-01, by the Office Of Health Care Access ("OHCA"), dated October 17, 2001, as amended by the Revised Final Decision, Docket No. 01-486-01R, by OHCA, dated December 14, 2001.

Potential/Threatened Litigation

Name	Claim Filed	Attorney	Progress/Status
Dr. Ari Namon	N/A	Jackson Lewis P.C.	Unfiled dispute regarding discourse between Dr. Namon and previous Hospital CEO. Settlement discussions in progress.
Nannette R. Pizzoni, Conservator of the Estate of Nicole R. Pizzoni	Connecticut Superior Court (Litchfield)	Deakin, Edwards & Clark LLP	Compliant filed August 11, 2016 regarding a medical malpractice claim against Dr. David Kurish, Essent Healthcare of Connecticut, Inc. and RegionalCare Hospital Partners, Inc.

Schedule 4.16
Tax Returns

1. Regional Healthcare Associates, LLC has not filed its federal or state income tax returns, or paid any corresponding income taxes, for the last two fiscal years ending September 30, 2014 and 2015.

Schedule 4.16(a)
Tax Extensions

The tax extensions below relate to Essent Healthcare of Connecticut, Inc. and to Sharon Hospital Holding Company.

1. Tax Year January 1, 2015 through December 3, 2015

    (a) Federal Form 1120, U.S. Corporation Income Tax Return
        (i) Extended to September 15, 2016

    (b) Connecticut Form CT-1120, Connecticut Business Tax Return
        (i) Extended to October 1, 2016

2. Tax Year December 4, 2015 through December 31, 2015

    (a) Federal Form 1120, U.S. Corporation Income Tax Return
        (i) Extended to September 15, 2016

    (b) Connecticut Form CT-1120, Connecticut Business Tax Return
        (i) Extended to October 1, 2016

Schedule 4.16(b)
Tax Audits

State of Connecticut:

1. Essent Healthcare of Connecticut, Inc. - Sales Tax Refund Claim, April 1, 2011 through June 30, 2014. A third party consulting firm was engaged to pursue a refund claim on overpayments of sales tax. The State of Connecticut is currently reviewing this claim.

Schedule 4.16(c)
Tax Partnerships

1. Essent Healthcare of Connecticut, Inc. holds the following ownership interest in Connecticut Hospital Laboratory Network, LLC. Ownership Percentage (as of September 30, 2015): 4.7619047%

2. Regional Healthcare Associates, LLC is treated as a partnership for federal and applicable state income tax purposes.

2. Tri State Women's Services, LLC is treated as a partnership for federal and applicable state income tax purposes.

Schedule 4.17(a)
Employees

Independent Contractor Physician/Physician Group Agreements

1. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and David Kurish, M.D., dated 08/01/2005
2. Professional Services Agreement (General Surgery) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Peter Reyelt, M.D., dated 08/18/2008
3. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
4. Medical Director Agreement by and between Essent Healthcare, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., dated 01/01/2010 (and Amendment to Medical Director Agreement and Release of Claims, dated 09/04/2012)
5. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 08/01/2005
6. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 02/01/2012
7. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Howard G. Mortman, M.D., dated 01/01/2011
8. Medical Director Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Evan Rashkoff, M.D., dated 01/01/2011
9. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Saint Francis Medical Group, Inc., dated 05/05/2014
10. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated 01/01/2011
11. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
12. Anesthesiology Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Milford Anesthesia Associates, P.C., dated 11/01/2003
13. Agreement for Radiology Department Coverage [Group Coverage] by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Hudson Valley Radiologists, P.C., dated 06/18/2015
14. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
15. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated 10/09/2014
16. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated 10/01/2006

17. Professional Services Agreement for On Call Coverage for Individual Physician by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Abdulmasih Zarif, M.D., dated 05/12/2016
18. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated 06/01/2016
19. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated 07/31/2015
20. Pathology Services Agreement by and between RCHP d/b/a Sharon Hospital and Consultants in Pathology, P.C., dated 01/01/2012
21. Lithotripsy Services Agreement by and between UMS Connecticut Lithotripsy, LP and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated 06/08/2006
22. Professional Services Agreement for Physician Group by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Associated Northwest Urology, PC, dated 05/02/2016
23. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Saint Francis Medical Group, Inc., dated 05/01/2014.
24. Professional Services Agreement by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 05/01/2012
25. Professional Services Agreement for On Call Coverage by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 01/01/2012, as assigned to Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
26. Billing and Collection Services Agreement by and between Women's Health Connecticut and Tri State Women's Services, dated 05/01/2012

Other Clinical Agreements

1. Memorandum of Agreement for Organ/Tissue/Eye Procurement by and between Sharon Hospital and LifeChoice Donor Services, Inc., dated May 1, 2012.
2. American Red Cross Blood Services Agreement by and between Sharon Hospital and The American National Red Cross, Connecticut Blood Services Region, dated October 1, 2014
3. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010

Other Agreements

1. The Chief Executive Officer, Chief Financial Officer and the Chief Nursing Officer of the Hospital are employed by RCHP Management Company, Inc.
2. Contractor Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Silloo Peters-Marshall, dated 4/28/2016

Supplies Agreements

1. Instrument Service Agreement by and between Trinity Biotech and Sharon Hospital, dated May 27, 2016
2. Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 8, 2008
3. Local Service Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 27, 2015
4. Equipment Lease Agreement by and between Tri State Women's Services and Physician's for Women's Health, dated 05/01/2012

Facilities Services

1. Transaction Schedule by and between Sharon Hospital and General Electronic Company, dated May 1, 2009
2. Contract Agreement by and between Connecticut Peer Review Organization d/b/a Qualidigm and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated February 1, 2016
3. Medicaid Eligibility Services Agreement by and between The Collection Bureau of Hudson Valley, Inc., Healthcare Billing Services, NY, Inc. and Sharon Hospital-RegionalCare Hospital Partners, dated January 6, 2012
4. Peak Performance Service Agreement No. PM114 by and between D & E Technologies and Sharon Hospital, dated January 1, 2016
5. Engagement Letter Agreement by and between Sharon Hospital and Updike, Kelly & Spellacy, PC, dated November 19, 2015
6. Services Agreement by and between Haytel Cardiac Services d/b/a Remote Cardiac Services and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated April 20, 2015
7. Rental Customer Order and Support Customer Order by and between CareFusion Solutions, LLC and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated January 11, 2016
8. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013
9. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
10. Pharmacy Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Cardinal Health Solutions, Inc., dated October 1, 2007
11. Cyracom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
12. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated April 1, 2014
13. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
14. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
15. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011

16. Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Horizon Mental Health Management, Inc., dated April 12, 2002
17. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
18. Service Solution Proposal by and between Tyco SimplexGrinnell and Sharon Hospital, dated 06/01/2014
19. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
20. Agreement by and between Essent Healthcare of Connecticut, Inc. dba Sharon Hospital and Agile Consulting Group, Inc., dated July 19, 2013
21. Masimo Pulse Oximetry Supply Agreement Deferred Equipment Purchase Plan by and between Masimo Americas, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated May 9, 2014
22. Business Electricity Authorization Connecticut Large Commercial Sales Standard Product Agreement by and between Essent Healthcare of CT dba Sharon Hospital and NextEra Energy Services, dated June 2, 2016
23. 2016 Environmental Compliance Master Services Agreement by and between Fuss & O'Neill and Sharon Hospital, dated January 15, 2016
24. Security Service Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Apollo Security International, Inc., dated May 1, 2016
25. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
26. Medical Record Custodial Agreement by and between Regional Healthcare Associates, LLC and Torrington-Winsted Pediatric Associates, P.C., dated January 13, 2016

IT Agreements

1. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
2. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
3. Grant Consulting Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and SpectraCorp Technologies Group Inc., dated July 8, 2013
4. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013
5. Support Agreement by and between Clinical Computer Systems, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated September 1, 2010
6. Master Agreement and Customer Order by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
7. EMR Agreement by and between Tri State Women's Services LLC and Women's Health Connecticut, Inc., dated May 1, 2012
8. Merchant Processing Application and Agreement by and between Tri State Women's Services LLC and First Data Merchant Services, dated _____, 2012, with Addendum
9. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain

Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016

10. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
11. Amicas Limited Sublicense Agreement by and between Imaging On Call, LLC and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, undated
12. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
13. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013

Miscellaneous

1. Services Agreement by and between Sharon Hospital Holding Company and Regional Healthcare Associates, LLC, dated February 25, 2014
2. Services Agreement by and between Sharon Hospital Holding Company and Tri State Women's Services, LLC, dated October 1, 2014
3. There are no employees of Tri State Women's Services, LLC. All non-provider employees are employees of Sharon OBGYN or Physicians for Women's Health. All physicians are employees or independent contractors of Sharon OBGYN or Physicians for Women's Health

Schedule 4.17(b)
Employment Claims

None.

Schedule 4.17(c)(i)
Employment Contracts

1. Each of the Agreements listed in Schedule 4.17(a) is incorporated herein, except those Employment Agreements between RCHP Management Company, Inc. and individuals.
2. Agreement for Hospice General Inpatient Level Care in a Hospital by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Salisbury Visiting Nurse Association, Inc., dated July 1, 2016
3. Non-Exclusive Professional Services Agreement by and between Sharon Hospital and Sharon Healthcare, dated April 1, 2012
4. Non-Exclusive Professional Services Agreement by and between Sharon Hospital and Geer Nursing and Rehabilitation, dated April 1, 2012
5. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended
6. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and A. Martin Clark, Jr., M.D., dated 09/24/2012
7. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Kristin Newton, M.D., dated 07/06/2015
8. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Leonard Astrauskas, M.D., dated 10/08/2015
9. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Michelle Apiado, M.D., dated 07/22/2015
10. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and John Sussman, M.D., dated 04/01/2013
11. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Suzanne Lefebvre, M.D., dated July 5, 2011
12. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Tracey Sheedy, PA, dated 02/09/2016

Schedule 4.17(c)(ii)
Employment Loss

None.

Schedule 4.18
Material Contracts

(a)

Employment Agreements

1. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended
2. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and A. Martin Clark, Jr., M.D., dated 09/24/2012
3. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Kristin Newton, M.D., dated 07/06/2015
4. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Leonard Astrauskas, M.D., dated 10/08/2015
5. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Michelle Apiado, M.D., dated 07/22/2015
6. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Josh Sussman, M.D., dated 04/01/2013
7. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Suzanne Lefebvre, M.D., dated July 5, 2011
8. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Tracey Sheedy, PA, dated 02/09/2016

Independent Contractor Agreements

1. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and David Kurish, M.D., dated 08/01/2005
2. Professional Services Agreement (General Surgery) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Peter Reyelt, M.D., dated 08/18/2008
3. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
4. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 08/01/2005
5. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Howard G. Mortman, M.D., dated 01/01/2011
6. Medical Director Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Evan Rashkoff, M.D., dated 01/01/2011
7. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Saint Francis Medical Group, Inc., dated 05/05/2014
8. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 02/01/2012

9. Medical Director Agreement by and between Essent Healthcare, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., dated 01/01/2010 (and Amendment to Medical Director Agreement and Release of Claims, dated 09/04/2012)
10. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated 01/01/2011
11. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
12. Anesthesiology Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Milford Anesthesia Associates, P.C., dated 11/01/2003
13. Agreement for Radiology Department Coverage [Group Coverage] by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Hudson Valley Radiologists, P.C., dated 06/18/2015
14. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
15. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated October 9, 2014
16. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated October 1, 2006
17. Professional Services Agreement for On Call Coverage for Individual Physician by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Abdulmasih Zarif, M.D., dated 5/12/2016
18. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated June 1, 2016
19. Non-Exclusive Professional Services Agreement for Interpretations of Diagnostic Tests by and between Mountainside Treatment Center and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 8, 2016
20. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated July 31, 2015
21. Pathology Services Agreement by and between RCHP d/b/a Sharon Hospital and Consultants in Pathology, P.C., dated 01/01/2012
22. Lithotripsy Services Agreement by and between UMS Connecticut Lithotripsy, LP and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated 06/08/2006
23. Professional Services Agreement for Physician Group by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Associated Northwest Urology, PC, dated May 2, 2016
24. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Saint Francis Medical Group, Inc., dated 05/05/2014
25. Professional Services Agreement by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 05/01/2012

26. Professional Services Agreement for On Call Coverage by and between Tri State Women's Services LLC and Physicians for Women's Health, dated January 1, 2012, as assigned to Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
27. Billing and Collection Services Agreement by and between Women's Health Connecticut and Tri State Women's Services, dated 05/01/2012
28. EMR Agreement by and between Tri State Women's Services LLC and Women's Health Connecticut, Inc., dated May 1, 2012
29. Medical Record Custodial Agreement by and between Regional Healthcare Associates, LLC and Torrington-Winsted Pediatric Associates, P.C., dated January 13, 2016
30. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016
31. Agreement for Hospice General Inpatient Level Care in a Hospital by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Salisbury Visiting Nurse Association, Inc., dated July 1, 2016

Lease Agreements

1. Office Lease Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Saint Francis Medical Group, Inc., dated 04/18/2014
2. Medical Office Lease Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Torrington Winsted Pediatric Associates, P.C., dated 12/07/2015
3. Lease Agreement between Essent Healthcare of Connecticut d/b/a Sharon Hospital and David R. Kurish, M.D., dated 1/28/2009
4. Physician Space Occupancy Agreement (Suite 1900) by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Westwood Ear Nose & Throat, P.C., dated 10/02/2013
5. Lease Agreement by and between Essent Healthcare of Connecticut and Litchfield County Gastroenterology Associates, LLC, dated 11/01/2008, as assigned to Connecticut GI, P.C.
6. Connecticut Residential Lease Agreement by and between Essent Healthcare of Connecticut and Anu Properties, dated 10/27/2008
7. Physician Space Occupancy Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Arthritis and Allergy Associates P.C., dated 06/01/2013
8. Lease Agreement by and between Regional Healthcare Associates, LLC and Robert J. Orlandi, dated 04/22/2013
9. Lease Agreement by and between Regional Healthcare Associates, LLC and Robert J. Orlandi, dated 04/30/2013, as amended.
10. Timeshare Lease Agreement by and between Tri State Women's Services, LLC and Bruce Janelli, M.D., dated 08/01/2012
11. Physician Space Lease Occupancy Agreement by and between Tri State Women's Services, LLC and Orlito Trias, M.D., dated 11/01/2015
12. Lease Agreement by and between Winsted Health Center, Inc. and Tri State Women's Services, LLC, dated 9/1/2013

13. Equipment Lease Agreement by and between Tri State Women's Services and Physician's for Women's Health, dated 05/01/2012
14. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and Candlewood Properties, LLC dated 05/05/2016
15. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and ANU Properties, LLC dated 05/05/2016
16. Lease by and between Tri State Women's Services and Sharon Medical Office Building, dated 05/31/2012
17. Commercial Lease by and between Regional Health Care Associates, LLC and Kenmil Realty LLC, dated 08/01/2016

(b)

1. Contract by and between Sharon Hospital and Torrington Area Health District, dated July 14, 2015
2. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
3. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
4. American Red Cross Blood Services Agreement by and between Sharon Hospital and The American National Red Cross, Connecticut Blood Services Region, dated October 1, 2014
5. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013
6. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
7. Pharmacy Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Cardinal Health Solutions, Inc., dated October 1, 2007
8. Cyracom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
9. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated April 1, 2014
10. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
11. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011
12. Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Horizon Mental Health Management, Inc., dated April 12, 2002
13. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Insight Financial Corporation, dated October 23, 2006
14. Master Lease Agreement (Quasi) by and between Essent Healthcare of Connecticut, Inc. and General Electric Capital Corporation, dated January 29, 2013, including all related schedules
15. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
16. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011

17. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
18. Grant Consulting Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and SpectraCorp Technologies Group Inc., dated July 8, 2013
19. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013
20. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010
21. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Bhavana Daruvuri, D.O., dated October 1, 2015
22. Local Service Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 27, 2015
23. Support Agreement by and between Clinical Computer Systems, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated September 1, 2010
24. Service Solution Proposal by and between Tyco SimplexGrinnell and Sharon Hospital, dated 06/01/2014

(c)

Managed Care Agreements

1. Hospital Services Agreement by and between Aetna Health Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated April 1, 2014, as amended.
2. Facility Agreement by and between Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield and Sharon Hospital Inc., dated August 1, 2013, as amended.
3. Hospital Managed Care Agreement by and between CIGNA Healthcare of Connecticut, Inc. and Sharon Hospital, dated September 1, 1999, as amended.
4. Hospital Agreement by and between ConnectiCare Inc. and Essent-Sharon Hospital, dated April 1, 2008, as amended.
5. Facility Agreement by and between Empire HealthChoice HMO, Inc. d/b/a Empire BlueCross BlueShield HMO and Empire HealthChoice Assurance, Inc. d/b/a Empire BlueCross BlueShield and Sharon Hospital, dated November 1, 2014, as amended.
6. Standard Hospital Provider Agreement 2.0 by and between New York State Catholic Health Plan, Inc. d/b/a Fidelis Care New York and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated December 17, 2012, as amended.
7. Hospital Agreement by and between MVP Health Plan, Inc., MVP Health Services Corp., MVPHP PA, Inc. and MVP Select Care, Inc. and Sharon Hospital, dated January 1, 1999, as amended.
8. Facility Participation Agreement by and between UnitedHealthcare Insurance Company and Essent Healthcare of Connecticut Inc., dba Sharon Hospital, dated June 1, 2009, as amended.

(d)

1. Master Agreement and Customer Order by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
2. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
3. Services Agreement by and between Sharon Hospital Holding Company and Regional Healthcare Associates, LLC, dated February 25, 2014
4. Services Agreement by and between Sharon Hospital Holding Company and Tri State Women's Services, LLC, dated October 1, 2014
5. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
6. Security Service Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Apollo Security International, Inc., dated May 1, 2016
7. 2016 Environmental Compliance Master Services Agreement by and between Fuss & O'Neill and Sharon Hospital, dated January 15, 2016
8. Business Electricity Authorization Connecticut Large Commercial Sales Standard Product Agreement by and between Essent Healthcare of CT dba Sharon Hospital and NextEra Energy Services, dated June 2, 2016
9. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011
10. Agreement by and between Essent Healthcare of Connecticut, Inc. dba Sharon Hospital and Agile Consulting Group, Inc., dated July 19, 2013
11. Masimo Pulse Oximetry Supply Agreement Deferred Equipment Purchase Plan by and between Masimo Americas, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated May 9, 2014
12. Engagement Letter Agreement by and between Sharon Hospital and Updike, Kelly & Spellacy, PC, dated November 19, 2015
13. Medicaid Eligibility Services Agreement by and between Sharon Hospital - RegionalCare Hospital Partners and The Collection Bureau Hudson Valley and Healthcare Billing Services, NY, Inc., dated January 6, 2012
14. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
15. Amicas Limited Sublicense Agreement by and between Imaging On Call, LLC and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, undated
16. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
17. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013

Schedule 4.19(d)
Assumed Contract Consents

Real Estate Leases:

1. Connecticut Residential Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Anu Properties Corp., dated July 15, 2012, as amended by First Amendment dated April 21, 2014, and further amended by Second Amendment dated June 29, 2015
2. Commercial Lease by and between Regional Healthcare Associates, LLC and Kenmil Realty LLC, dated 08/01/2016
3. Lease Agreement by and between Regional Healthcare Associates LLC and Robert J. Orlandi, dated 04/22/2013
4. Lease Agreement by and between Regional Healthcare Associates LLC and Robert J. Orlandi, dated 04/30/2013, as amended.
5. Lease Agreement by and between Winsted Health Center, Inc. and Tri State Women's Services, LLC, dated 09/1/2013
6. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and Candlewood Properties, LLC dated 05/05/2016
7. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and ANU Properties, LLC dated 05/05/2016

Material Contracts:

1. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
2. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
3. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013, as amended by that certain Addendum to Contract by and between Sharon Hospital and Otis Elevator Company, dated July 1, 2015
4. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
5. American Red Cross Blood Services Agreement by and between Essent Healthcare of Connecticut, Inc. dba Sharon Hospital and The American National Red Cross, Connecticut Blood Services Region, dated October 1, 2014
6. Pharmacy Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Cardinal Health Solutions, Inc., dated October 1, 2007 as amended Proposal by and between Sharon Hospital and SimplexGrinnell LP, dated June 1, 2014
7. CyraCom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
8. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Haytel Cardiac Services, Inc., d/b/a Remote Cardiac Services, dated 4/9/15
9. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated October 1, 2006

10. Master Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
11. Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Horizon Mental Health Management, Inc., dated April 12, 2002
12. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Insight Financial Corporation, dated October 23, 2006
13. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
14. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
15. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
16. Amendment to the Support Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Clinical Computer Systems, Inc., dated September 1, 2014
17. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013
18. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated October 9, 2014
19. Master Lease Agreement (Quasi) by and between Essent Healthcare of Connecticut, Inc. and General Electric Capital Corporation, dated January 29, 2013, including all related schedules
20. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010
21. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
22. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated 01/01/2011
23. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
24. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
25. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
26. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated July 31, 2015
27. Memorandum of Agreement for Organ/Tissue/Eye Procurement by and between Sharon Hospital and LifeChioce Donor Services, Inc., dated 05/01/2012
28. Professional Services Agreement by and between Tri State Women's Services, LLC and Physicians for Women's Health, dated 05/30/2012
29. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended

30. Each of the Managed Care Contracts listed on Schedule 4.18(c) is incorporated herein.
31. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated June 1, 2016
32. Non-Exclusive Professional Services Agreement for Interpretations of Diagnostic Tests by and between Mountainside Treatment Center and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 8, 2016
33. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016
34. Medical Record Custodial Agreement by and between Regional Healthcare Associates, LLC and Torrington-Winsted Pediatric Associates, P.C., dated January 13, 2016
35. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
36. Amicas Limited Sublicense Agreement by and between Imaging On Call, LLC and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, undated
37. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
38. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013

Schedule 4.19(e)
Assignment Penalties

None.

Schedule 4.21
Insurance

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
Combined Specialty; 02-825-28-57	12/3/2015-12/3/2016	$32,000,000	D&O: $150,000 Employment Practices: $150,000 Fiduciary: $0 Employed Lawyers: $10,000 All Crimes: $50,000	National Union Fire Ins. Co. of Pittsburg	AON
Excess D&O; SISIXFL21245015	12/3/2015-12/3/2016	$10,000,000; excess of $10,000,000	N/A	Starr Indemnity & Liability Company	AON
Excess D&O; G25543440 001	4/29/2016-12/3/2016	$10,000,000; excess of $20,000,000	N/A	ACE America Insurance Company	AON
Excess D&O; DOX10009086400	4/29/2016-12/3/2016	$10,000,000; excess of $30,000,000	N/A	Endurance Risk Solutions Assurance Co.	AON
D&O - Excess Side A; EPG0016937	12/3/2015-12/3/2016	$10,000,000; excess of $40,000,000	N/A	RLI Insurance Company	AON
Excess Crime; BCCR-45002131-20	12/3/2015-12/3/2016	$5,000,000; in excess of $5,000,000	N/A	Berkley Regional Insurance Company	AON
Special Crime; UKA3009239.15	12/3/2015-12/3/2016	Control Risks Fees and Expenses: Unlimited Per Insured Event: $1,250,000 Ransom, Transit, Additional Expenses, Legal Liability: $1,000,000 Personal Accident-Per Person: $250,000	N/A	Hiscox Insurance Company	AON
Automobile;	10/1/2015-	$1,000,000 per Accident	$1,000	Zurich American	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
BAP582254403	10/1/2016		Comprehensive $1,000 Collision	Insurance Co.	
Non-Owned Aircraft Liability; BA-15-10-0073	10/1/2015-10/1/2016	$10,000,000 Combined Single Limit Bodily Injury and Property Damage Liability $10,000,000 Personal Injury Liability Each Offense and in the Aggregate $25,000 Medical Expense Any One Person	N/A	StarNet Insurance Co.	Willis
Healthcare Umbrella Liability; HPC583350503	10/1/2015-10/1/2016	$25,000,000 Specific Loss Unit $25,000,000 Aggregate $25,000,000 Professional Liability Aggregate Limit	Professional Liability - $2,000,000 Each Medical Incident SIR General Liability - $2,000,000 Occurrence SIR Abusive Acts Liability - $2,000,000 Rach Abusive Act Retained Limit all other coverages - $100,000	Zurich/Steadfast Insurance Co.	Willis
Excess Healthcare Liability; 001475703	10/1/2015-10/1/2016	$25,000,000 Per Claim/Aggregate Excess of $25,000,000 $2,000,000 SIR	N/A	Ironshore Specialty Insurance Co.	Willis
Pollution Liability; PLC13246672	10/1/2015-10/1/2016	$20,000,000 Each Incident $20,000,000 Aggregate	$25,000 Each Incident $50,000 Applies to 4 USTs	AIG Speciality Insurance Co.	Willis
Property;	10/1/2015-10/1/2016	$500,000,000 - Buildings, Personal Property,	$100,000 Deductible All	Zurich/American Guarantee and Liability	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
ZMD583360703		Business Income Limit	other Perils Other deductibles apply for Flood, EQ and Named Storm	Ins. Co.	
Workers Compensation; WC583354503	10/1/2015-10/1/2016	Workers Compensation - Statutory Bodily Injury by Accident: $1,000,000 per accident Each Employee Bolidy Injury by Disease: $1.,000,000 Policy Limit, Bodily Injury by Disease: $1,000,000	$250,000 Per Occurrence $3,550,000 Estimated Annual Deductible Aggregate	American Zurich Insurance Co.	Willis
Privacy and Network Liability (Cyber); 0310-1202	4/29/2016-4/29/2017	$10,000,000 Privacy, Network Security or Media Wrongful Acts $10,000,000 Breach Consultant Services $10,000,000 Breach Response Services Coverage $10,000,000 Supplemental Privacy Coverage $10,000,000 Policy Aggregate	$250,000 N/A Breach Consultant Services	Allied World Assurance Company (U.S.), Inc.	Willis
1st Excess Privacy and Network Liability (Cyber); MTE 9033485	4/29/2016-4/29/2017	$10,000,000 Aggregate Limit of Liability Excess of $10,000,000	$250,000 SIR	Indian Harbor Ins. Co.	Willis
2nd Excess Privacy and Network Liability (Cyber);	4/29/2016-4/29/2017	$10,000,000 Aggregate Limit of Liability Excess of $25,000,000	$250,000 SIR	Liberty Surplus Insurance Corp.	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
EO5NABAX8P001					

Schedule 4.22
Cost Reports

	FYE		Status	NOPR Date	Filed	Finalized	Reopening NOPR Date	Reopening Settlement
Medicare								
	9/30/2013		Audited	6/16/2015	2/28/2014	6/16/2015	N/A	N/A
	9/30/2014		Tent. Settlement	N/A	2/28/2015	N/A	N/A	N/A
	9/30/2015		Filed	N/A	2/29/2016	N/A	N/A	N/A
Medicaid								
	9/30/2013		Audited	7/2/2015	2/28/2014	N/A	N/A	N/A
	9/30/2014		Audited	2/28/2015	N/A	N/A	N/A	N/A
	9/30/2015		Filed	N/A	6/30/2016	N/A	N/A	N/A

Schedule 4.23
Medical Staff Matters

None.

Schedule 4.25
Compliance Program

(a) None.

(b) None.

(c) None.

(d) None.

Schedule 4.26
Environmental Matters

The specific matters set forth below in Schedules 4.26(a) through 4.26(j) as more fully described in the following reports.

1. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 2016 (including all reports contained or referenced therein) ("Document 1"). (Provided by Buyer.)

2. *Phase I Environmental Site Assessment, 1 and 3 Low Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 2016 (including all reports contained or referenced therein) ("Document 2"). (Provided by Buyer.)

3. *Limited Environmental Compliance Review, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 20, 2016 (including all reports contained or referenced therein) ("Document 3"). (Provided by Buyer.)

4. *Limited Environmental Compliance Review, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated August 10, 2016 (including all reports contained or referenced therein) ("Document 4"). (Provided by Buyer.)

5. *Asbestos Sampling Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated May 10, 2012 (including all reports contained or referenced therein) ("Document 5"). (Provided in Data Room.)

6. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated July 22, 2011 (including all reports contained or referenced therein) ("Document 6"). (Provided in Data Room; Included in Document 1.)

7. *Interim Remedial Action Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by Berkshire Environmental Services & Technology, LLC, dated June 19, 2009 (including all reports contained or referenced therein) ("Document 7"). (Included in Document 1.)

8. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated December 7, 2006 (including all reports contained or referenced therein) ("Document 8"). (Provided in Data Room; Included in Document 1.)

9. *Quarterly Groundwater Monitoring Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by ATC Associates, Inc. for The Paratus Group, LLC, dated June 5, 2006 (Paratus cover letter dated June 7, 2006) (including all reports

contained or referenced therein) ("Document 9"). (Provided in Data Room; Included in Document 1.)

10. *Environmental Review of Four Hospitals of Essent Healthcare, Inc.* (relating to Sharon Hospital, Sharon, Connecticut), prepared by Environ International Corporation, dated October 2004 (including all reports contained or referenced therein) ("Document 10"). (Provided in Data Room; Included in Document 1.)

11. *Groundwater Monitoring Well Installation and Sampling Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Nicks Group, Inc., dated March 15, 2004 (including all reports contained or referenced therein) ("Document 11"). (Included in Document 1.)

(a) Noncompliance; Permits and Governmental Authorizations

1. The specific interior and exterior spills and releases involving petroleum and chemicals described in Document 1, pages ii, iii, iv, 8, 9, 11, 13, 14, 15, 16-17, 18, 19, 20, 21, 22, 24, 25, 31, 32, 36, 37 and Document 10, page II-2.
2. The specific historical on-site UST related release incidents described in Document 1, pages iii, 17, 18, 19, 20, 21, 22, 24, 25, 36; Document 9, pages 1-4, figures, table, and appendix; Document 10, pages II-2, V-3, V-5, V-7, V-8, V-9; and Document 11, pages 1-13.
3. Potential for impact to on-site stormwater pathways specifically described in Document 1, pages iv, 9, 17, 31, 36-37 and Document 10, pages II-4
4. Historical on-site waste incinerator. (*See* Document 1, pages iv, 9, 12, 33, 35, 37.)
5. A minor quantity of petroleum contaminated soil was left in place at 50 Hospital Hill Road, Sharon, Connecticut after removal of an underground storage tank due to proximity to a building foundation. (*See* Document 6, pages 4, 32, 36; Document 7, pages 1-14, figures, tables, and appendices; Document 8, pages 3, 24, 27, 28; Document 10, pages II-2, V-3, V-8; and Document 11, pages 1-13 for more details.)

(b) Materials of Environmental Concern on the Properties

1. A minor quantity of petroleum contaminated soil was left in place at 50 Hospital Hill Road, Sharon, Connecticut after removal of an underground storage tank due to its proximity to a building foundation. (*See* Document 6, pages 4, 32, 36; Document 7, pages 1-14, figures, tables, and appendices; Document 8, pages 3, 24, 27, 28; Document 10, pages II-2, V-3, V-8; and Document 11, pages 1-13 for more details.)

(c) Pending or Threatened Environmental Claims

None.

(d) Materials of Environmental Concern at Off-Site Locations

1. In 1999, Sharon was identified as a potentially responsible party for the Amenia Town Landfill. In 2002, Sharon paid $340,000 and entered into a settlement agreement to resolve its liability for this matter. (*See* Document 4, page 8; Document 10, pages II-5, VII-7.)

(e) Liability or Obligations of Third Parties

None.

(f)(i) Underground Storage Tanks

The following underground storage tanks are present on the property at 50 Hospital Hill Road, Sharon Connecticut:

1. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: UG-1
    - Tank Size: 20,000
    - Tank Type: UST
    - Construction: Steel
    - Contents: Fuel Oil
    - Install Date: 1988
    - Retro Date: N/A
    - Leak Detection: CPIC
    - Overfill Protection: None
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A
    - Piping Const.: DW
    - Piping Leak Det.: None

2. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: UG-2
    - Tank Size: 10,000
    - Tank Type: UST
    - Construction: Fiberglass
    - Contents: Kerosene/Diesel
    - Install Date: 1994
    - Retro Date: N/A
    - Leak Detection: IM
    - Overfill Protection: AL
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A

- Piping Const.: DW
- Piping Leak Det.: None

3. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: Not Issued
    - Tank Size: 1,950
    - Tank Type: UST
    - Construction: Steel
    - Contents: Propane
    - Install Date: 2006
    - Retro Date: N/A
    - Leak Detection: None
    - Overfill Protection: None
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A
    - Piping Const.: N/A
    - Piping Leak Det.: N/A

4. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: Not Issued
    - Tank Size: 1,000
    - Tank Type: UST
    - Construction: Steel
    - Contents: Propane
    - Install Date: 1994
    - Retro Date: N/A
    - Leak Detection: None
    - Overfill Protection: None
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A
    - Piping Const.: N/A
    - Piping Leak Det.: N/A

(f)(ii) Asbestos-Containing Materials

1. Potential asbestos in buildings on site. (*See* Document 1, page 21; Document 2, pages ii, 3, 14, 15; Document 3, pages 3, 14-15; Document 4, pages 2, 13-14; Document 5, pages 1-8, appendices A - D; Document 6, pages 4, 33, 36; Document 8, pages 3, 25, 27, 28; Document 10, pages II-6, VII-11, VII-34.)

(f)(iii) Polychlorinated Biphenyls (PCBs)

1. Hazardous wastes generated at the site have included PCB-containing wastes. (*See* Document 1, page 15; Document 10, pages V-3, VII-11, VII-12.)
2. Pad-mounted or other transformers. (*See* Document 1, page 35; Document 2, page 14; Document 3, page 15; Document 4, page 14; Document 6, pages 31, 35; Document 8, pages 23, 27; Document 10, page VII-35.)

(g) Properties Encumbered Under Environmental Laws

None.

(h) Noncompliance with Medical Waste Laws

None.

(i) Environmental Reports Not Provided

1. *Phase I Environmental Site Assessment*, prepared by The Nicks Group, Inc., August 2002. (Referred to in Document 1, page 17; Document 10, pages I-3, V-2, but not in the possession, custody or control of Sellers.)
2. *Groundwater* Monitoring Reports, beginning after March 15, 2004. (Referred to in Document 1, page 17; Document 10, page 13, but not in the possession, custody or control of Sellers.)

(j) Connecticut Transfer Act

1. To the extent applicable to the transaction covered by the Agreement, Sharon shall file the appropriate Property Transfer Form (with all applicable accompanying forms) with the Connecticut Department of Energy & Environmental Protection following Closing in accordance with the Connecticut Transfer Act.

Schedule 4.27(a)
Owned Intellectual Property

Mark	Goods/Services	Registration Number & Registration Date
	Healthcare	Registration No. 4981620; Registration Date: June 21, 2016

Trade Names

Sharon Hospital (Town of Sharon, Connecticut)

Domain Names

http://sharonhospital.com/

Schedule 4.27(b)
Other Intellectual Property

No.	Solution/Application	Service Provided
1.	3M	Clinical Documentation Improvement
		CPT Lookup
		ICD-9 Lookup
		MS-DRG Lookup & Grouping
		OP Coding
		RCS Medicare
2.	Abbott	Lab POC
3.	Acmeware, Inc	Meaningful Use Metrics
		Report Writing
4.	ADP HRB	HR - Benefits
5.	Agilum	ERP Reporting
6.	Animas Corporation	Lab POC
7.	AthenaHealth	Practice Management & EHR
8.	Cadwell	EEG
		Sleep Study
9.	CCSI	Fetal Monitoring System/Perinatal Documentation
10.	Clinicalpharmacology.com	Pharmacy Drug Interactions
11.	Datacard Corporation	Employee Badge ID System
12.	DCS Global - AuditLogix	Insurance Eligibility Verification
		Insurance Verification/Medical Necessity
13.	Dell	Offsite Image Archive
14.	DigitalTechnology LLC	Pathology dictation/transcription
15.	EVS Guard	Maternity Security - video cameras
16.	Forward Advantage	Meditech Outbound Interface
17.	GE	Cardiology ECG
		Holter Monitor system
		Stress Test monitor
18.	HealthLine Systems, Inc	Credentialing
19.	HealthStream	Employee Education & Certification
20.	Hologic	Mammography Diagnostic Viewing Station
21.	HUGS	Infant Security
22.	Intelligent Medical Objects	Nomenclature Mapping
23.	Interbit Data	Faxing Software
24.	Johnson Controls	Temperature/AC Controls
25.	KRONOS	HR - Time and Attendance
26.	Maintenance Connection	Work Order & Maintenance Management System
27.	McKesson	Case Management
		Nurse Scheduling
28.	MedAllies	Practice Management & EHR

No.	Solution/Application	Service Provided
		Transition of Care
29.	Meditech	Accounts Payable
		Admission/Registration
		Billing Accounts Receivable
		Budgeting & Forecasting
		Case Mix Abstracting
		Data Repository
		EDIS
		Executive Support System
		General Ledger
		HRIS - HR & Payroll
		Lab (LIS)
		Lab Anatomic Pathology
		Lab Blood Bank
		Lab Microbiology
		Materials Management
		Medical Records
		Nursing Documentation
		Order Entry
		Pharmacy
		Pharmacy-Bedside Med Admin
		Physician Care Manager
		Physician Documentation
		Radiology (RIS)
		Scheduling & Referral Management
30.	Meditech/paper	Surgery Documentation
		Surgery Scheduling
31.	Merge (AMICAS)	PACS
32.	Micromedex	ED Discharge Instructions
		Patient Education
33.	Milt	Medication packaging system
		Pharmacy Labeling system
34.	Morgan Scientific	Pulmonary Function Testing
35.	MRS	Mammography Reporting System
36.	Nuance	Dictation/Transcription
37.	Occurrence Insight	Incident Reporting system
38.	Optum LYNX (ePoint)	ED Coding/Leveling
39.	Perceptive Lexmark (ImageNow)	Patient Scanning & Archiving System
40.	PrecisionWeb	QC for Abbott POC
41.	Press Ganey	Patient Satisfaction
42.	Provation Medical	Evidence-Based Order Sets
43.	Provider Trust	Background checking website
44.	Pyxis	Pharmacy Dispense

No.	Solution/Application	Service Provided
45.	Quest	Lab Reference Lab
46.	RelayHealth	Patient Portal
47.	RepTrax	Vendor Credentialing & Badge Printing
48.	Sage	Fixed Assets
49.	SAI Global	Contract Management
50.	Sentri7	Clinical Surveillance, RPH documentation
		Infection Control
		Pharmacy Decision Support and Surveillance
51.	Sonic Wall	Guest wireless content filtering and support
52.	Sorna	Imaging CD Burner
		Radiology CD burner
53.	SpaceLabs	Automatic BP cuff
54.	Standing Stone	Coumadin clinic
55.	Symantec	A/V & Malware Protection
56.	The Advisory Board	Crimson Quality Management
57.	The SSI Group	Claim Scrubbing
58.	TrackVia	Investigation Tracking system
59.	Truven Health Analytics	Core Measures
60.	Uptodate	Clinical Decision Support
61.	Vitrea	CT 3D Reconstruction
62.	Whitecloud	Analytics Solution
63.	Wolters Kluwer	Pharmacy Formulary Content
64.	Women's Health	Practice Management & EHR
65.	Xeleris	Stress Test - nuclear medicine

Schedule 4.27(d)
Patents, Copyrights and Trademarks

None.

Schedule 4.29
Sellers' Brokers

None.

Schedule 4.30
Sellers' Knowledge

Name	Organization	Title
Peter Cordeau	Sharon Hospital	Chief Executive Officer
Christian Bergeron	Sharon Hospital	Chief Financial Officer
Cliff Hedges	Sharon Hospital	Ethics and Compliance Officer
Lori Puff	Sharon Hospital	Chief Nursing Officer
Martin Rash	RegionalCare Hospital Partners, Inc.	Chairman and Chief Executive Officer
Michael Browder	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Financial Officer
Rob Jay	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Operating Officer
Howard Wall	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Administrative Officer, General Counsel and Secretary

Schedule 5.2(b)
Buyer Required Consents

Refer to matters set forth on Schedule 8.1(a).

Schedule 5.5
Buyer's Brokers

1. Cain Brothers.

Schedule 6.4(j)
Sellers' Negative Covenants

Peter Cordeau	Sharon Hospital	Chief Executive Officer
Christian Bergeron	Sharon Hospital	Chief Financial Officer
Cliff Hedges	Sharon Hospital	Ethics and Compliance Officer
Lori Puff	Sharon Hospital	Chief Nursing Officer

Schedule 8.1
Governmental Approvals

(a)

1. Certificate of Need Review/Hospital Transfer of Ownership – Office of Health Care Access (Conn. Gen. Stat. § 19a-630 et seq.)

2. Certificate of Need Review/Large Group Practice Transfer of Ownership – Office of Health Care Access (Conn. Gen. Stat. § 19a-630 et seq.)

3. Acute Care General Hospital Licensure – Department of Public Health (Conn. Gen. Stat. § 19a-493)

4. Public Health Laboratory License(s) – Department of Public Health (Conn. Gen. Stat. §19a-30)

5. Blood Collection Facility License(s) – Department of Public Health (Conn. Gen. Stat.§19a-30)

6. Office of Attorney General and Department of Public Health Group Practice Notifications (Conn. Gen. Stat. § 19a-486i).

7. Office of Attorney General Hospital System Affiliation Notification (Conn. Gen. Stat. § 19a-486i).

(b)

1. Acute Care General Hospital Licensure – Department of Public Health (Conn. Gen. Stat. § 19a-493)

Schedule 8.6
Material Contract Consents

None.

MANAGEMENT AGREEMENT

THIS HOSPITAL MANAGEMENT AGREEMENT (this "Agreement") is made and entered into as of the 13th day of September, 2016, by and between Vassar Health Connecticut, Inc., (the "Manager"), and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital (the "Company"), which presently owns and operates Sharon Hospital, a 78-bed medical surgical hospital located in Sharon, Connecticut (the "Hospital"). Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest") joins this Agreement solely for the purposes of Article XIV herein.

W I T N E S S E T H:

WHEREAS, the Company, Manager and certain of their affiliates have entered into that certain asset purchase agreement dated as of the date hereof (the "Purchase Agreement"), pursuant to which Manager shall acquire certain of the assets and assume certain of the liabilities of the Hospital upon the satisfaction of the terms and conditions set forth therein (the "Transaction").

WHEREAS, the Company, Manager and such affiliates will be filing a certificate of need application with the State of Connecticut Department of Public Health, Office of Healthcare Access Division ("OHCA") to seek the approval of OHCA for the Transaction.

WHEREAS, the Company desires to retain the Manager for the purpose of rendering management, administration, consulting and purchasing services and support, and all other support needed for the operation of the Hospital on the terms and conditions hereinafter set forth, subject to the policies established by the Company and the general direction and control of the Board of Directors of the Company (the "Board"); and

WHEREAS, the Manager desires to provide those management services that are set forth in more detail in this Agreement for the account of the Company.

NOW, THEREFORE, in consideration of the foregoing, of the mutual premises contained herein and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending legally to be bound, hereby agree as follows. Capitalized terms not defined herein shall have the meanings ascribed to them in the Purchase Agreement.

ARTICLE I. ENGAGEMENT OF MANAGEMENT SERVICES

1.1. The Company hereby engages the Manager, and the Manager agrees to provide the management services set forth in this Agreement (collectively, the "Management Services") upon the terms and conditions hereinafter set forth. Each of the Manager and the Company agree to work cooperatively to manage the Hospital as provided for herein and in accordance with the terms and provisions of the Purchase Agreement and neither party shall take, or fail to take, any action that will cause any breach of the representations and warranties and covenants of the other party in the Purchase Agreement. The Hospital and the businesses conducted at or in connection with the operation of the Hospital shall be collectively referred to herein as the "Business".

1.2. In carrying out its duties hereunder, Manager shall comply in all material respects with the charity care policy adopted by the Company.

ARTICLE II. RETENTION OF CONTROL

2.1. The Company shall retain all powers incident to ownership of the Hospital including, without limitation, the following: (a) approving the appointment of Key Personnel (as hereinafter defined), (b) appointing and dismissing members to the medical staff, (c) establishing policies regarding the admission of patients, (d) determining the general and fiscal policies of the Hospital, (e) making or filing any notification of non-compliance or self-disclosure, including self-disclosure made pursuant to the CMS Self-Referral Disclosure Protocol, with any governmental body or third-party payor, and (f) establishing the scope of services to be provided at the Hospital. During the Term (as defined herein), neither the Board nor the Advisory Board of Trustees (the "Advisory Board") of the Hospital shall change and the Company shall be and shall remain the owner and holder of all licenses, contracts, certificates and accreditations, shall maintain such control over the assets and operations of the Hospital that is required by applicable licensing, certification, accreditation and other applicable laws and shall be the "provider of services" within the meaning of any third party contracts for services. The Manager shall follow the policies and procedures of the Company in performing its obligations hereunder. The Company shall also have certain approval and notification rights as described herein. All matters requiring the professional medical judgment of a provider shall remain the responsibility of the Hospital's medical staff and other health professionals. The Manager shall have no responsibility whatsoever to exercise any professional medical judgment, whether reserved by applicable law to licensed physicians or other healthcare professionals on the Hospital's medical staff or otherwise. The parties acknowledge that by entering into this Agreement, the Company does not delegate to Manager any of the powers, duties and responsibilities vested in the Board by law or the Hospital's Bylaws.

2.2. The Manager shall ensure that any new relationships with providers that it authorizes or enters into during the term of this Agreement pursuant to Section 2.3 below, including the Hospital's medical staff and other healthcare professionals, are in full compliance with all applicable laws, regulations and orders of governmental bodies and agencies. The Manager covenants and agrees that prior to presenting a new member to the medical staff for admission, contracting with a health professional on behalf of the Company, or entering into a new agreement with a contractor on behalf of the Company, the Manager will conduct appropriate credentialing of those providers, including, but not limited to, taking reasonable steps to determine whether those providers have ever been included on the Office of Inspector General's "exclusion list" of providers sanctioned, suspended or excluded from participation in a federal or state health care program. Manager's actions in this regard shall be consistent with industry standards. Throughout the Term, to the extent its participation is necessary or appropriate, the Manager will follow the Medical Staff Bylaws and Peer Review procedures of the Company governing the Hospital as of the Effective Time.

2.3. Manager will carry out its duties and responsibilities under this Agreement subject to the ultimate authority of the Company and nothing in this Agreement is intended to alter, weaken, displace or modify the ultimate authority of the Company's Board. The Manager shall not terminate or reduce any inpatient or outpatient services offered by the Hospital as of the

Effective Date, except with the prior written consent of the Company and in compliance with all applicable laws, regulations and orders. Company shall consult with the Hospital's Advisory Board, prior to the termination or reduction of any inpatient or outpatient service.

2.3.1 Manager acknowledges and agrees that certain authority of the Manager and its authorization to act on behalf of the Company is expressly conditioned on the consent and approval of the Board as set forth in this Agreement and, if applicable, its prior consultation with the Advisory Board.

2.3.2 Notwithstanding anything to the contrary in this Agreement, the parties agree and acknowledge that the Manager is authorized on behalf of and without any further approval from the Board (except as otherwise noted in this Section 2.3.2) (a) to take any action that is contemplated in any then current operating or capital budgets for the Hospital or other budget approved by the Board, including without limitation the physician recruitment budget, if any; (b) to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, less than $10,000 per year; (c) after written notice to the Company (including a copy of such proposed contract) to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, between $10,000 and $24,999 per year; and (d) after written notice to the Company (including a copy of such proposed contract) and consent of the Company, to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, over $25,000 per year. Manager shall be authorized to execute, amend or terminate any contract with affiliates of Manager without the prior approval of the Board provided such contract is on fair market value terms and at rates equal to, or less than, those amounts being paid by the Company to third party(ies) for the same services. Upon consummation of the Transaction, Manager shall be obligated to assume all agreements entered into on behalf of the Company during the Term. Notwithstanding the foregoing, Manager shall not have authority to enter into, make, amend, extend or modify any managed care contract.

2.3.3 Subject to and in accordance with the terms, conditions and limitations of this Agreement and applicable law, regulations and orders, and the general direction and control of the Board, it is the intention and understanding of the parties that the Manager is delegated the complete authority to manage the operations of the Hospital for the account of the Company.

2.3.4 Manager shall deliver to the Company monthly (and, if requested by the Company, more frequent) status reports as to the business and financial operations of the Hospital and the performance of Manager's duties and services under this Agreement. Furthermore, from the date hereof until the Closing Date, Manager shall in a timely manner provide the Company with such information that it obtains in its role as Manager regarding the operations of the Hospital necessary for the Company and its affiliates to comply with all

reporting and information requirements set forth in the Purchase Agreement, the Hospital's Bylaws or as required by law.

2.4. Manager shall manage the operations of the Hospital in accordance with all applicable laws, regulations and orders. Manager shall promptly notify the Company, and the Company shall promptly notify Manager, of any investigation or inquiry, instituted by any third party (including those relating to any federal health care program) in respect of the Hospital or the Business or of any event, circumstance or fact that the notifying party believes is a violation of law.

ARTICLE III. MANAGEMENT SERVICES

3.1. Subject to the provisions of this Agreement, the Manager or its Affiliates will be responsible for overseeing all services necessary for the Hospital to operate on a daily basis. Prior to the Effective Date, the Board shall present Manager with the 2016 operating and capital budgets for the Hospital. During the Term, Manager shall manage the operations of the Hospital within and in accordance with such budgets (including any amendments or revisions thereto), provided that (1) the capital budget for 2017 shall be pro-rated on a monthly basis in accordance with the 2016 capital budget for the Hospital and (2) the operating budget for 2017 shall be modified as follows:

(a) No later than October 31st of each year during the Term, Manager shall prepare an operating budget (the "Revised Budget") to be presented to the Board. Upon the Board's approval, the Manager shall provide the Management Services in a manner consistent with the Revised Budget, subject to the terms of this Agreement.

3.2. Notwithstanding the foregoing, in the event a circumstance exists at the Hospital that poses an imminent life safety risk to patients or employees, the Manager shall be empowered to take reasonable steps to remedy such situation at the expense of the Company. Manager shall inform the Company as soon as practicable of the situation and the Manager's remediation efforts.

ARTICLE IV. ACCOUNTING AND BOOKKEEPING SERVICES

4.1. The Company shall be responsible for providing the following accounting and bookkeeping systems with respect to the operation of the Hospital:

(a) record keeping, billing and accounts payable accounting systems;

(b) accounting systems and data processing systems at the Hospital that are utilized to perform the functions necessary to efficiently and effectively operate the Hospital, including, without limitation, such accounting systems as are necessary and appropriate to enable the Hospital to allocate its costs and revenues to designated cost centers, and in connection therewith, providing and maintaining all equipment necessary to provide the Management Services; and

(c) payroll systems.

4.2. The Manager shall be responsible for overseeing the accounting and bookkeeping functions under the systems provided by the Company and described in Section 4.1. In furtherance of the foregoing, the Manager will:

(a) not make any material changes in the accounting, financial or bookkeeping practices or systems of the Hospital without the consent of the Company;

(b) implement and administer policies and procedures for the management and control of purchases, accounts payable, cash disbursements and all business related transactions, including the maintenance of books of account and financial records;

(c) provide Management Services in accordance with the Company's policies and procedures for the management and control of patient billing, claims filing, accounts receivable, credit collection and receivables activities and all necessary patient account transactions;

(d) cooperate in periodic audits of the Hospital by state and/or federal agencies and the preparation and submission of all financial and other reports required to be submitted to OHCA, the Department of Public Health and the Office of the Attorney General;

(e) cooperate in the preparation of periodic financial statements, including those as required by the Company's organizational documents (if any);

(f) cooperate, when required, with the Company's internal audit and compliance requirements;

(g) deposit in the bank accounts for the Hospital all funds generated from the operation of the Hospital and supervise the disbursement of such funds for the operation of the Hospital subject to the budgets approved by the Company and the limitations agreed to by the parties; and

(h) prepare, or provide for the preparation of, information necessary for Company to process payroll.

ARTICLE V. OTHER MANAGEMENT SERVICES

Subject to the prior approval of the Company, the Manager and the Company may agree in writing to modify the Management Services to be provided pursuant to this Agreement.

ARTICLE VI. EMPLOYEES

During the term of this Agreement, the Manager will provide the Company with the services of a Chief Executive Officer, the Chief Financial Officer and the Chief Nursing Officer of the Hospital (the "Key Personnel"), each of whom shall be subject to the prior approval of the Board, provided, however, that if Manager offers employment to the Hospital's existing Chief Executive Officer, Chief Financial Officer or Chief Nursing Officer, such individuals shall be deemed to be approved by the Board. In addition to the Key Personnel,

certain other employees of the Manager and its affiliates may assist Manager in performing the Management Services (the "Other Employees").

All Key Personnel, and Other Employees when assisting Manager in performing Management Services, shall be responsible to the Board or the Chief Executive Officer as required by applicable law or regulations. All other employees of the Company providing services at the Hospital shall remain employees of the Company until the Closing of the Transaction. During the Term, the Manager shall have, in accordance with and subject to the Company's policies and procedures and any applicable state and federal employment laws, the right to control and direct the employees as to the performance of duties and as to the means by which such duties are performed. The Manager shall comply with the Company's human resources policies and procedures in sanctioning any employee of the Company, and shall not terminate any such employee without consulting with and obtaining the consent of the Company's Director of Human Resources. Any replacement or substitution of any Key Personnel during the term of this Agreement shall be subject to the prior approval of the Board. In the event that this Agreement terminates for any reason other than expiration at Closing, the Manager shall terminate the Key Personnel and Company shall be required to offer employment to the Key Personnel on the terms and conditions that it offered to such personnel prior to the Effective Date.

ARTICLE VII. LEGAL ACTIONS

The Manager shall advise and assist the Company in instituting or defending, as the case may be, in the name of the Company and/or the Manager, all actions arising out of the operation of the Hospital and any and all legal actions or proceedings relating to the Hospital and operations therefrom to which either the Company or the Manager is a named or threatened party. The Manager also shall assist the Company in taking such actions as are necessary to protest, arbitrate or litigate to a final decision in any appropriate court or forum any violation, penalty, sanction, order, rule or regulation affecting the Hospital. Upon request of the Company, Manager shall assist the Company with the filing of any notification of non-compliance or self-disclosure, including self-disclosure made pursuant to the CMS Self-Referral Disclosure Protocol, with any governmental body or third-party payor. Ultimately the Company shall determine when to engage outside legal counsel for a specific issue or matter and how to defend any such action.

ARTICLE VIII. TERM

The term of this Agreement shall commence on October 1, 2016 (the "Effective Date"), and shall remain in place and effective until the Closing, unless sooner terminated as provided herein.

ARTICLE IX. DEFAULT AND TERMINATION

9.1. It shall be an event of default ("Event of Default") hereunder:

9.1.1. If the Company shall fail to make or cause to be made any payment to the Manager required to be made hereunder and such failure shall continue for thirty (30) days after notice thereof shall have been given to the Company.

9.1.2. If either party fails in any material respect to comply with its obligations under this Agreement, including a failure by the Manager in any material respect to make available to the Company any material portion of the Management Services required by this Agreement, and such failure shall not be cured: (a) within thirty (30) days after notice thereof by the non-breaching party to the breaching party if such failure is capable of cure within such period; or (b) within a reasonable period of time for cure if such failure cannot reasonably be cured within such thirty (30) day period, provided the breaching party commences its curative actions within such thirty (30) day period and proceeds diligently to cure thereafter (in which event, the breaching party shall have a reasonable time beyond such thirty (30) day period to complete its cure of the alleged basis for the non-breaching party's election to terminate).

9.1.3 If either the Company or Manager is excluded from participation in any federal or state healthcare program, including Medicare and Medicaid, for any reason, or if either is convicted of violating a federal or state healthcare law that is material to the business or operations of such party in which case the excluded or convicted party, as applicable, shall promptly notify the other party in writing.

9.1.4. If either the Company or the Manager shall apply for or consent to the appointment of a receiver, trustee or liquidator of such party or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangements with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days.

9.1.5. If any Event of Default by the Company shall occur and be continuing, or if any Event of Default by Manager shall occur and be continuing, the non-defaulting party may forthwith terminate this Agreement, and neither party shall have any further obligations pursuant to this Agreement, except those provided pursuant to the provisions of Articles IX, X, XII, and XIII hereof. If any Event of Default by the Company or Manager listed in Section 9.1.4 shall occur, the term of this Agreement shall terminate, at the option of the non-defaulting party, upon written notice to the bankrupt party.

9.1.6 If the Purchase Agreement expires or is terminated for any reason, this Agreement shall terminate.

9.2. Upon termination hereof, the Manager's obligations to perform services hereunder shall completely cease; provided, however, that the Company and the Manager shall perform such matters as are necessary to wind up their activities pursuant to this Agreement in an orderly manner. In the event of termination of this Agreement, the Manager also shall turn over to the Company as soon as possible any and all information related to the Company's

receivables, ledgers and other business records which are then in the Manager's possession. The Manager shall be entitled upon termination of this Agreement to receive payment of all amounts theretofore unpaid which have been earned and are due to the Manager through the date of termination.

ARTICLE X. MANAGEMENT FEES

10.1. In exchange for the Manager's provision of the Management Services, the Company shall pay the Manager a fair market value fee that, at a minimum, is equal to the Manager's direct costs in providing the Management Services (the "Management Fee"). Notwithstanding the above, any costs incurred by the Manager relating to the compensation of its employees, other than the Key Personnel, shall be excluded from the Management Fee.

10.2. The Management Fee will be Manager's sole compensation for the Management Services. The Manager acknowledges that the Management Fee is intended to be exempt from the Connecticut sales and use tax pursuant to Section 12-412 (5) of the Connecticut General Statutes through June 30, 2017 and that the Management Fee may be subject to the sales and use tax for periods arising after such date.

10.3. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the Manager and any of its affiliates providing services with a value or cost of $10,000 or more over a twelve (12) month period shall make available to the Secretary the contract, books, documents and records that are necessary to verify the nature and extent of the cost of providing such services. Such inspection shall be available up to four years after the rendering of such services. The parties agree that any applicable attorney-client, account-client or other legal privilege shall not be deemed waived by virtue of this Agreement.

ARTICLE XI. NO PARTNERSHIP

The Manager and the Company affirmatively state that they do not have the intention to form a joint venture or partnership for tax or any other purposes, nor have they done so, by entering this Agreement. If, however, a joint venture or partnership is found to exist for federal income tax purposes (a) capital accounts will be maintained for the Manager and the Company on a tax accounting basis; (b) net income will be allocated to the Manager in the amount of the payments due the Manager pursuant to Article XI hereof; (c) all remaining net taxable income or loss will be allocated to the Company; and (d) upon termination, distributions will be in accordance with the Manager's and the Company's capital account balances.

ARTICLE XII. OWNERSHIP OF ASSETS; CONFIDENTIALITY

12.1. Systems Ownership. The Company retains all ownership and other rights in all the Assets, including but not limited to all systems, manuals, computer software, materials and other information, in whatever form (collectively referred to as the "Systems") and nothing contained in this Agreement shall be construed as a license or transfer of such Systems or any portion thereof, either during the Term or thereafter. Upon the termination or expiration of this

Agreement, the Company shall retain all of the Systems except as set forth in the Purchase Agreement.

12.2. Systems Confidentiality. The Manager acknowledges that the Company has invested a significant amount of its resources in developing and maintaining the Systems and that the value to the Company of the Systems may be diminished or destroyed if the Manager discloses the Systems or any portion thereof to a third party. Accordingly, the Manager shall maintain the confidentiality of the Systems. The Manager shall not duplicate or permit the duplication of any portion of the Systems and shall not permit access to the Systems by the Manager's personnel or any third party other than as reasonably necessary or appropriate to provide Management Services in the ordinary course of business. The Manager shall take at least those commercially reasonable steps to protect the Company's information that it would take to protect its own confidential information. The provisions of this Article XIV shall survive any termination or expiration of this Agreement, except as set forth in the Purchase Agreement.

12.3. Treatment of Confidential Information. Each party and its affiliates shall treat all non-public information regarding the other party or its affiliates that is obtained as part of this engagement as confidential and proprietary and shall not release or share such information with any third party, except as may be required by law or as authorized by the party to which the information pertains or as reasonably necessary in connection with the performance of its duties hereunder. Certain non-public information relating to Company, including but not limited to managed care contracts, managed care reimbursement rates, strategic and business plans, operating and capital budgets, physician recruitment plans, and employee compensation, may be considered competitively sensitive ("Competitively Sensitive Information") under federal and state antitrust laws. Company shall only disclose Competitively Sensitive Information to: (a) Key Employees; and (b) other employees of Manager as required to oversee and to maintain the operations of Company. Company shall not disclose, and Manager shall institute policies and procedures to prevent disclosure of, Competitively Sensitive Information to employees of Manager who also have direct responsibilities for the operations of Manager's other hospitals and employed physician groups. Summaries of Competitively Sensitive Information that are aggregated or blinded as to specific managed care organizations, vendors, or employees shall not be Competitively Sensitive Information hereunder. This restriction on sharing Competitively Sensitive Information shall only expire upon Closing of the Transaction and shall continue indefinitely in the event of a termination of this Agreement for any other reason.

12.4. Covenant Not to Solicit. During the Term, and for a period of one (1) year following the early termination or expiration of the Term for any reason other than the Closing, Manager shall not, through an affiliate or separate employee leasing or staffing company or otherwise, specifically solicit for employment, any employee or independent contractor of Company (collectively referred to herein as the "Employees" or individually as the "Employee"), unless Company gives its written consent thereto. As liquidated damages for any breach of this Section 12.4 by Manager, Manager agrees that, if it breaches this Section 12.4 of the Agreement, Manager will pay Company an amount equal to two times (2x) the then current salary of such Employee within 30 (thirty) days of the employment as reasonable compensation to Company for damages incurred by such actions on the part of Manager. The Parties acknowledge and agree that this amount (a) a constitutes a fair, reasonable and appropriate resolution of a violation of this Section and the resulting damages incurred by Company, and (b) does not constitute a

penalty. Manager's failure to pay this amount on or before the date due shall create an immediate right on the part of Company to pursue collection of this amount with interest. Manager agrees to reimburse Company for any and all reasonable attorney's fees, other costs, fees and expenses as may be incurred by Company in order to enforce its rights set forth in this Section 13.4. In the event that Manager fails to uphold its obligations hereunder, the Parties confirm that Company may seek any and all remedies in law or equity, including injunctive relief as applicable, relating to any violation of this Section or of any other provisions of this Agreement. By way of clarification, the Parties agree that Manager may generally advertise and post job openings and may hire an Employee who responds to such general solicitation.

ARTICLE XIII. INDEMNIFICATION

13.1. Indemnification by the Company. The Company agrees to indemnify and hold harmless the Manager, its affiliates and shareholders, and their respective shareholders, directors, officers, employees and agents (collectively, a "Manager Indemnified Party") from and against any and all losses, claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims) (a "Loss"), which may be asserted against any of the Manager Indemnified Parties arising in connection with performance of its duties or obligations hereunder, including without limitation matters relating to: (a) the breach of this Agreement by the Company; (b) any pending or threatened malpractice or other tort claims asserted against the Manager relating to the Hospital; (c) any action against the Manager brought by any current or former medical staff members or employees, and (d) any act or omission by any medical staff member, or employee, or other personnel who were under the supervision of a member of the medical staff as a result of providing medical services to such medical staff member's patient; provided that such Loss has not been caused by the breach of this Agreement by Manager or by the gross negligence or willful misconduct of or a knowing violation of law by, the Manager Indemnified Party seeking indemnification pursuant to this Agreement.

13.2. Indemnification by the Manager. The Manager agrees to indemnify and hold harmless the Company and its members, partners, or shareholders (as appropriate), its directors, and its officers, employees and agents (collectively, a "Company Indemnified Party") from and against any Loss, which is caused by: (a) the breach of this Agreement by the Manager; or (b) a violation of law by the Manager; provided that such Loss has not been caused by the gross negligence or willful misconduct of or a knowing violation of law by, the Company Indemnified Party seeking indemnification pursuant to this Agreement.

13.3. Sole Remedy. This Article XIII shall constitute the sole remedy of the parties hereto with respect to any Loss resulting from a third party claim.

ARTICLE XIV. GUARANTEE

14.1. HealthQuest Guarantee. HealthQuest hereby unconditionally and irrevocably guarantees, as a primary obligor and not only a surety (the "**HealthQuest Guarantee**"), the prompt and complete payment and performance (not just collection) of any and all of the Manager's obligations to the Company under this Agreement (the "**Obligations**"), if, as, when and to the extent that such Obligations are required to be performed pursuant to such

agreements. If Manager does not perform an Obligation, HealthQuest shall promptly perform the Obligation. The obligations of HealthQuest under the HealthQuest Guarantee are independent of the obligations of the Manager under the Agreement and a separate action or actions may be brought against HealthQuest, whether action is brought against the Manager or whether the Manager is joined in any such action or actions; provided, however, as a condition precedent to the commencement of any action against HealthQuest, (i) Manager shall have first failed to satisfy an Obligation in the time specified in the Agreement, taking into account any notice and cure periods, and (ii) Company shall have an ongoing duty to provide to Manager any notices required under this Agreement. Except as set forth in this Article XIV, HealthQuest hereby waives all rights and defenses of a surety under applicable law. Notwithstanding the foregoing, HealthQuest shall be entitled to assert as a defense to any claim under this Article XIV, (i) that the Obligations in respect of which a demand has been made are not yet due under the terms of this Agreement, (ii) that such Obligations have been previously performed in full, and (iii) any claims, defenses, counter claims, setoffs or circumstances excusing payment or performance which the Manager would be entitled to assert under this Agreement. Except as specifically set forth in this Article XIV, the HealthQuest Guarantee is an absolute, irrevocable, primary, continuing, unconditional, and unlimited guaranty of performance and payment subject to and within the limitations of this Agreement. The HealthQuest Guarantee shall remain in full force and effect (and shall remain in effect notwithstanding any amendment to this Agreement) for HealthQuest until all of the obligations of the Managers have been paid, observed, performed, or discharged in full.

ARTICLE XV. MISCELLANEOUS

15.1. Business Associate. Manager acknowledges that the services it provides hereunder may make it a business associate of the Hospital. Manager agrees to execute a HIPAA business associate agreement, in substantially the form attached hereto as Exhibit A, separately outlining its obligations as a business associate with respect to the privacy and security of individually identifiable health information it may acquire in the course of its duties hereunder.

15.2. Referral Disclaimer. The amounts to be paid hereunder represent the fair market value of the services to be provided as established by arm's length negotiations by the parties and have not been determined in any manner that takes into account the volume or value of any potential referrals between the parties. No amount paid hereunder is intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any party to any other party. In addition, the amounts charged hereunder do not include any discount, rebate, kickback or other reduction in charges, and the amount charged is not intended to be, nor shall it be construed to be, and inducement or payment for referral of patients by any party to any other party. Further, it is agreed that none of the parties shall refer or attempt to influence the referrals of any patients to any particular program.

15.3. Material Change in Law. In the event any material change in any federal or state law or regulation creates a significant likelihood of sanction or penalty based on the terms of this Agreement or would prohibit either party from billing for or receiving payment for any services provided by the parties, then upon request of either party, the parties hereto shall enter into good faith negotiations to renegotiate the affected provision or provisions of the

Agreement to remedy such term or condition. In the event the parties are unable to reach agreement on the affected provision or provisions, so as to bring such provision or provisions into compliance with the law or regulation within thirty (30) days of the initial request for renegotiation, this Agreement shall terminate upon ten (10) days' written notice or the effective date of such change (whichever is earlier). Each party hereto expressly recognizes that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith.

15.4. Notices. All notices, demands and other communications to be given or delivered pursuant to or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (i) when personally delivered; (ii) on the business day sent (or the next business day if sent on a non-business day) if delivered by facsimile with receipt confirmation; (iii) one day after deposit with Fed Ex, UPS or similar reputable overnight courier service; or (iv) three days after being mailed by first class mail, return receipt requested. Notices, demands and communications to the Manager and the Company shall, unless another address is specified in writing, be sent to the addresses indicated below:

If to the Company:

Essent Healthcare of Connecticut, Inc.
103 Continental Place
Suite 200
Brentwood TN 37027
Attn: General Counsel

with a copy to:

RegionalCare Hospital Partners, Inc.
103 Continental Place
Suite 200
Brentwood TN 37027
Attn: General Counsel

Waller Lansden Dortch & Davis, LLP
Nashville City Center
511 Union Street, Suite 2700
Nashville, Tennessee 37219
Fax No. 615-244-6804
Attn: MaryEllen S. Pickrell

If to the Manager:

Health Quest Systems, Inc.
1351 Route 55, Suite 200
Lagrangeville, NY 12540
Attention: Michael Holzhueter, Senior Vice President and General Counsel

Email: mholzhue@health-quest.org

with a copy to:

McDermott Will & Emery
28 State Street
Boston, MA 02109-1775
Attn: Charles Buck Esq.

15.5. Section Captions. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

15.6. Assignment. Manager shall have the right to assign this Agreement without prior written consent of the Company if such assignment is to an affiliate of Manager. The Company shall not assign this Agreement without the prior written consent of Manager. Subject to the foregoing, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and permitted assigns. This Agreement is intended solely for the benefit of the parties hereto and is not intended to, and shall not, create any enforceable third party beneficiary rights.

15.7. Severability. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

15.8. Amendment. No changes in, additions or amendments to this Agreement shall be effective unless and until made in writing and signed by both parties hereto.

15.9. Counterpart Execution. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.

15.10. Integrated Agreement. This Agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations or warranties among the parties other than those set forth herein or herein provided for.

15.11. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Connecticut without regard to its principles of conflicts of laws.

15.12. Waiver. Failure by any party to enforce any of the provisions hereof for any length of time shall not be deemed a waiver of its rights set forth in this Agreement. Such a waiver may be made only by an instrument in writing signed by the party sought to be charged with the waiver. No waiver of any condition or covenant of this Agreement shall be deemed to imply or constitute a further waiver of the same or any other condition or covenant, and nothing contained in this Agreement shall be construed to be a waiver on the part of the parties of any right or remedy at law or in equity or otherwise.

15.13. Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

15.14. Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

15.15. Force Majeure. Neither party shall be liable for any failure, inability or delay to perform hereunder, if such failure, inability or delay is due to any cause beyond the reasonable control of the party so failing, and due diligence is used in curing such cause and in resuming performance.

[Signature page follows]

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their duly authorized representatives effective as of the date and year first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: _____

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF ARTICLE XIV OF THIS AGREEMENT:

HEALTH QUEST SYSTEMS, INC.

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their duly authorized representatives effective as of the date and year first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name: _____
Title: _____

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: President

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF ARTICLE XIV OF THIS AGREEMENT:

HEALTH QUEST SYSTEMS, INC.

By: _____
Name: _____
Title: _____

[Signature Page to Management Agreement]

EXHIBIT A

HIPAA BUSINESS ASSOCIATE AGREEMENT

[SEE ATTACHED]

HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 13th day of September, 2016, by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation (the "Company"), and Vassar Health Connecticut, Inc., (the "Manager"), a Connecticut non-profit corporation ("Business Associate").

1. Purpose. The Company and Business Associate hereby enter into this Agreement because Business Associate provides services for the Company which may involve the use and/or disclosure of individually identifiable health information relating to the Company's patients ("Protected Health Information" or "PHI"). In accordance with the federal privacy and security regulations set forth at 45 CFR Part 160 and Part 164 (the "HIPAA Regulations"), which require the Company to have a written contract with each of its business associates, the parties wish to incorporate satisfactory assurances that the Business Associate will appropriately safeguard the privacy and security of Protected Health Information.

2. Effective Date. The effective date of this Agreement shall be October 1, 2016 (the "Effective Date").

3. Permitted Uses and Disclosures. Business Associate shall not use or disclose any Protected Health Information other than as permitted by this Agreement or the Hospital Management Agreement by and between the Company and Business Associate dated September 9, 2016 (the "Underlying Agreement") in order to perform Business Associate's obligations hereunder or as required by law. Business Associate shall not use or disclose the PHI in any way that would be prohibited if used or disclosed in such a way by Company. Business Associate may also use or disclose PHI as required for Business Associate's proper management and administration, provided that if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring that party (i) to hold the PHI confidentially and not to use or further disclose the PHI except as required by law, and (ii) to notify Business Associate immediately of any instances of which it becomes aware in which the confidentiality of the PHI is breached.

4. Minimum Necessary Information. Business Associate shall only request from Company, and shall only use and disclose, and the Company shall only provide to Business Associate, the minimum amount of PHI necessary to carry out the Business Associate's responsibilities under this Agreement and the Underlying Agreement.

5. Reporting. If Business Associate becomes aware of any use or disclosure of PHI in violation of this Agreement, Business Associate shall immediately report such information to Company. Business Associate shall also require its employees, agents, and subcontractors to immediately report any use or disclosure of PHI in violation of this Agreement. Business Associate shall cooperate with, and take any action reasonably required by, the Company to mitigate any harm caused by such improper disclosure.

6. Agents and Subcontractors. Business Associate shall require its employees, agents, and subcontractors to agree not to use or disclose PHI in any manner except as specifically allowed herein, and shall take appropriate disciplinary action against any

employee or other agent who uses or discloses PHI in violation of this Agreement or the Underlying Agreement. Business Associate shall require any agent or subcontractor that carries out any duties for Business Associate involving the use, custody, disclosure, creation of, or access to PHI to enter into a written contract with Business Associate containing provisions no less restrictive than the restrictions and conditions set forth in this Agreement.

7. Company Policies, Privacy Practices, and Restrictions. The Company shall provide Business Associate with access to the Company's notices, policies, and procedures, including updates thereto provided from time to time by the Company, and Business Associate shall comply with all such notices, policies, and procedures. Business Associate shall assure that each of employees has received appropriate training regarding HIPAA confidentiality and patient privacy compliance issues.

8. Patient Rights. Business Associate acknowledges that the HIPAA Regulations require the Company to provide patients with a number of privacy rights, including (a) the right to inspect PHI within the possession or control of the Company, its business associates, and their subcontractors, (b) the right to amend such PHI, and (c) the right to obtain an accounting of certain disclosures of their PHI to third parties. Business Associate shall establish and maintain adequate internal controls and procedures allowing it to readily assist the Company in complying with patient requests to exercise any patient rights granted by the Privacy Regulations, and shall comply with all Company requests to amend, provide access to, or create an accounting of disclosures of the PHI in the possession of Business Associate or its agents and subcontractors. If Business Associate receives a request directly from a patient to exercise any patient rights granted by the Privacy Regulations, Business Associate shall immediately forward the request to the Company.

9. Safeguards. Business Associate shall use appropriate physical, technical, and administrative safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement and by the Company's privacy and security policies. Upon Company's reasonable request, Business Associate shall allow the Company to review such safeguards; provided, however, that any such review that requires access to Business Associate's facilities shall occur during normal business hours and shall be conducted in a manner that does not disrupt Business Associate's operations.

10. Security.

a. If Business Associate creates, receives, maintains, or transmits electronic PHI (as defined under HIPAA) on behalf of the Company, the Business Associate shall comply with the HIPAA Security Rule and shall:

i. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;

ii. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate safeguards to protect the electronic PHI; and

iii. Report to the Company any security incident of which Business Associate becomes aware. The term "security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system (the parties acknowledge and agree that this section constitutes notice by Business Associate to Company of the ongoing existence and occurrence or attempts of unsuccessful security incidents for which no additional notice to Company shall be required).

b. For purposes of this section of this Agreement, "electronic PHI" shall mean PHI that is transmitted by electronic media or maintained in any electronic media. As used herein, "electronic media" shall mean:

i. Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

ii. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

11. Audits and Inspections. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Company for inspection upon request, and to the Secretary of Health and Human Services to the extent required for determining the Company's compliance with the Privacy Regulations. Notwithstanding the above, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by the Company or Business Associate by virtue of this provision.

12. Termination and Return of PHI. Notwithstanding anything to the contrary in the Underlying Agreement, the Company may terminate this Agreement immediately if, in the Company's reasonable opinion, Business Associate has breached any provision of this Agreement and has not cured such breach within thirty (30) days of Business Associate's receipt of written notice of such breach from the Company. Upon termination of this Agreement for any reason, Business Associate shall, if feasible, return or destroy all PHI received from the Company or created by Business Associate on behalf of the Company. If such return or destruction is not feasible, the parties agree that the requirements of this Agreement shall survive termination and that Business Associate shall limit all further uses and disclosures of PHI to those purposes that make the return or destruction of such information infeasible.

13. Interpretation; Change in Law. Any ambiguity in this Agreement shall be resolved to permit the Company to comply with the HIPAA Regulations. In the event of any inconsistencies between the terms of the Underlying Agreement and this Agreement, the terms of this Agreement shall prevail. The parties acknowledge that the American Recovery and

Reinvestment Act of 2009 ("ARRA") requires the Secretary of Health and Human Services to promulgate regulations and interpretative guidance that is not available at the time of executing this Agreement. In the event Company determines in good faith that any such regulation or guidance adopted or amended after the execution of this Agreement shall cause any paragraph or provision of this Agreement to be invalid, void or in any manner unlawful or subject either party to penalty, then the parties agree to renegotiate in good faith to amend this Agreement to comply with the change in law, regulation or interpretative guidance.

[Signature page follows]

IN WITNESS WHEREOF, the parties hereby indicate their acceptance of this Agreement.

ESSENT HEALTHCARE OF CONNECTICUT, INC. d/b/a Sharon Hospital, a Connecticut corporation

By: _____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties hereby indicate their acceptance of this Agreement.

ESSENT HEALTHCARE OF CONNECTICUT, INC. d/b/a Sharon Hospital, a Connecticut corporation

By: _____
Name: _____
Title: _____

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: Robert Hussey
Title: President

[Signature Page to HIPAA Business Associate Agreement]

EXHIBIT D

Demographics Expert 2.7

2016 Demographic Snapshot

Area: Sharon PSA SSA

Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	140,901	308,745,538
2016 Total Population	137,450	322,431,073
2021 Total Population	135,728	334,341,965
% Change 2016 - 2021	-1.3%	3.7%
Average Household Income	$88,734	$77,135

	2016	2021	% Change
Total Male Population	67,602	66,741	-1.3%
Total Female Population	69,848	68,987	-1.2%
Females, Child Bearing Ag	22,186	21,767	-1.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	20,913	15.2%	18,954	14.0%	19.0%
15-17	5,415	3.9%	5,150	3.8%	4.0%
18-24	11,074	8.1%	11,462	8.4%	9.8%
25-34	13,972	10.2%	14,504	10.7%	13.3%
35-54	36,522	26.6%	31,297	23.1%	26.0%
55-64	22,522	16.4%	24,142	17.8%	12.8%
65+	27,032	19.7%	30,219	22.3%	15.1%
Total	137,450	100.0%	135,728	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	4,308	7.6%	12.3%
$15-25K	4,983	8.8%	10.4%
$25-50K	11,406	20.2%	23.4%
$50-75K	10,568	18.7%	17.6%
$75-100K	8,067	14.3%	12.0%
Over $100K	17,209	30.4%	24.3%
Total	56,541	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	3,851	3.8%	5.8%
Some High School	6,582	6.6%	7.8%
High School Degree	29,169	29.2%	27.9%
Some College/Assoc. Degree	28,127	28.1%	29.2%
Bachelor's Degree or Greater	32,319	32.3%	29.4%
Total	100,048	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	117,307	85.3%	61.3%
Black Non-Hispanic	3,126	2.3%	12.3%
Hispanic	11,509	8.4%	17.8%
Asian & Pacific Is. Non-His	2,905	2.1%	5.4%
All Others	2,603	1.9%	3.1%
Total	137,450	100.0%	100.0%

EXHIBIT E

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

November 1, 2016

T: 860-808-5020
F: 860-808-5347

Robert Friedberg, President
Health Quest Systems, Inc.
1351 Route 55, Suite 200
LaGrangeville, NY 12540

Re: Request for Interpretation of Attorney General's 2001 Decision in Sharon Hospital, OAG Docket No. 01-486-01

Dear Mr. Friedberg:

I write in response to your letter of August 22, 2016, regarding the Attorney General's 2001 Final Decision in the Sharon Hospital conversion case, OAG Docket No. 01-486-01 (the "Sharon Decision"). Specifically, you ask whether four conditions in the Sharon Decision will be applicable to Health Quest Systems, Inc. ("HQ"), a nonprofit 501(c)(3) entity, after it purchases substantially all of the assets of Sharon Hospital from Essent Healthcare of Connecticut, Inc. ("Essent").

The four conditions you identified in the Sharon Hospital Decision are as follows:

1. Community Advisory Board. This condition requires, among other things, that subsequent purchasers of Sharon Hospital must maintain a Community Advisory Board as set forth in the Amended Purchase Agreement between the original, nonprofit Sharon Hospital and Essent.

2. Indigent and Charity Care. The Sharon Decision requires, by reference, that subsequent purchasers of Sharon Hospital maintain indigent and charity care as was the practice of the original, nonprofit Sharon Hospital.

3. Cross-collateralization. This condition prohibited the cross-collateralization of Sharon Hospital's assets for purposes unrelated to Sharon Hospital. The Sharon Decision did not require that this provision must be honored by subsequent purchasers.

4. Notice to Referred Patients. The Sharon Decision required that all patients be fully informed regarding limitations on the scope and range of medical services and "end-of-life care" available to the patient at the hospital or health care institution to which the patient is

referred. The Sharon Decision did not require that this provision must be honored by subsequent purchasers.

After our review of the policies underlying these conditions, the Asset Purchase Agreement pursuant to which HQ will acquire Sharon Hospital's assets, and the Grant Agreement between HQ and the Foundation for Community Health, Inc., we conclude that none of these conditions should apply to HQ. First, HQ, a nonprofit organization, will have a corporate board that will properly represent the community's needs, so there is no need to maintain an Advisory Board of Trustees. Second, because HQ will be obligated to offer indigent and charity care to the community pursuant to federal laws governing nonprofit hospitals, the condition in the Sharon Decision that requires all subsequent purchasers of Sharon Hospital to offer indigent and charity care is unnecessary and, therefore, need not apply to HQ.

The Sharon Decision did not extend the two remaining conditions to subsequent purchasers. Regardless, in the context of this acquisition, the prohibition against cross-collateralization will not benefit Sharon Hospital, and there is no concern regarding the scope services offered at HQ's referral hospitals. Accordingly, these conditions do not apply to HQ.

Should you have any questions regarding this letter, please do not hesitate to contact me.

Very truly yours,

Gary W. Hawes
Assistant Attorney General

EXHIBIT F

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0071

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Essent Healthcare of Connecticut, Inc. of Sharon, CT d/b/a Sharon Hospital is hereby licensed to maintain and operate a General Hospital.

Sharon Hospital is located at 50 Hospital Hill Road, Sharon, CT 06069-2096.

The maximum number of beds shall not exceed at any time:

16 Bassinets
78 General Hospital Beds

This license expires **March 31, 2018** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, April 1, 2016. RENEWAL.

Raul Pino, MD, MPH
Commissioner

SH000358

11/03/2016

EXHIBIT G

ROBERT FRIEDBERG

Cell:
Work: 845-475-5910

Professional Experience

Health Quest Systems, Inc. LaGrangeville, NY 2014 - Present
President

- Vassar Brothers Medical Center Bed Tower CON, Groundbreaking 2019

Health Quest Systems, Inc., LaGrangeville, NY 1999 – Present

Health Quest (HQ) is the Mid-Hudson Valley's largest integrated healthcare system. HQ includes Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center, as well as The Heart Center, Health Quest Medical Practice, Hudson Valley Homecare and the Thompson House. HQ's annual revenue approximates $870 million with more than 6,000 staff, 1,400 medical staff, a total of 697 licensed beds and provides healthcare to 1.5 million residents in the Hudson Valley.

PREVIOUS POSITIONS

Delnor Hospital, Geneva, IL
President & EVP of Operations

Rush Presbyterian/St. Luke's Medical Center, Chicago, IL
Senior Administrator

MacNeal Health Network, Berwyn, IL
Vice President and Chief Operating Officer

EDUCATION & PROFESSIONAL DEVELOPMENT

Cornell University, Ithaca, NY
Master's Degree in Health Administration

University of Rochester, Rochester, NY
Bachelor's Degree

PROFESSIONAL AFFILIATIONS/BOARDS/COMMUNITY ACTIVITIES

LICENSURE & CERTIFICATION

PERSONAL DATA

Married with two children.

GLENN LOOMIS, MD, MSHM, FAAFP

Cell: 859-462-3134
Work: 845-475-9506
Fax: 845-475-9511

Professional Experience

Health Quest Systems, Inc. LaGrangeville, NY Date January 2016 - Present
Title: Chief Medical Operations Officer &
President, Health Quest Medical Practice

Chief Medical Operations Officer:

- Provide leadership for urgent care, ambulatory and physician operations & issues
- Provide leadership for all quality operations in all facilities
- Lead numerous initiatives
- Lead clinical integration start-up and strategy
- Critical role in creating an integrated physician/hospital enterprise.
- **President, Health Quest Medical Practice**:
- Report directly to the Board of Directors and provide executive leadership to a physician organization of 125+ physicians, 200+ providers and 525+ employees
- Oversee group growth and development including practice acquisitions.
- Provide physician leadership for ambulatory HER implementation and optimization.

Health Quest Systems, Inc., LaGrangeville, NY 1999 – Present

Health Quest (HQ) is the Mid-Hudson Valley's largest integrated healthcare system. HQ includes Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center, as well as The Heart Center, Health Quest Medical Practice, Hudson Valley Homecare and the Thompson House. HQ's annual revenue approximates $870 million with more than 6,000 staff, 1,400 medical staff, a total of 697 licensed beds and provides healthcare to 1.5 million residents in the Hudson Valley.

St. Elizabeth Healthcare/St. Elizabeth Physicians, Edgewood, KY 2010 – 2016
President/CEO, St. Elizabeth Physicians
Senior VP, St. Elizabeth Healthcare 2010 – 2015

St. Francis Hospitals/St. Francis Medical Group , Beech Grove, IN 2008 - 2010
President, St. Francis Medical Group
Associate Director, Family Practice Residency Program 1999 – 2002
Physician Advisor, Integrated Case Management 2001 - 2002

Sparrow Health System/Sparrow Medical Group, Lansing, MI 2002 - 2006

PREVIOUS POSITIONS

President, Sparrow Medical Group 2007 – 2008

Carson City Hospital
Member, Board of Directors 2007 – 2008

Mercy Health System
Associate System Medical Director 2005 – 2006
Program Director, Family Medicine Residency Program 2002 - 2006

United States Air Force Medical Corps, Malcolm Grow Medical Center, MD 1995 – 1999
Faculty Physician, Family Medicine Residency
Staff Flight Surgeon & Interim Dept. Chair, Flight Medicine Clinic
Staff Family Physician

EDUCATION & PROFESSIONAL DEVELOPMENT

Department of Health and Human Services
Primary Health Care Policy Fellowship

American Academy of Family Physicians
National Institute for Program Director Development Fellowship

University of North Carolina
Faculty Development Fellowship

University of Texas
Masters of Science in Healthcare Management

Community Hospitals of Indianapolis Family Medicine
Chief Administrative Resident

Ohio State University College of Medicine
Doctor of Medicine

Ohio State University College of Arts and Sciences
Bachelors of Science in Psychology/Biology

PROFESSIONAL AFFILIATIONS/BOARDS/COMMUNITY ACTIVITIES	
American Medical Group Association	2007 - present
American College of Physician Executives	2205 - present
American Medical Association	1998 - present
Kentucky Medical Association	1998 - present
American Academy of Family Physicians	1998 - present
Kentucky Academy of Family Physicians	2011 - present
Indiana Academy of Family Physicians	1999-2002/2009-2010
Michigan Academy of Family Physicians	2007 - 2008
Wisconsin Academy of Family Physicians	2003 - 2008
Indiana State Medical Association	1999-2002/2009-2010
Wisconsin Medical Society	2003 - 2006
Michigan State Medical Society	2007 - 2009
Comprehensive Primary Care Initiative	2012 - 2015
HealthBridge (Regional Health Information Exchange)	2011 - 2015
Indiana Health Information Exchange/Quality Health First	2009 - 2011
Janesville Community Health Center	2006
Central Indiana Coalition to Reinvent Healthcare	2000 - 2002
Central Indiana Health Improvement Council	2001 - 2002
Indiana State Health Commissioner's Chronic Disease Advisory Council	2000 - 2002

LICENSURE & CERTIFICATION

1992 - present:
State of New York Medical License - unrestricted
State of Kentucky Medical License - unrestricted
State of Indiana Medical License - unrestricted
State of Michigan Medical License – unrestricted
State of Wisconsin Medical License – expired
State of Missouri Medical License – expired
1999 - present:
American Academy of Family Physicians, Fellow
1995 - present:
American Board of Family Medicine, Board
1993 - present:

DEA – current registration, active

PERSONAL DATA

Married with three children.

GARY ZMRHAL

3108 Twilight Avenue
Naperville, Illinois 60564

Cell:
Work: 845-475-9538
gzmrhal@health-quest.org

Professional Experience

Health Quest Systems, Inc. LaGrangeville, NY 2014 - Present
Title Senior Vice President and Chief Financial Officer

Health Quest Systems, Inc., LaGrangeville, NY 1999 – Present

Health Quest (HQ) is the Mid-Hudson Valley's largest integrated healthcare system. HQ includes Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center, as well as The Heart Center, Health Quest Medical Practice, Hudson Valley Homecare and the Thompson House. HQ's annual revenue approximates $870 million with more than 6,000 staff, 1,400 medical staff, a total of 697 licensed beds and provides healthcare to 1.5 million residents in the Hudson Valley.

PREVIOUS POSITIONS

CIRE CONSULTING LLC, Naperville, IL 2000-2003, 2004-2005, 2008 - Present
Managing Director

Interim CFO for a Chicago-suburban, acute-care hospital June 2014 -Present

Project Director for a large Chicago-suburban, multi-hospital system January – June 2014

Interim CFO for a Peoria, Illinois, acute-care hospital 2013

Interim CFO for a Topeka, Kansas, acute-care hospital 2010 - 2013

Acting President of Empire Health Foundation in Spokane, Washington 2008 - 2010

SAINT VINCENT CATHOLIC MEDICAL CENTER, NYC 2004 - 2005
Provided executive-level expertise in finance and operations

SAINT JOSEPH'S WAYNE HOSPITAL, Wayne, NJ
Acting CFO

RIVERSIDE HOSPITAL Kankakee, Il 2000 - 2003
Supervisor of Projects, Marketed professional services, planned/directed consulting assignments, and developed/implemented recommendations

HOLY CROSS HOSPITAL, Chicago, IL 2005 - 2008
Vice President and CFO

PREVIOUS POSITIONS

BLACKMAN KALLICK BARTELSTEIN LLP, Chicago, IL — 2003 - 2004
Partner-Consulting/Tax

MACNEAL HEALTH NETWORK AND FOUNDATION, Berwyn, IL — 1996 - 2000
Vice President and CFO

STRATEGIC BUSINESS CONSULTING, Indianapolis, IN — 1993 - 1996
Senior Consultant

ARTHUR ANDERSEN & CO., Chicago, IL and Indianapolis, IN — 1971 - 1993
Indianapolis Tax Partner-in-Charge (1987 to 1993)
Chicago Tax Partner (1983 to 1986)
Chicago Tax Manager (1976 to 1983)
Chicago Senior Tax Accountant (1972 to 1976)
Chicago Audit Staff Accountant (1971 to 1972).

EDUCATION & PROFESSIONAL DEVELOPMENT

Illinois State University
B.S. in Accounting

PROFESSIONAL AFFILIATIONS/BOARDS/COMMUNITY ACTIVITIES

Chartered Global Management Accountant	
American Institute of CPA's Illinois CPA Society	

LICENSURE & CERTIFICATION

PERSONAL DATA

David Ping
Senior Vice President of Strategic Planning and Business Development
Health Quest

David Ping joined Health Quest in September of 2005 and serves as the Senior Vice President of Strategic Planning and Business Development. In this role, David is responsible for the development of the strategic direction for Health Quest and its family of providers. David is also responsible for business development activities, analyzing potential new service offerings, provider acquisitions and increasing volume at Health Quest. David is also responsible for Health Quest Community Education, which provides CPR and other health related courses.

David has a BA from Indiana University and a Master's in Healthcare Administration from the University of Minnesota. David is an adjunct faculty member of University of Minnesota, teaching planning in the MHA independent Study Program.

David was the recent Chair of the American Heart Association Dutchess and Ulster Heart Walks and is the current Chair of the American Heart Association Dutchess and Ulster Board of Directors. He also is on the board of directors of Family Services and Walkway Over the Hudson. David and his wife Cyndie live in Rhinebeck and have three children.

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1/20/16

ROBERT DIAMOND

19 Hopeview Court
Newburgh, NY 12550

Cell: 845-224-5847
Work: 845-483-6790
rdiamond@health-quest.org

Professional Experience

Health Quest Systems, Inc., LaGrangeville, NY 2007 – Present
Title: Chief Information Officer

Responsible for all facets of the IS department of Health Quest Systems and its affiliates. Directly accountable for the management of all IT related executive activities including strategic and operational planning, budgeting (capital/operational), IT leadership staff management, contract negotiations and prospective contract management.

- Ultimately responsible for vendor relations and their adherence to project scope, timelines and budgets.
- Executive owner of the HQ multi-thousand node wide area network and all applications and data that resides on this network.
- Principle owner for both clinical and revenue cycle workflow redesign and standardization across the organization.
- Executive manager over all Bio Med services for the organization.

Health Serve, Inc. (Subsidiary of Health Quest Systems Inc.) 2007 - Present
President
Provides IT related services to a multitude of clients including local health care providers, national organizations and other regional and national hospitals.

Health Quest Systems, Inc., LaGrangeville, NY 1999 – Present

Health Quest (HQ) is the Mid-Hudson Valley's largest integrated healthcare system. HQ includes Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center, as well as The Heart Center, Health Quest Medical Practice, Hudson Valley Homecare and the Thompson House. HQ's annual revenue approximates $870 million with more than 6,000 staff, 1,400 medical staff, a total of 697 licensed beds and provides healthcare to 1.5 million residents in the Hudson Valley.

PREVIOUS POSITIONS

Orange Regional Medical Center, Middletown, NY 2003 – 2007
Vice President of Business Process Management/CIO
Vice President of Information Systems/Chief Information Officer

Kingston Regional Health Care System, Kingston NY 2001 – 2003

Vice President of Information Technology/CIO
Interim CFO, Revenue Cycle

Healthcare Associates, LLC, Lake Katrine, NY 1999 – 2001
Vice President/Chief Information Officer

New York Association of Homes and Services for Aging, Albany, NY 1988 – 1999
Vice President of Information Systems
Director of Information Systems
Applications Programmer

EDUCATION & PROFESSIONAL DEVELOPMENT

New York State University at New Paltz, New Paltz, NY
Bachelor of Arts Degree in Computer Science-Information System/Business Systems

PROFESSIONAL AFFILIATIONS/BOARDS/COMMUNITY ACTIVITIES

NYS Dept. of Health-Data Protection Review Board - Board Member	1995 – 2015
Healthcare Association of New York State-CIO Committee - Member	2004 - Present
Greater Hudson Valley-Regional Health Information Organiz.-Board Member	2006 – 2007
Kingston Board of Education – Board Member	1998 -2001
Kingston City Laboratory – Board Member	2015 – Present
Healthcare Association of New York State	
Health Information Managers Society	
College of Healthcare Management Executives	
Greater New York Hospital Association	
Health Facilities Managers Association	

LICENSURE & CERTIFICATION

PERSONAL DATA

Married; 3 daughters

MICHAEL HOLZHUETER, ESQ.

Cell:
Work: 845-475-9808
mholzhueter@health-quest.org

Professional Experience

Health Quest Systems, Inc. LaGrangeville, NY 2014 - Present
Senior Vice President and General Counsel

Health Quest Systems, Inc., LaGrangeville, NY 1999 – Present

Health Quest (HQ) is the Mid-Hudson Valley's largest integrated healthcare system. HQ includes Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center, as well as The Heart Center, Health Quest Medical Practice, Hudson Valley Homecare and the Thompson House. HQ's annual revenue approximates $870 million with more than 6,000 staff, 1,400 medical staff, a total of 697 licensed beds and provides healthcare to 1.5 million residents in the Hudson Valley.

PREVIOUS POSITIONS

Cadence Health, Chicago, IL
VP and General Counsel

Cleveland Clinic Foundation, Cleveland, IL

University of Chicago Medical Center, Chicago, IL

Advocate Health Care

McDermott, Will and Emery

EDUCATION & PROFESSIONAL DEVELOPMENT

Loyola University Chicago School of Law, Chicago, IL
Juris Doctor (Health Law Focus)
Loyola University
Bachelors in Economics

PROFESSIONAL AFFILIATIONS/BOARDS/COMMUNITY ACTIVITIES

LICENSURE & CERTIFICATION

PERSONAL DATA

Married with two children.

PETER R. CORDEAU, RN, BSN, MBA

43 Rockwall Court • Goshen, Connecticut 06756
(860) 491-1190 • Peter.Cordeau@gmail.com

Exceptionally qualified healthcare administrator, with more than 29 years of experience managing and enhancing operations for reputable healthcare systems ranging from department startups to acute care hospitals with 1500+ employees, serving 200+ patients. Continuously improve performance and level of patient care through effective team leadership and superior clinical skills. Dynamic communicator and motivator, with demonstrated success in forging positive relationships with peers, subordinates, and general public. Key strengths include:

Hospital Administration • Critical & Acute Care Nursing • Staffing • Recruitment • Organizational Development
Case Management • Cross-Functional Team Leadership • Performance Management • Policy Development
Patient Relationship Management • Patient Advocacy • Regulatory Compliance • Training & Development
Grievance & Appeal Claims • Presentations • Emergency Preparedness • Home Care Coordination

PROFESSIONAL EXPERIENCE

SHARON HOSPITAL, Sharon, Connecticut • Chief Executive Officer (March 2016 – present)

Responsible for the overall operation and strategic direction of the hospital. Responsible to the Governing and Advisory Boards for the organization as well as the management of the organization in accordance with policies established by and subject to the direction of the Board. Required to demonstrate fiscal accountability to the Board and corporate parent to ensure appropriate systems and structures are in place for the effective management and control of resources. Highly visible leader in the community, sponsoring, volunteering, and speaking at community events, as well as serving on the Northwest Chamber of Commerce Board of Directors.

SHARON HOSPITAL, Sharon, Connecticut • Interim Chief Executive Officer (November 2015 – March 2016)

SHARON HOSPITAL, Sharon, Connecticut • Chief Nursing Officer / Chief Operating Officer
(October 2013 – November 2015)

78 bed for-profit, full service community hospital, servicing Connecticut, New York, and Massachusetts. Work in collaboration with CEO and CFO in the development of strategic, financial, and operational plans for the organization. Responsible for the performance and operations of all inpatient nursing units, ED, Wound Care, Pharmacy, Senior Behavior Health, Radiology, Lab, HIM, and CRM.

- Improved HCAPH scores from 56th to 76th percentile
- Redesigned inpatient organizational structure improving patient throughput, employee satisfaction, and physician satisfaction.
- Recruited, hired, and oriented 5 new clinical directors (Surgical Services, OB, ICU, Med/Surg, and Senior Behavioral Health).
- Eliminated the need for travel nurses and contracted sitters, reduced overtime, improved staffing coverage, resulting in decreased year over year salary expenditure.
- Redesigned radiology scheduling process to improve patient throughput, employee satisfaction, and physician satisfaction.
- Created position control for all inpatient units to accurately assess and address staffing needs and replacement factor for all departments.
- Participate in Governing Board of Directors, Advisory Board of Directors, Medical Executive Committees, Physician Leadership Council, and all clinical section meetings.

ST. MARY'S HOSPITAL, Waterbury, Connecticut • (June 2002 – October 2013)
200-bed non-profit acute care inner-city hospital, servicing greater Waterbury community; teaching hospital affiliated with the Yale School of Medicine.

Director Cardiac Service Line – (April 2012 – October 2013)
Director of the first ever Cardiac Service Line. Management and leadership of thirteen cost centers and 300+ employees. Responsibilities as listed below in addition to managing Cardiology, Cath lab, EKG, EP, EEG, Respiratory, Rehab, and Laboratory.

Director of Critical Care, CVU, and Telemetry (October 2008- April 2012)
Nursing Director for Critical Care, Telemetry and Cardiovascular Unit (CVU). Responsible for the management of a 14.8 million dollar budget, 120 clinical and non-clinical staff, 6 mid-level practitioners and 2 Clinical Managers.

- Co-chair Clinical Content and Process committee for EMR rollout.
- Received Gold Awards in both CHF and AMI from American Heart Association
- Increased voluntary retention from 80% to 95%.
- Improved staff satisfaction to 93rd percentile in recent 2011 Health Stream staff satisfaction survey.
- Created corrective action plans in response to Department of Public Health (DPH) and Centers for Medicaid and Medicare Services (CMS) audits.
- Created Cardiac Quality Workgroup to review all PCI and open heart surgery quality markers.
- Developed throughput analysis resulting in improved employee satisfaction, patient satisfaction, decreased ED wait times and increased throughput.
- Developed and championed the new "Falling Star" program which has reduced falls by greater than 40% over two years.
- Developed processes and procedures to eliminate central line associated blood stream infections (CLABSI's); effectively reducing CLABSI's to a median of zero over the past twelve months.

Clinical Nursing Supervisor (2004-2008)
Manage hospital administration during 16-hour period (3pm-7am); Managed 100+ employees daily, from ER doctors to housekeeping staff. Oversee staffing of entire hospital, balancing financial needs of hospital without sacrificing patient care. Directly supervise and manage "float pool," comprised of 7 RN's, 4 nurse aides, and 2 clerical staff. Maintain working relationship with state and local police, Connecticut Organ Bank, and State Medical Examiner.

- Garnered a Service Excellence Award for loyal and dedicated service in May 2008.
- Ensured preparation for any internal or external disaster.
- Interfaced with local media pertaining to sensitive patient information; ensured HIPPA regulations were adhered to accordingly.
- Collaborated with underprivileged families to assist with funeral arrangements and provide appropriate referrals and contacts on their behalf.

Staff Nurse, Intensive Care Unit (2002-2004)
Managed direct patient care for critically ill (ACLS certification required for position).

- Functioned as preceptor for new hires as well as nursing students.
- Served as patient advocate between patient, family, and medical team.
- Assisted families with coping and life changing decisions.

AETNA U.S. HEALTHCARE, Middletown, Connecticut • 1998-2002
One of the nation's leading healthcare companies.

Healthcare Consultant, Grievance & Appeals Unit (2000-2002)
Retroactively reviewed previously denied claims. Made determinations for authorization or denial of claims based on ISD and M&R guidelines .Collaborated frequently with Medical Directors and Department of Insurance.

Concurrent Review Nurse (1999-2000)
Reviewed clinical information on members' inpatient hospitalizations. Certified or denied days based on ISD and M&R guidelines.

Diabetes Disease Case Manager / Home Care Coordinator (1998-1999)
Reviewed cases by diagnostic set, i.e. a diagnosis of diabetes. Reviewed pharmacy records and hospital admissions, focused on disease prevention. Educated members and provided resources to avoid hospitalization. Conducted regular presentations of disease/case management program to participating providers. Coordinated home care and durable medical equipment for states of Connecticut, Rhode Island, New York, New Hampshire, and Massachusetts.

- Facilitated development of new Home Care department from ground up in 6 months; encompassed implementation of new policies/procedures.

OMNI HOME HEALTH SERVICES, Wallingford, Connecticut • 1995-1998
Largest for-profit home health agency in State of Connecticut at the time (now defunct).

Case Manager, Corporate Office (1997-1998)
Served as Case Manager for all managed care contracts as part of corporate team. Contracts included MDHP, Oxford, Northeast Health Direct, Connecticut Health Plan, and Medspan.

Director of Patient Services (1995-1997)
Managed 40 licensed and non-licensed staff at agency's largest branch; encompassed hiring, firing, annual reviews, and licensure requirements. Also oversaw contract employees (Physical Therapy and Occupational Therapy were outsourced). Ensured appropriate allocation of staff to provide services to meet clients' needs daily; also maintained excess capacity in order to provide same-day service for unexpected referrals. Ensured compliance with state and federal regulations.

- Doubled census in first 3 months by marketing services to area hospitals and ECF's.

EARLY CAREER NOTES (full details on request)

INTERIM HEALTH CARE, Middlebury, Connecticut / Case Manager • Sales Representative

ST. MARY'S HOSPITAL, Waterbury, Connecticut / Intensive Care Unit Staff Nurse

EDUCATION

Master of Business Administration
University of Hartford, West Hartford, Connecticut

Bachelor of Science, Nursing (BSN)
University of Connecticut, Storrs, Connecticut

ADDITIONAL TRAINING

Advanced Cardiac Life Support

Baptist Leadership Training

PROFESSIONAL ACTIVITIES

HPI – (Healthcare Performance Institute) High Reliability Trainer
Member ONE – CT (The Organization of Nurse Executives-Connecticut)
Northwest Chamber of Commerce Board of Directors
Chairman of Clinical Content and Process Committee for electronic health record transition 2010
Chairman SMH Cardiac Quality
Co-Chair Joint Quality Oversight Committee
Co-chair St. Mary's Employee Enrichment Grant Fund
Member of Editorial Advisory Board for "The Compass" (Hospital Newsletter)
Executive Leader 2008-2009 Connecticut Hospital Association (CHA) Falls Collaborative
Executive Leader Blood Stream Infection Collaborative in conjunction with Johns Hopkins University 2009
Executive Champion CAUTI collaborative with Connecticut Hospital Association

CHRISTIAN S. BERGERON

43 Marjorie Lane • Manchester, Connecticut 06042
CBergeronCT@aol.com • 860.918.6072 (C)

FINANCE PROFESSIONAL

A result oriented Finance Professional with extensive experience in healthcare, financial analysis, cost accounting, reporting and process improvement with a history of partnering effectively with line management and senior leadership in order to deliver solutions that achieve business objectives. Strong negotiator, communicator, and leader with high integrity level, courage to make tough decisions and proven success in developing and retaining talented financial teams.

Core Competencies include:

- Strategic Financial Planning
- Cost Reduction & Control
- Financial Analysis & Modeling
- Reporting & Forecasting
- Operational Efficiency
- Business Case Modeling
- Capacity Planning
- Cost Accounting
- Team Building & Coaching

Key Accomplishments include:

- **Identified and implemented numerous cost saving initiatives and processes, resulting in savings of over $15+ million in ongoing expenses**
- **Conceptualized, developed, and launched capacity planning models that became a vital tool utilized across the operations organization.**
- **Extensive IT infrastructure and consumption analysis, resulting in significant rebates to business segment.**
- **Identified and negotiated over $2+ million of contractual savings.**

PROFESSIONAL EXPERIENCE

FALLON COMMUNITY HEALTH PLAN — WORCESTER, MASSACHUSETTS

SENIOR DIRECTOR, STRATEGIC COST ANALYSIS — (2011 TO CURRENT)

Responsible for: Cost Accounting, Expense Control, Procurement, Facilities, Business Continuity Planning, Accounts Payable, Payroll, Strategic Planning, and Competitive Analysis

Brief Description: Partner with Senior Leadership on the development of strategic plans and the identification of emerging cost trend changes. Hands on development and maintenance of cost accounting models utilized for pricing. Actively support State and regulatory filing requirements (e.g. NAIC Supplement, DOI Supplement, MLR reporting, product expansion efforts). Negotiation of all non-provider related contracting and procurement efforts. Management of accounts payable and payroll functions. Real estate management activities (approx. 170,000 sqft.) including business continuity, disaster recovery planning, landlord relations, space planning and general building maintenance.

Report To: Chief Financial Officer ***Direct Reports:*** 9 finance professionals

Selected Achievements:

- Identified and negotiated **over $2M of contractual savings**.
- Developed **activity based costing model focused on providing insight and transparency** to Fallon administrative cost structure by line of business.
- Instituted several administrative **process improvements**. For example, established American Express Corporate Card program, payroll deposit of employee expense reimbursements, and payroll self-service.
- Concurrent real estate expansion and site build out of 5 locations across Massachusetts.

CHRISTIAN S. BERGERON • CBergeronCT@aol.com • (860) 918-6072

CIGNA — BLOOMFIELD, CONNECTICUT

CONTROLLER/MANAGER, IT FINANCE (2008 TO 2011)

Responsible for: Financial Reporting and Analysis, Month Close, IT Project Controller

Brief Description: Partner with IT leadership to accurately forecast project spends, execute monthly close and consolidated reporting for project (capital) portfolio. Conduct ad-hoc portfolio analysis and research required for specific cost/benefit requests. Develop controls and process improvements to increase efficiency and accountability across the project controller function.

Report To: Senior Director ***Direct Reports:*** 2 finance professionals

Selected Achievements:

- Developed new ledger structure to **improve accountability, control and expense transparency** across the project portfolio.
- Conducted **activity analysis focused on providing a competitive comparison and recommendations** associated with specific system capabilities.

UNITEDHEALTH GROUP — HARTFORD, CONNECTICUT

DIRECTOR, STRATEGIC COST MANAGEMENT (UNITEDHEALTHCARE) (2004 TO 2008)

Responsible for: Cost Accounting, Financial Analysis, Cost Control and Sales Incentive Administration

Brief Description: Partnered with CEO, CFO and Departmental Vice Presidents on articulating cost trend changes and proposing recommendations on go-forward pricing. Hands on maintenance of cost accounting models utilized for internal and external pricing. Conducted ad-hoc financial analysis and research required for specific costing requests. Development and execution of organizational expense control plans.

Report To: Chief Financial Officer (2004 – 2007) *VP* (2008) ***Direct Reports:*** 5 finance professionals

Selected Achievements:

- Created and implemented expense savings programs, producing **over $3 million in operational savings** during tenure.
- Conceptualized, customized, and implemented **customer level profitability reporting** enabling accurate determination of price penetration opportunities across specific books of business.
- **Increased program member retention by 10%** through participating in creation of targeted rebate program.
- Key **participant in extensive IT infrastructure project** which analyzed, targeted, and made recommendations regarding application consumption and transactional activity.

DIRECTOR, MANAGEMENT REPORTING & INTERCOMPANY PRICING (UNIPRISE) (2004)

Responsible for: Reporting and Forecasting, Financial Analysis, Intercompany Transactions

Brief Description: Held full accountability for supporting operations and IT monthly closing processes and variance analysis. Perform intercompany price negotiations, forecasting, and variance analysis.

Report To: Vice President ***Direct Reports:*** 8 finance professionals

Selected Achievements:

- Controlled costs through **establishment of internal practices and authorization procedures** *around purchasing of certain intercompany services.*
- Reduced staffing by 2 associates while **improving productivity by 20%** through consolidation of activities and cross-functional training.

COST CONTROLLER (UNIPRISE) (2002 TO 2004)

Responsible for: Cost Control, Operational Efficiency, Strategic Financial Planning, Analysis and Modeling

Brief Description: Evaluation, initiation, monitoring and tracking of business sponsored expense reduction initiatives that delivered true value to the enterprise.

Report To: Director ***Direct Reports:*** 5 finance professionals

Selected Achievements:

- Researched, data mined, and project managed a bulk mailing of Explanation of Benefits, reducing number of mailing and **generating $10 million** in postage savings.
- Member of team that **performed emergency recovery of third party billing vendor.** Remediation and recovery efforts included: contract negotiations, financial remediation, action plans to re-establishing service standards, and training staff.

REGIONAL FINANCE MANAGER (UNIPRISE) (1999 TO 2002)

Responsible for: Financial Planning and Analysis, Reporting, Operational Efficiency, Accounting

Brief Description: Managed all aspects of financial planning, budget and analysis for 6 claim / customer service centers in the Northeast region.

Report To: Regional Vice President ***Direct Reports:*** Individual Contributor

Selected Achievements:

- Spearheaded migration of all Flexible Spending Account administration into single site.
- Designed and introduced **site level capacity planning models** for managing claims and call center operations, adopted for national application.
- Developed northeast region disaster recovery plans and project managed Y2K readiness initiatives.

BUSINESS MANAGER (UNIPRISE) (1997 TO 1999)

Responsible for: Frontline Management, Financial Planning and Analysis, Mail Operations

Brief Description: Managed daily claim inventories, service levels, and proactive relationship with national account employer groups on a daily basis.

Report To: Site Director ***Direct Reports:*** 30 claim & customer service professionals

Selected Achievements:

- Established and developed teams that consistently ranked **1 or 2 in service, productivity, and quality.**
- Created internal standards enabling **no performance payouts** to accounts during tenure.

ST. PETER'S HOSPITAL ALBANY, NEW YORK

FINANCIAL TRANSACTION COORDINATOR (1992 TO 1997)

Responsible for: Financial Analysis and Modeling, Operational Efficiency, Accounting, Internal Controls

Brief Description: Supported Medicare and Medicaid cost reporting compilation. Provided financial analysis on insurer contract proposals and physician owned practices. Oversaw account receivables collection, cashier's office, audit and internal control functions.

Report To: Director ***Direct Reports:*** 5 clerical / accounting professionals

Selected Achievements:

- **Selected to Physician Orthopedic Council** charged with evaluation of physician cost efficiency relating to specific procedures.
- Optimized collection vendor selection, improving overall **collection recovery rate by 10%**.

CHRISTIAN S. BERGERON • CBergeronCT@aol.com • (860) 918-6072

PREVIOUS EMPLOYERS	ALBANY, NEW YORK
ALBANY MEDICAL CENTER – Albany, New York	1991 to 1992
HOME AND CITY SAVINGS BANK – Albany, New York	1989 to 1991

EDUCATION AND CREDENTIALS

Master of Business Administration (Honors) • UNIVERSITY OF HARTFORD – West Hartford, CT (2009)

Bachelors of General Studies • UNIVERSITY OF CONNECTICUT – West Hartford, CT (2006)

Associates in Applied Science (Accounting) • HUDSON VALLEY COMMUNITY COLLEGE – Troy, NY (1995)

SAS Activity Based Software Training – Minneapolis, MN (2008)

Dale Carnegie Institute Certification – Albany, NY (1994)

COMPUTER SKILLS

Proficient in: Excel, Word, PowerPoint, Visio, and Outlook

PROFESSIONAL ASSOCIATIONS & HONORS

Healthcare Financial Management Association (2008 to Present)

Beta Gamma Sigma – University of Hartford (Honors)

Lori Puff

20 Woodland Rd., Craryville, NY 12521 Cell (518) 965-5540 lori_puff@yahoo.com

PROFESSIONAL SUMMARY

Chief Nursing Officer with twenty years of health care experience with a passion for generating results through people, innovative approaches, and teamwork. Proven expertise in creating positive professional practice environment with emphasis on high quality care, patient experience, and patient safety; strong departmental strategic planning, operations management, problem solving, decision making, and change management.

SKILLS

Adept at prioritizing deadlines	Regulatory compliance	Professional integrity
Patient focused care	Critical care nursing	Staffing management

WORK HISTORY

Sharon Hospital – 50 Hospital Hill Rd., Sharon CT 06069

Chief Nursing Officer - promoted and accepted 11/2015

- Provide direct leadership and oversee day to day operations for: Nursing, Surgical Services, Senior Behavioral Health, Pharmacy, Wound Care Center, Advanced Therapy, Radiology, and Laboratory
- Oversee productivity, hiring, budget, quality measures, and patient satisfaction
- Utilized management skills to successfully guide the team through a state DPH and CMS survey
- Collaborate with CQO to organize monthly quality reporting for corporate review
- Attend and present to Medical Staff Committees, Medical Executive Committee, and Governing Board
- Report to CEO

Chief Quality Officer, Safety and Risk Officer – promoted and accepted 10/2012

- Provided direct leadership and day to day oversight of: Quality, Infection Control, Nursing Supervision, and Bio-Med
- Enhanced the quality program adding structure to ensure regulatory compliance; successfully led team through Joint Commission Accreditation survey; Recognized by Joint Commission as Top Key Performer on Key Quality Measures
- Analyzed organizational data to improve processes and/or implement evidence based practice
- Chaired Fall Prevention Committee for eight hospital system developing best practices in fall reduction strategies
- Collaborated with CMO to improved relationships between nursing and physicians
- Planned, coordinated, and implemented Patient Safety Program for 500+ employees/physicians, transforming culture to High Reliability Organization
- Obtained Rural Health grant two consecutive years; instrumental in coordinating system wide use of CPOE
- Collaborated with Medical Staff Coordinator with direct oversight of FPPE, OPPE, and Peer Review process

Director of Nursing Resources – 4/2011 – 10/2012

- Provided direct leadership to Nursing Supervision; collaborated with nursing directors to improve communication
- Functioned in Nursing Supervisor role; direct oversight of organization, reported to clinical directors and CNO

Columbia Memorial Hospital – 71 Prospect St., Hudson, NY 12534

Assistant Director, Emergency Services – 12/2003 – 12/2013

- Provided leadership and managed 22 bed emergency department, 35.000 annual visits; monitored budget to ensure financial objectives were met
- Responsibilities included staffing, coordination of services, and evaluation of activities in accordance with organizational policies, regulatory and union guidelines
- Ensure patient safety, delivery of quality care, improved patient and staff satisfaction; supported just culture and self-governance model

Lori Puff

20 Woodland Rd., Craryville, NY 12521 Cell (518) 965-5540 lori_puff@yahoo.com

- Minimized staff turnover through initiation of peer interview process, improved orientation process and staff education and competency development
- Collaborated with medical, staffing, and ancillary personnel in Lean Design project; improving patient flow
- Participated in planning expansion project for psychiatric services within emergency department; developed staffing model and mental health worker job description

Hudson Valley Hospital Center – 1980 Crompond Rd., Cortlandt Manor, NY 10567
Clinical Coordinator, Emergency Services 09/2000 – 12/2003

- Level II Trauma center, 36, 000 annual visits; assisted with restructuring staffing for efficiency of patient flow
- Planned, coordinated, organized, and directed nursing assignments; coordination of patient flow
- Collaborated with peers to coach and develop a care team consistently ranked among the top in the region for key clinical performance
- Provided administrative and clinical leadership to nursing staff; evaluated employee performance, supported a just culture

Sound Shore Medical Center of Westchester – 16 Guion Place, New Rochelle, NY 10802
Registered Nurse, Staff/Charge Emergency Services 07/1996 – 09/2000

- 350 bed community based teaching hospital, Level II Trauma Center
- RN position 42 bed surgical unit with step-down unit, rotated charge nurse position
- Transfer to Emergency Department after one year of service, promoted to Charge Nurse role within first year of transfer
- Evaluated and prioritized patient needs, treatment, and maintained patient flow
- Conducted probationary and annual job performance of nursing and ancillary staff

EDUCATION

State University of New York, Institute of Technology, Utica, NY
Master of Science: Nursing Administration, 2014
Bachelor of Science: Nursing, 2007

ACCOMPLISHMENTS

- Recipient of Connecticut Rural Health Grant 2013-14, 2014-15
- Developed and chaired multidisciplinary Fall Prevention team, reduced fall rate by 75%
- Implemented concurrent Core Measure review process, improving overall compliance to ≥95%
- Reduced serious safety events by 50% within first year of implementing patient safety program

LICENSURE

- Registered Nurse – New York State
- Registered Nurse – Connecticut

PROFESSIONAL PRESENTATIONS

- Invited: Healthcare Performance Improvement, presenter at National Safety Summit 2015, "Building a culture of safety; Successes and challenges of a small rural hospital"
- Invited: Emergency Nurses Association, National annual conference 2007, "Emergency Preparedness"

EXHIBIT H

State of Connecticut

SENATE

SENATOR CLARK CHAPIN
THIRTIETH DISTRICT

LEGISLATIVE OFFICE BUILDING
SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
Capitol: (800) 842-1421
E-mail: Clark.Chapin@cga.ct.gov
Website: www.SenatorChapin.com

DEPUTY MINORITY LEADER

RANKING MEMBER
ENVIRONMENT COMMITTEE

CHAIR
REGULATIONS REVIEW COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE

November 2, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Dear Deputy Commissioner Addo:

I write in enthusiastic support of Sharon Hospital's request for a Certificate of Need (CON). Upon obtaining a CON, Sharon Hospital will be able to complete the process of transitioning to a non-profit hospital and join a group of other non-profit hospitals known as Health Quest.

As a member of the Sharon Hospital Advisory Board for the past four years, I can personally vouch for the expert level care that the hospital consistently provides to residents of northwest Connecticut. With your approval, area residents will have improved access to a high level of quality care for years to come.

Thank you for your consideration of this worthwhile request.

Sincerely,

Clark

Clark J. Chapin
State Senator, 30th District

October 20, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am currently an Attending Staff Physician at Sharon Hospital and serve as the Medical Director for the Department of Emergency Medicine. I am writing to support the proposed acquisition of Sharon Hospital into the HealthQuest hospital network.

As part of a larger healthcare system, Sharon Hospital will have access to a wealth of resources that will ultimately serve and benefit our local community. As an ED physician, I have seen firsthand and continue to experience on a daily basis the impact that a hospital has on its community's quality of life, both in the acute phase of an illness as well as the ongoing care that is often required.

A partnership between our hospital and HealthQuest will allow us to pool our resources and offer specialty services locally instead of requiring our patients to drive to another part of the state to obtain. Furthermore, the financial stability that a larger health system affords will allow us to focus on our main goal, taking care of people.

Thank you for your time,

Ron M. Santos, DO, JD
Medical Director
Department of Emergency Medicine
Sharon Hospital

November 1, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I have lived in Lakeville CT for 17 years and work as an Emergency Physician at Sharon Hospital and Fairview Hospital (Great Barrington, MA). Sharon Hospital is a critical part of this community. In addition to providing crucial access to health care (that would otherwise necessitate a 45 minute drive in any direction, including for Emergency Department services), Sharon Hospital provides jobs, for many is an important part of the decision to live in the area, and is an important component of outpatient community health.

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

I believe that Health Quest represents the best possible solution for the current financial and clinical challenges that Sharon Hospital faces today. I am very worried that Sharon Hospital will be forced to eliminate clinical services and at worst, close its doors, if this acquisition agreement is not completed.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

Arthur Eugene Chin, MD

59 Old Asylum Road

Lakeville CT 06069

gchinsem@sbcglobal.net

Mark J. Marshall, DO, MA, FACP,FHM
Board Certified in Internal Medicine and Palliative Medicine
Director of the Hospitalist Program
Chief Medical Officer,
Sharon Hospital
50 Hospital Hill Road
Sharon Connecticut 06069

Ms. Yvonne T. Addo, MBA, Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308
October 17, 2016

Dear Ms. Addo,

I wish to express my support for the pending sale of Sharon Hospital to Health Quest. I have been on the medical staff at Sharon Hospital for the last seventeen years. During this time I have served as Associate Chief of Staff, Chief of Staff and most recently, Chief Medical Officer. I have always found Sharon Hospital to be a place of great caring. Our administration is always striving to provide the best care possible for our patients close to home.

The partnership between Sharon Hospital and Health Quest will bring much needed medical expertise and capital to our hospital and our community. The availability of a regional tertiary care partner will improve access to subspecialty services for our patients and our families. In addition, our reversion to not-for-profit status will allow us to reconnect with local community organizations and participate in joint projects for the purpose of improving the health of our neighbors. Please support the approval of the certificate of need for the sale of Sharon Hospital to Health Quest.

Thank you,

Mark J. Marshall, DO

October 17, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing to support the CON for Sharon Hospital to join the Health Quest hospital network and convert to not-for profit status. I have been an active member of the Sharon Hospital Medical staff since 2005. I presently serve as the Chairman of Medicine and the Medical Director of the Wound Center.

While I greatly appreciate the support and administrative expertise of Sharon Hospital's corporate partners over the years, I do feel it is time for our community hospital to strengthen local ties while becoming part of a larger regional network.

I am excited that significant new capital investments in our facility are planned. I foresee opportunities to reestablish and expand services in areas such as oncology subspecialties that were withdrawn over the years by other regional health networks. I am also pleased that we will again be able to partner with The Foundation for Community Health to improve the health of our citizens.

Thank you for your consideration,

Douglas A. Finch, MD, FIDSA

Chairman of Medicine
Director, Sharon Hospital Wound Center
Sharon Hospital

November 1, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am a retired pediatrician on the Emeritus Medical Staff of Sharon Hospital after practicing for 30 years with offices in Sharon and Canaan, Connecticut and with significant numbers of patients in adjacent New York State and Massachusetts.

I have watched Sharon Hospital change since I arrived in 1962. It was very busy and expanded into the 1980's. Then it experienced a time of little growth followed by retrenchment, especially as high tech specialty care developed. This led to our having to send out many patients that we used to treat. This resulted in the eventual sale of the Hospital to a for profit company based in Tennessee, which has itself been sold twice. With these sales we lost much of the local control we previously enjoyed. Now Health Quest, working in towns adjacent to our New York service area, wishes to buy us, returning us to local and near local control as a non-profit entity.

I have been on the Board of the Foundation for Community Health for most of the time since its inception in 2003. We have thoroughly investigated Health Quest for over a year. We believe it is a responsible, well run operation that will stabilize Sharon Hospital and improve the delivery of care to our citizens.

I sincerely believe the sale should be approved.

John W. Gallup, MD

COPY

SEP 26 2016

23 Gay Road
Millerton, New York 12546
September 23, 2016

Mr. Peter Cordeau
CEO
Sharon Hospital
50 Hospital Hill
Sharon, CT 06069

Dear Mr. Cordeau:

My husband and I were absolutely thrilled to read that Sharon Hospital will be joining HealthOuest in New York State.

We are a retired couple who have United Healthcare coverage but our plan (MedicareComplete Choice) is limited to New York State and specific counties. Therefore, Sharon Hospital and its doctors have been "out of network" for us. We have lived all our lives in Sharon and/or Millerton and enjoyed using Sharon Hospital and doctors for our health care. In addition, I was a Sharon Hospital employee for 22 years.

A couple of years ago I made the mistake of using a Sharon, CT physical therapy facility thinking it was "participating" in my plan. Actually, they thought so too since they did participate in United Healthcare but, not our particular plan. After several visits I received my EOBs only to discover I owed an "out of network" balance. Neither the facility nor I thought I would be billed in that way and we made many phone calls and wrote many letters of complaint to UHC. Eventually, UHC agreed to the "in network" fees but admonished me and encouraged me to be more careful about where I received my care in the future. I also wrote to my NYS Senator and Congressman stating that all insurances should be able to cross state lines; especially border states when the nearest hospital is located there.

Since that time my husband and I have chosen doctors in Dutchess and Columbia counties but we have to travel anywhere from 20 to 35 or more miles each way. As we continue to age this would be even more of a burden. You can see why it is such a relief to know that in the near future we will once again be able to use our favorite facility (seven minutes away) and its doctors. From what I have read and heard I know that Sharon Hospital will flourish under its new leadership.

With all best wishes going forward as Sharon Hospital's CEO.

Sincerely,

Diane Walters

Diane Walters

FOUNDATION
for
COMMUNITY
HEALTH

Prevention, Access, Collaboration

October 28, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

As the CEO of the Foundation for Community Health, I write this letter in support of Health Quest Systems, Inc.'s acquisition of Sharon Hospital from Regional Care, a for-profit corporation based in Tennessee.

Integrating Sharon Hospital into Health Quest is a perfect option for the residents of Northwestern Connecticut and will have a dramatic effect on enhancing healthcare in the region. Health Quest is a local nonprofit organization and is an active member of the communities it serves. It has a proven track record of running hospitals and other practices in small communities, with successful operations in Rhinebeck and Carmel. Its system hub, Vassar Brothers Medical Center in Poughkeepsie, provides access to the quality of care and patient experience the region's residents deserve. Health Quest reinvests in its communities and is committed to bringing both technological innovation and top physicians into its markets. The same would be true in Sharon. The Health Quest communities take pride in their hospitals and share the same core values. I firmly believe the Sharon community will equally embrace that commitment to these values.

As a local nonprofit organization, Health Quest's only shareholders are the communities it serves. Its "profits" are reinvested in the system, updating facilities, purchasing the latest technology and hiring the best physicians, nurses and staff members, whose commitment to healthcare is second to none.

About one-third of the residents who go to Sharon Hospital, especially on the New York side, already go to Health Quest for their tertiary care. The system is developing a hub-and-spoke system with Vassar Brothers Medical Center in the center and the other hospitals and affiliates as the healthcare arms that reach into the outlying communities. On the eastern side of this wheel, Sharon Hospital will mesh well as an important addition to the population health model, opening up access for multidisciplinary, specialized care in the eastern Dutchess County, New York, northwestern Connecticut region.

Health Quest has the Foundation's full support and we look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Nancy L. Heaton, MPH
Chief Executive Officer
Foundation for Community Health

The Foundation for Community Health (FCH) is a private, not-for-profit foundation dedicated to improving the health and wellbeing of the residents of the greater Harlem Valley in New York and the northern Litchfield Hills of Connecticut with an emphasis on serving those most vulnerable. FCH works with health and social service providers, other foundations and with government for change that improves rural health and rural healthcare delivery systems.

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

Gertrude O'Sullivan

Director of Communications & Special Programs

Foundation for Community Health

November 2, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

As Administrator of a nursing home and retirement village located 8 miles from Sharon Hospital I can attest to the crucial services they provide to our residents on a daily basis. We are dependent on their services and the availability of critical care for our elderly population. As a resident of the same area I am greatly enthused by the possibility of the hospital returning to not for profit status.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family. I hope for a speedy and favorable decision on behalf of the Health Quest proposal.

Sincerely
Eileen M. Mulligan

Eileen M. Mulligan

Administrator

Noble Horizons

Salisbury, CT

October 31, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care.

I am a full-time resident of Millbrook and I frequently use Sharon Hospital and feel so lucky to have it in our community. I delivered both of my children there, and we have visited the Sharon Emergency Room for various bumps and bruises over the years and we also frequently use the lab for blood work, etc., etc.

Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

Krista B. Fragos

Krista B. Fragos
183 Route 343
Millbrook, NY 12545

Karren Garrity, LPC

56 Elizabeth Street Kent, CT 06757 860.927.1464

October 31, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

As a fulltime, 28 year resident, and local business owner in Kent, CT I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. I am very excited about the possibility of Health Quest taking the reins of Sharon Hospital. Not only is Health Quest is a not-for-profit, locally based organization but it has also demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my complete support is their goal of acquiring Sharon Hospital.

Sincerely,

Karren Garrity

Miriam Tannen
796 Camby Road
Millbrook, NY 12545

October 31, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

As a resident of this Community, Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family. I think it is important to this Community that Sharon Hospital returns to its not-for-profit status. The services that Health Quest brings to a Community are sorely needed in our area that serves residents of both NYS and Connecticut.

Sincerely

Miriam Tannen

Grace Episcopal Church, Millbrook, NY

Grace Latino Outreach

GLO

Lighting the Future ~ Iluminando el Futuro

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

As at Not-for-Profit in the Northeastern Dutchess area we have many of our immigrant community population who will be dependent on this organization to be a part of the community and the population. We are looking forward to working very closely with Health Quest to ensure that this community is able to have their health care needs met.

Health Quest has our full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Evelyn E. Garzetta

Director Grace Latino Outreach
917-705-9600

EGE

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Evelyn E. Garzetta

29 Briarwood Lane
Millerton, New York 12546

Evelyn E. Garzetta

917-705-9600

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

As a member of the community for over 45 years, a member of the Sharon Hospital staff for 12 years when it was still not for profit, and a member of the FCH Board who has been active in working with HealthQuest in acquiring Sharon Hospital, I strongly support Sharon Hospital becoming a part of the HealthQuest care system.

I and my colleagues have looked carefully at Sharon Hospital and the structure and functioning of the HealthQuest system. They have demonstrated their high levels of competence in running hospitals and in assuring steady consistent meaningful quality improvement.

Keeping the hospital in a very respected locally based health system, bringing it back to a not for profit status, and expanding and improving services is very important to me and all the members of the community I have spoken with.

Having the depth and scope of a tertiary system reassures me that Sharon Hospital will continue to have an important place in our community and a meaningful future.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

John Charde, MD

October 31, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. I am a resident of Millbrook and I frequently use Sharon Hospital. Both of my children were born there, and we have gone to Sharon for various bumps and bruises over the years. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

James G. Snyder
183 Route 343
Millbrook, NY 12545

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family. It will be wonderful to have locally based, expanded and improved access to services for the Sharon Hospital catchment area, as the medical care provided here has been vital to so many members of our communities. My children were born at Sharon Hospital; I taught prepared childbirth classes at Sharon Hospital for over fifteen years; and both my parents received their end of life care Sharon Hospital when it was a quality not-for-profit hospital. As a community member I support this acquisition and conversion back to not-for-profit status.

Currently, I am the Board Chair for the Foundation for Community Health and we are very excited to support this acquisition and return to not-for-profit status. The FCH Board looks forward to working closely with Sharon Hospital and Health Quest during this transition process.

Sincerely,

Nancy T. Murphy

11 Linden Ct

Millbrook, NY 12545

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for- profit, locally based organization. As a local member of the community I am glad to see Sharon Hospital returning to not-for-profit status, Health Quest have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services. Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Ryan Murphy
Associate Director
Four Way Books

EXHIBIT I

FOUNDATION
for
COMMUNITY
HEALTH

Prevention, Access, Collaboration

A Study of Community Health Needs Conducted for the Foundation for Community Health

October 2014

Prepared by:
Karen Horsch, M.Ed.
Karen Horsch Consulting, LLC
Manchester, New Hampshire

TABLE OF CONTENTS

ACRONYMS

ACA	Affordable Care Act
ACS	American Community Survey
BRFSS	Behavioral Risk Factor Surveillance Survey
CHIME	Connecticut Hospital Information Management Exchange
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
CT	Connecticut
CAPE	Council on Addiction and Prevention Education
DARE	Drug Abuse Resistance Education
EBT	Electronic Benefit Transfer
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ESL	English as a Second Language
FCH	Foundation for Community Health
HHS	Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HP2020	Healthy People 2020
ICA	Integrated County Assessment
NAMI	National Alliance on Mental Illness
NECC	North East Community Center
ND	No date
NY	New York
NYC	New York City
NYS	New York State
NYSDOH	New York State Department of Health
OASAS	Office of Alcoholism and Substance Abuse Services
PCS	Patient Characteristics Survey
SPARCS	Statewide Planning and Research Cooperative System
STI	Sexually Transmitted Infection
SWSCR	Student Weight Status Reporting System
US	United States
USDA	United States Department of Agriculture
VNA	Visiting Nurse Association

INTRODUCTION

The Foundation for Community Health (FCH), founded in 2003[1], is a private, not-for-profit foundation dedicated to maintaining and improving the physical and mental health of the residents of the greater Harlem Valley in New York and the northern Litchfield Hills of Connecticut, with an emphasis on serving those most vulnerable.[2]

Since its inception, FCH has awarded nearly $8 million in grants to a variety of nonprofit organizations in the region. In addition to its direct funding of health projects, the Foundation initiates forums, research, conferences, workshops, and other educational programs aimed at improving access to healthcare for people living in the FCH community. For the first ten years of its work, FCH focused its efforts in three priority areas: oral health, mental health, and access to healthcare. These priorities were identified based on a health needs assessment commissioned by the Foundation in 2004.

In 2014, FCH's Board of Directors was interested in reassessing the Foundation's strategy to determine where it could best serve community needs. This needs assessment was commissioned to help inform those decisions. Community health needs assessments (CHNAs) had recently been conducted in each of the three counties with towns in FCH's service area; these assessments described social, economic and health conditions in the counties and identified priorities for addressing health needs. This needs assessment focuses more specifically on the health conditions and health needs of those living in the 17 communities FCH serves. The Foundation's Board was also very interested in learning what community residents and providers serving the community see as the key health needs in the region. Thus, in addition to secondary data about health and health care needs, the data collected for this needs assessment includes the results of a survey of community stakeholders and focus groups with residents and providers. It is important to note that the Foundation takes a population/public health approach to fulfilling its mission; the focus of this needs assessment is on exploring broadly the trends and factors affecting the health and well-being of community residents rather than examining specific health care systems or interventions.

The report has four sections. The first describes the data collection methodology for the study. The second section draws on existing secondary data from county, state, and national sources to provide an overview of FCH communities and residents' health status. This is followed by a discussion of health and healthcare needs based on information gathered through an online survey and focus groups with residents, service providers, and community leaders. The report concludes with a summary of findings.

DATA COLLECTION METHODS

This report presents quantitative and qualitative data that come from the following sources:

- *Secondary Data*. This report compiles data from the U.S. Census and state agencies (labor, education, and public health) as well as data collected by community-based agencies and researchers. In addition, over the past two years, health departments and community

[1] FCH was initially funded with assets from the sale and conversion of Sharon Hospital to a for-profit organization.
[2] The communities served are: Amenia, Ancram, Copake, Dover, Northeast, Pine Plains, Stanford, and Washington (NY) and Canaan (Falls Village), Cornwall, Goshen, Kent, Norfolk, North Canaan, Salisbury, Sharon, and Warren (CT).

organizations in the region have conducted CHNAs and these have also informed this report. These assessments include the *Columbia County Community Health Assessment and Community Health Improvement Plan, 2014-2017,* the *Dutchess County Community Health Assessment 2013-2017,* and the *2012 Community Health Needs Assessment. Litchfield County.* A complete list of data sources is provided at the end of this report.

It is important to note that because the region covered in this assessment includes two states, obtaining the same data for some socio-economic and health indicators is difficult. Each state has different data collection systems, may not report data for the same years, and may use different definitions of measures. In this report, every attempt was made to find data that were comparable across the region. In a few cases, equivalent data were not found and in this case, different measures or definitions are presented here. These are noted where relevant.

- *Community Stakeholder Survey.* To better understand community-level health concerns and challenges, a brief, anonymous survey was conducted for this project. The survey was conducted using SurveyMonkey, a web-based survey tool. The survey asked about health concerns in and needed health services in the communities. Because recent CHNAs had identified priority health needs in the three counties that comprise FCH's service area, the survey questions focused more specifically on gathering deeper feedback about these specific issues. An email link to the anonymous survey was sent to approximately 450 stakeholders in or serving the 17 communities, including health care providers, social service professionals, the faith community, government representatives, business people, and community residents. Respondents were initially identified through FCH's database of key contacts to which additional medical, mental, and oral health providers were added, including all medical providers at Sharon Hospital. In total, 194 individuals responded to the survey, yielding an approximate response rate of 43%, a typical response rate for this type of survey. Descriptive statistics were used to analyze survey results. The survey instrument is provided in Appendix A.

- *Focus Groups.* Ten focus groups with 82 community stakeholders were conducted to gather a more in-depth perspective on health and health care status and needs in the communities served by the Foundation. Focus groups were held with local business leaders, seniors, youth, patients of a local health center, clients of social service organizations, social service provider staff, and community leaders. Groups included 15 Spanish speakers and 67 English speakers. Because the Foundation's mission emphasizes meeting the needs of the region's most vulnerable populations, focus groups were specifically organized to include these perspectives. The number of focus group participants ranged from five to twelve and each group was between 60 and 90 minutes in duration. Parental permission was obtained from all youth focus group members. Standard qualitative data analysis techniques of coding and characterizing were used to analyze the data collected through focus groups. The focus group protocol is provided in Appendix B.

It is important to note that there are several limitations to the data collected for this study. As described above, the sample size for the Community Stakeholder Survey represents a "convenience sample;" as such, there is little ability to generalize results to the larger population in FCH communities. Focus group members as well were a sample of individuals selected because they received services from local agencies and/or played leadership roles in the community. However, they shared their own opinions and perceptions and were not asked to speak on behalf of particular agencies, constituencies, or the general population. Focus groups are typically utilized in CHNA

processes as they provide an in-depth perspective on community issues or experiences and allow for insights and discussion that cannot be obtained through quantitative approaches. Although these limitations create challenges, the reliability of the results and findings in this report is grounded in the Foundation's intent to gather perceptions of a diverse group of stakeholders and then triangulate emergent themes with existing regional, state, and national secondary source data.

COMMUNITY BACKGROUND AND HEALTH STATUS

This section provides an overview of the factors affecting health and the health status of residents in the 17 communities served by FCH.

Factors Affecting Health

One's health status is affected by more than one's personal health behaviors or access to health care. As noted by Grantmakers in Health, *"decades of research and practical experience in the United States and other countries have shown that a number of economic and social factors – education, income, occupation, wealth, housing, neighborhood environment, race and ethnicity – have a powerful influence on health."*[3] Generally referred to as the "social determinants of health" these factors positively and negatively affect health in a community. This section describes the 17 communities comprising FCH's service area from a social determinants of health perspective.

The data shared below come from the American Community Survey (ACS), unless otherwise noted. The ACS is an ongoing survey conducted by the U.S. Census to obtain demographic, economic and social data that is used to guide decision making at the national, state, and local levels. The FCH data are presented for three geographic regions, FCH towns that are located in Columbia County (FCH/Columbia), those located in Dutchess County (FCH/Dutchess), and those located in Litchfield County (FCH/Litchfield). The data are reported by the ACS at the 5-digit zip code level and in some cases, data for more than one zip code were aggregated to obtain the data for the town. It is important to note that, due to small sample sizes in the towns, results should be interpreted with caution. For comparative purposes, data for Connecticut and New York are also included.

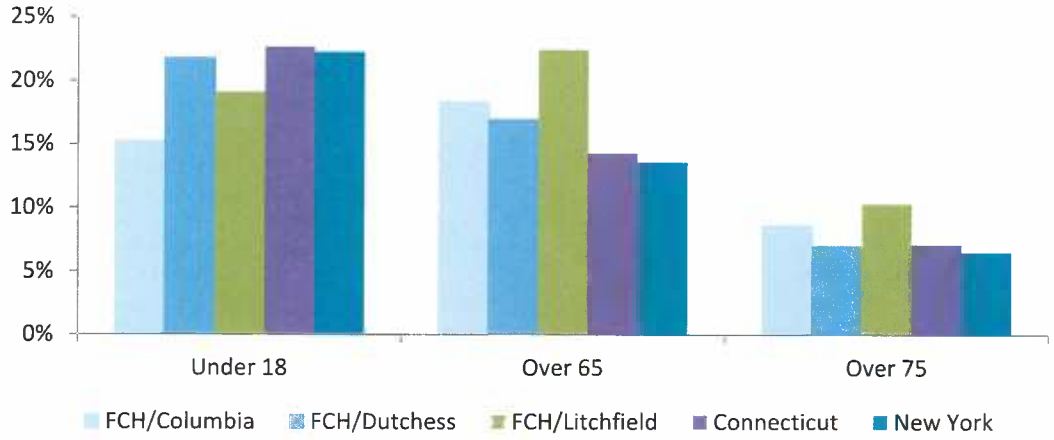
Demographics

According to the most recent ACS population estimates, the population of the 17 communities comprising the FCH service region is estimated to be about 51,410. Data indicate a regional population that is older than that in the states of New York and Connecticut. (Figure 1) In total, about 19% of the region's population is over age 65, compared to 14% for both Connecticut and New York. Further, approximately 9% of the region's population is over age 75, compared to 7% for Connecticut and about 7% for New York. By contrast, 20% of the region's population is under the age of 18, a smaller proportion than the two states (22%).

Data by FCH service region show that, overall, the communities in Litchfield County served by the Foundation are older than those served in Dutchess and Columbia although there is some variation across towns. In some Litchfield communities (Kent, North Canaan, and Salisbury), over one quarter of the population is over age 65. FCH communities in Dutchess, by contrast, have a comparatively younger population; notably over one quarter of Amenia's population and about 23% of the populations in Dover and Northeast are under age 18.

[3] http://www.gih.org/Focus/FocusOnIssues.cfm?MetadataID=24

Figure 1: Population by Age, FCH Regions, Connecticut, and New York, 2008-2012



Source: 2008-2012 American Community Survey 5-Year Estimates.

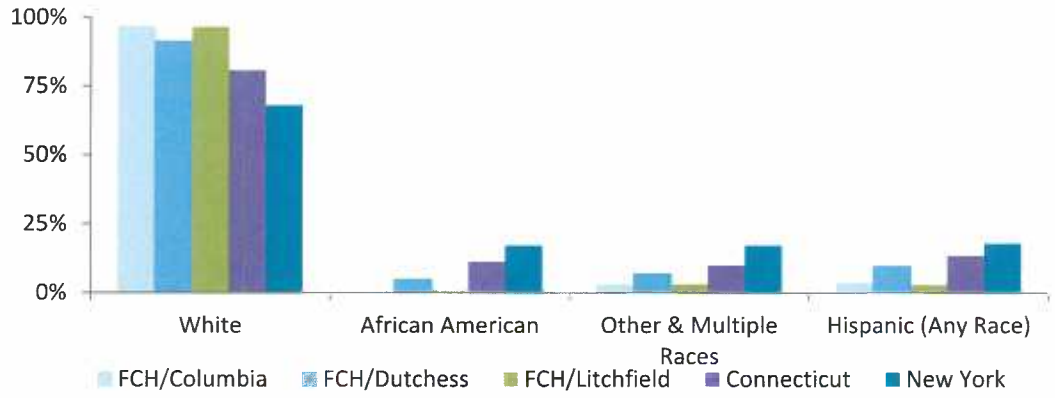
The FCH service area is predominantly White. (Figure 2) About 94% of the region's population is White, compared to 81% for the state of Connecticut and 68% for the state of New York. Hispanics of any race comprise 6% of the region's population. African Americans/Blacks make up 3% of the region's population and those of other races comprise about 4%.[4] The growing racial and ethnic diversification of the counties in the region has been documented in recent community health assessments. Both the Dutchess County and Litchfield County CHNAs reported a substantial increase in Hispanic populations in those counties between the 2000 and 2010 censuses.[5]

Data by FCH service region show that the most diverse towns in the region (Dover, Northeast, and Amenia) are located in Dutchess County. In Amenia, about 16% of the population is Hispanic while Dover's Hispanic population is nearly 10%. By contrast, a number of towns in the service area, notably Cornwall, Kent, Warren, and Goshen, have far less racial and ethnic diversity.

[4] Other races includes those who reported their race as Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, or some other race.

[5] Dutchess County Department of Health. (April 2013). *Dutchess County Community Health Needs Assessment 2013-2017.* Litchfield County Community Transformation Grant Coalition. (ND) *2012 Community Health Needs Assessment.*

Figure 2: Population by Race & Ethnicity, FCH Regions, Connecticut, and New York, 2008-2012



Source: 2008-2012 American Community Survey 5-Year Estimates.

Income and Poverty

The median household income in the FCH region varies by town, although it is important to note that data sources across the two states and timeframes for the data differ. (Figure 3) All FCH towns in New York had a median household income higher than the state of New York overall according to 2007-2011 ACS estimates. With the exception of North Canaan, FCH towns in Connecticut had higher median household income levels than the state according to the 2010 Census.

Figure 3: Median Household Income, FCH Towns, FCH Counties, Connecticut, and New York

NEW YORK	$56,951	**CONNECTICUT**	$64,321
Dutchess County	$71,125	Litchfield County	$70,291
Columbia County	$56,185	Canaan	$68,150
Amenia	$57,832	Cornwall	$77,243
Ancram	$59,550	Goshen	$78,571
Copake	$58,692	Kent	$71,008
Dover	$67,462	Norfolk	$73,426
Northeast	$61,823	North Canaan	$44,817
Pine Plains	$65,539	Salisbury	$64,758
Stanford	$68,168	Sharon	$69,258
Washington	$67,673	Warren	$76,122

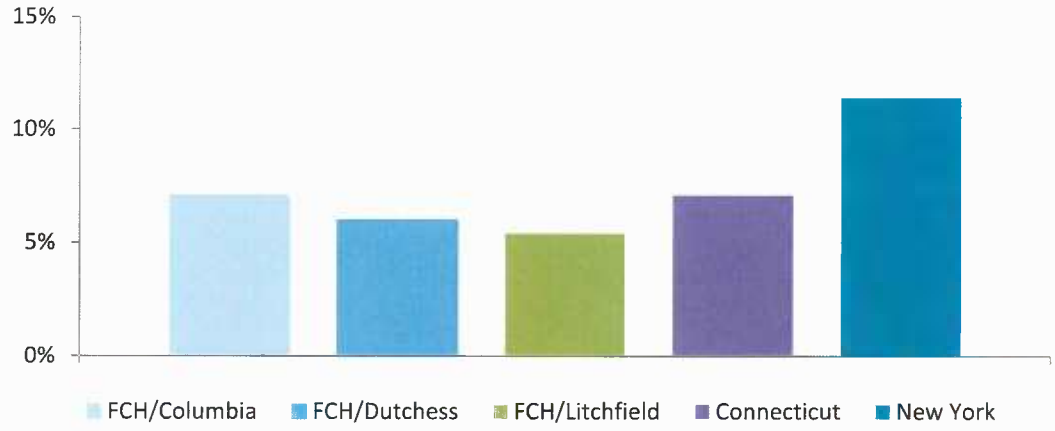
Source: NY: 2007-2011 American Community Survey as cited in County Profiles developed by Cornell Program on Applied Demographics. CT: 2010 US Census as cited in 2012 Litchfield County CHNA.

According to the 2008-2012 ACS, a smaller proportion of families in FCH regions are in poverty than in Connecticut and New York. (Figure 4) The poverty rate varies across the FCH towns, from a low of 1% in Salisbury and Cornwall to a high of 10% in Amenia. School lunch data provide another picture on poverty. Between the 2006-2007 and 2010-2011 school years, the proportion of students eligible for free or reduced lunch in Litchfield County increased from 15.3% to 23.1%.[6] In

[6] Connecticut State Department of Education as cited in 2013 Connecticut KIDS COUNT Data Book.

Dutchess County, the proportion of children receiving free or reduced price lunches rose from 25.8% to 31.9% over the same time period; in Columbia, the rate rose from 35.7% to 40.6%.[7]

Figure 4: Proportion of Families Below the Poverty Line in Prior 12 Months, FCH Regions, Connecticut, and New York, 2008-2012



Source: 2008-2012 American Community Survey 5-Year Estimates.

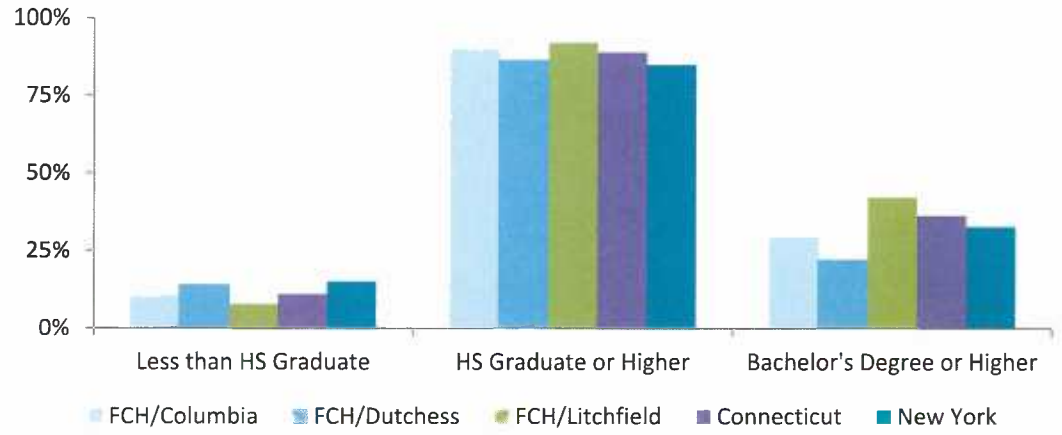
Education

ACS data show that about 89% of the FCH region's residents over the age of 25 are high school graduates or higher, a rate similar to the state of Connecticut and higher than the state of New York. (Figure 5) About 31% have a Bachelor's degree or higher.

Educational attainment rates vary substantially across FCH towns, however. Residents of FCH towns in Litchfield County have higher rates of education than those in either Dutchess or Columbia: 42% of residents in these towns over age 25 have a Bachelor's degree or higher compared to about 30% of those in Columbia and 22% of those in Dutchess. In many FCH communities in Dutchess and in Canaan (Falls Village) in Litchfield, over 10% of residents over age 25 have not completed high school or high school equivalency. By contrast, over half of residents over age 25 in Cornwall and Salisbury have a Bachelor's degree or higher.

[7] Kids Well-Being Indicators Clearinghouse. http://www.nyskwic.org/data_tools/custom_query.cfm

Figure 5: Educational Attainment (persons age 25 or older), FCH Regions, Connecticut, and New York, 2008-2012[8]



Source: 2008-2012 American Community Survey 5-Year Estimates.

Health Status

The following section examines existing quantitative data related to mortality and disease prevalence in the region. These data come from sources including vital statistics, the Behavioral Risk Factor Surveillance Survey (BRFSS), and hospitals.[9] Where available, targets established through the Healthy People 2020 (HP2020) Initiative have also been provided. Healthy People 2020 is a national initiative led by a variety of federal agencies that each decade sets out a 10-year agenda for improving the nation's health.[10] One aspect of this is identifying targeted measurable change in key health and health care indicators. These targets can be useful when examining community health.

Two limitations to these data should be noted. First, many health data points are either not available at the community level or comprise such small numbers that they cannot be meaningfully interpreted. Thus, county-level data are largely reported here. Additionally, because data sources, definitions of measures, and analysis timeframes sometimes differ between the two states, the ability to compare across the counties in the two states is limited. This is noted where relevant.

Self-Reported Health Status

According to the BRFSS, a lower proportion of Litchfield County residents reported poor or fair health than residents of Dutchess or Columbia counties. (Figure 6) The number of poor physical health days reported was similar across FCH counties and similar to Connecticut and New York. A higher number of poor mental health days were reported by residents in Columbia County than in Litchfield County, Dutchess County, and the states.

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[8] High school graduate rates include those who have completed equivalency tests.
[9] The Behavioral Risk Factor Surveillance Survey (BRFSS) is a national phone survey conducted by the Centers for Disease Control to gather information about population-level health. The survey is conducted annually although some questions are rotated over several years.
[10] http://www.healthypeople.gov/2020/about/default.aspx

Figure 6: Age-Adjusted Adult Health Status, FCH Counties, Connecticut, and New York, 2008-2012

	Poor or Fair Health	Poor physical health days in last 30 days	Poor mental health days in last 30 days
Columbia	13%	3.5	4.1
Dutchess	12%	3.0	3.2
Litchfield	9%	3.1	3.0
New York	15%	3.5	3.4
Connecticut	11%	3.0	3.1

Source: Behavioral Risk Factor Surveillance System, 2008-2012 as cited in 2014 County Health Rankings.

County Health Ranking data also provide a window on health status in counties. According to the 2014 County Health Rankings, Litchfield County ranked 4th out of eight Connecticut counties for health outcomes and for health factors.[11] Dutchess County ranked 11th of 62 New York counties for health outcomes and 9th for health factors in 2014. Columbia County ranked 46th of 62 New York counties for health outcomes and 13th for health factors in 2014.

Mortality Rates

Vital records data about age-adjusted mortality rates indicate that mortality rates in the FCH counties varies when compared to the two states. Note that due to different years of the data, rates cannot be compared across the two states. Rates of death due to heart disease, chronic lower respiratory diseases, accidents, and pneumonia and influenza were higher for Litchfield than Connecticut. (Figure 7) Rates of death due to diabetes and cancer were lower than for the state.

Figure 7: Age-Adjusted Mortality Rates, per 100,000 population, Litchfield County and Connecticut, 2005-2009

	Connecticut	Litchfield
All causes	687.7	689.8
Major Cardiovascular Disease	217.4	230.5
Cancer[12]	170.1	164.3
Chronic Lower Respiratory Diseases	34.5	40.3
Diabetes	16.7	13.6
Pneumonia and Influenza	17.2	19.7
Liver Disease/Cirrhosis	7.2	7.0
Accidents	32.9	35.0
Alcohol Induced	5.1	5.7
Drug Induced	11.1	11.8

Source: Connecticut Department of Public Health Vital Records, Mortality Files, 2005-2009 (five year average) as cited in Litchfield County CHNA.

[11] County Health Rankings are a collaboration of the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation. The Project assigns each county a Health Outcome rank based on mortality and morbidity and a Health Factor rank based on health behaviors, clinical care, social-economic factors, and the physical environment. http://www.countyhealthrankings.org Health outcome measures examine mortality and morbidity. Health factors measures include those related to health behaviors, clinical care, social and economic factors, and the physical environment.

[12] Healthy People 2020 target is 161.4 deaths per 100,000.

Data about mortality for New York show that rates of mortality due to all causes, heart disease, coronary heart disease, stroke, lung and colorectal cancer, chronic lower respiratory disease, and motor vehicle accidents were higher for residents of Columbia County than for Dutchess County and for the rest of the state. (Figure 8) Overall, death rates due to most diseases were lower in Dutchess County when compared to Columbia County. Death rates due to congestive heart failure, chronic lower respiratory diseases, lung and colorectal cancers, unintentional injuries, and motor vehicle accidents were higher for both Columbia and Dutchess counties compared to New York state. Diabetes mortality rates in the two counties were lower than for the state during the reporting period.

Figure 8: Age-Adjusted Mortality Rates, per 100,000 population, Columbia County, Dutchess County, and New York, 2009-2011

	New York	Columbia	Dutchess
All causes	658.1	735.1	687.7
Diseases of the Heart	198.6	216.2	185.9
Coronary Heart Disease	160.4	165.5	131.7
Congestive Heart Failure	11.2	15.3	16.1
Stroke[13]	26.9	32.2	27.1
Lung Cancer	63.6	73.3	65.2
Colorectal Cancer	15.4	18.6	16.7
Female Breast Cancer	21.6	14.9	24.1
Chronic Lower Respiratory Diseases	31.0	49.9	39.4
Diabetes	17.0	13.0	12.8
Unintentional injuries	22.7	26.5	28.9
Motor Vehicle Accidents	6.0	11.1	7.3

Source: New York State Department of Health, Health Indicators, 2009-2011.

Morbidity Rates

Vital records data about age-adjusted morbidity rates indicate that morbidity rates in the FCH counties also varied compared to those for Connecticut and New York State. Again, due to different years of the data and also due to different rate calculations, rates cannot be compared across the two states.

A review of age-adjusted hospitalization rates by County reveals that hospitalization rates in Litchfield are lower than for Connecticut for all causes reported with the exception of alcohol and drug abuse. (Figure 9)

[13] Healthy People 2020 target is 34.8 deaths per 100,000.

Figure 9: Age-Adjusted Hospitalization Rates, per 100,000 population, Litchfield County and Connecticut, 2005-2009

	Connecticut	Litchfield
All causes	10,036.5	8,845.3
Cancer, all sites	377.1	351.0
Diabetes	132.9	86.7
Alcohol & Drug Abuse	139.3	165.5
Major Cardiovascular Disease	1,401.8	1,177.0
Coronary Heart Disease	406.5	336.8
Acute Heart Attack	163.0	146.2
Congestive Heart Failure	172.8	115.6
Stroke	183.8	166.0
Chronic Obstructive Pulmonary Disease	277.8	207.2
Asthma	136.9	69.5
Liver Disease & Cirrhosis	27.4	21.1

Source: Connecticut Department of Public Health Connecticut Hospital Information Management Exchange (CHIME) Hospital Discharge Data Set, 2005-2009 (five year average) as cited in Litchfield County CHNA.

In New York, Columbia County had lower rates of hospitalization than both the state and Dutchess County for all causes reported. (Figure 10) Dutchess County hospitalization rates were lower than the state for many causes with the exception of unintentional injuries and drug-related causes.

Figure 10: Age-Adjusted Hospitalization Rates, per 10,000 population, Columbia County, Dutchess County, and New York, 2009-2011

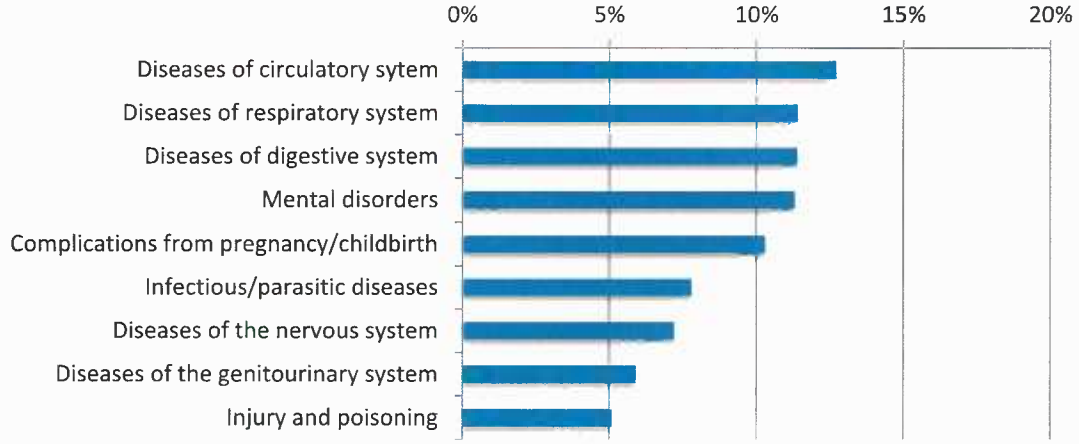
	New York	Columbia	Dutchess
Diabetes (primary diagnosis)	18.8	12.6	13.4
Diabetes (any diagnosis)	226.0	168.0	194.0
Disease of the Heart	107.9	79.0	85.8
Coronary Heart Disease	43.0	27.6	29.3
Congestive Heart Failure	27.6	19.8	24.9
Stroke	24.9	20.6	25.2
Chronic Lower Respiratory Disease	37.0	26.6	29.4
Asthma (all ages)	19.9	8.5	11.9
Unintentional injury	64.0	57.7	70.3
Poisoning	10.4	8.8	9.6
Drug-related	26.1	21.1	28.3
Falls (age 65+)	200.1	173.2	198.3

Source: New York State Department of Health, Health Indicators, 2009-2011.

Data from the Connecticut Inpatient Discharge Database provide a more specific picture of causes for emergency room and inpatient visits to local hospitals. At Sharon Hospital in 2013, there were 2,841 hospitalizations. (Figure 11) Hospitalization for diseases of the circulatory system comprised

the largest number of these hospitalizations, about 13%. This was followed by diseases of the respiratory system, diseases of the digestive system, and mental disorders. Data about hospitalization in any Connecticut hospital from residents of the FCH service area show a similar pattern. Hospitalization for diseases of the circulatory system comprised the largest proportion of hospitalizations (17%) followed by respiratory disease (12%), and digestive disease (11%).

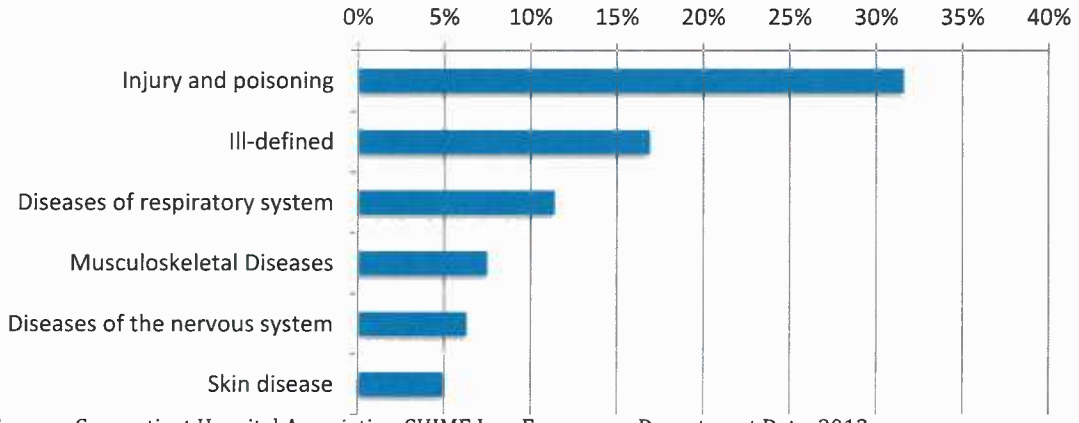
Figure 11: In-Patient Hospitalizations, Sharon Hospital, 2013



Source: Connecticut Department of Public Health, Office of Health Care Access, Acute Care Hospital Inpatient Discharge Database, 2013. Excludes newborns.

In 2013, there were 13,412 emergency room visits to Sharon Hospital. The largest proportion of visits was due to injury and poisoning (32%) followed by ill-defined conditions (17%). (Figure 12) Respiratory diseases accounted for the third highest number of visits to the emergency room at Sharon in 2013 (11%). Data about emergency room visits in any Connecticut hospital from residents of the FCH service area show a similar pattern.

Figure 12: Emergency Room Visits, Sharon Hospital, 2013



Source: Connecticut Hospital Association CHIME Inc., Emergency Department Data, 2013.

HEALTH AND HEALTH CARE NEEDS

The section summarizes health and health care needs in the region FCH serves. It begins with a discussion of top health needs identified by survey respondents and focus group members and then explores each of these (access to health care, mental health, substance use, obesity and chronic disease, and oral health) separately focusing on the nature and extent of the need, existing services to meet needs, and service gaps. The section concludes with a presentation of data, primarily from secondary sources, related to other community health concerns.

Data come from secondary sources, the community stakeholder survey, and focus groups conducted with residents of the FCH service area. Secondary data for this analysis come from various sources including the Behavioral Risk Factor Surveillance Survey (BRFSS), other surveys of community members, and data collected by state and local data systems as well as local community service providers. In addition, where relevant, findings from other recent studies and recent community health needs assessments (CHNAs) conducted in the region have been included. It is important to note that many of the data are collected at the county level and these are reported here where sub-county data are unavailable.

Community stakeholder survey results are presented for the overall region and for FCH counties. Respondents were asked in the survey to identify the counties served by their organizations from among the three counties FCH reaches—Columbia, Dutchess, and Litchfield. Respondents in many cases identified more than one county. Survey respondents were asked to specifically think about the FCH towns within the counties (rather than the whole county) when answering the questions. Respondents were also asked to identify their organizational affiliation and results were analyzed between health (including medical, mental, oral and home-based health) and non-health providers. It is important to note that survey respondents were asked separately about different community health needs and were limited to identifying three top needs and top three needed services in each category. This was done in an effort to identify those issues and priorities respondents saw as most important.

Top Health Concerns

Survey respondents were asked to identify the three top health concerns for the region from a list of 14 concerns. The concerns identified were similar to those identified in a needs assessment conducted for FCH in 2004 as well as those examined in recent CHNAs. Figure 13 shows that the top health concern among those listed was mental health; approximately 53% of respondents identified mental health as one of the top three health concerns for the region.[14] Over one third of respondents identified access to primary care, chronic disease, substance use, and lack of awareness of health and social services as top health concerns in the region. These results are similar to the top health issues raised in focus groups; however, focus group members more frequently reported obesity and dental care as health concerns for the region than survey respondents did.[15]

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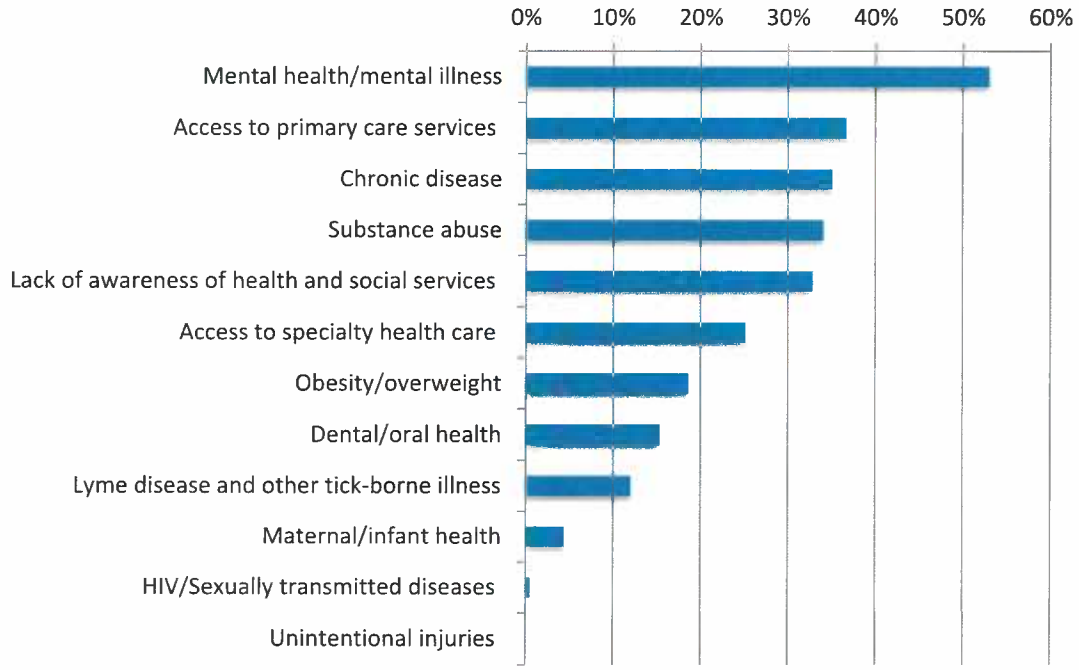
[14] Because respondents were asked to identify three top health concerns, the total proportion of responses across the health issues is greater than 100%. Mental health issues were identified separately as depression and other mental health/mental illness in the survey. The results were consolidated for the report.

[15] Focus group members were not limited to identifying three top health concerns. Substance use issues were identified separately as tobacco, alcohol, and other substance use in the survey. The results were consolidated for the report.

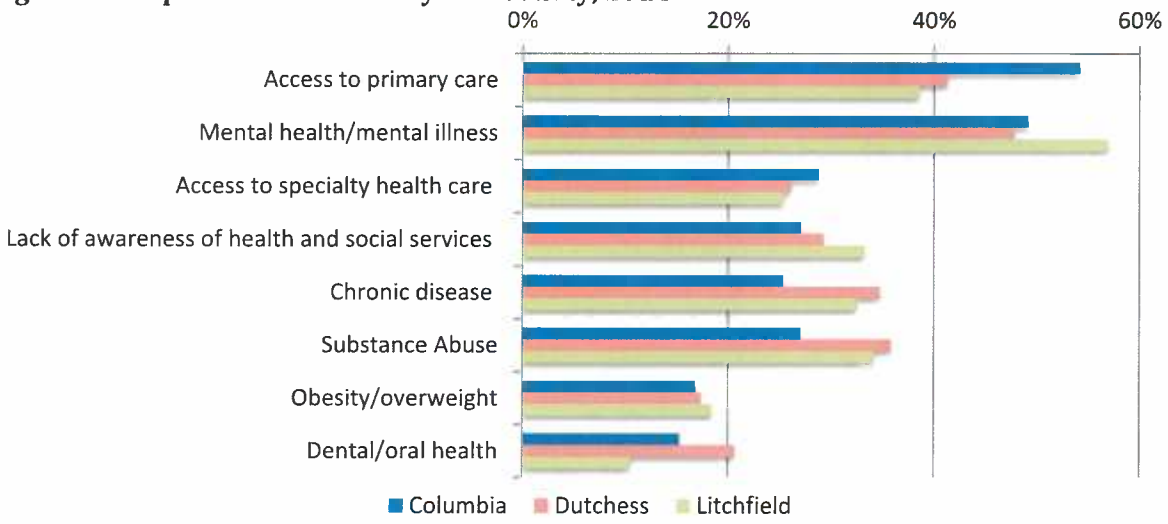
Figure 13: Top Health Concerns in the Region, 2014



Source: FCH Community Stakeholder Survey, 2014.

There were some differences in top health concerns across the three FCH counties. (Figure 14) In Columbia, for example, access to primary care was identified as a top concern by a higher proportion of survey respondents (over 50%) than in either Litchfield or Columbia. A higher proportion of respondents in Litchfield identified mental health as a top issue than in the other two areas. A higher proportion of health providers (45%) identified access to primary care and mental health as a top concern than non-health providers (35%). Lack of awareness of health and other services was rated as a top concern by a higher proportion of non-health providers (44%) than health provider respondents (19%).

Figure 14: Top Health Concerns by FCH County, 2014

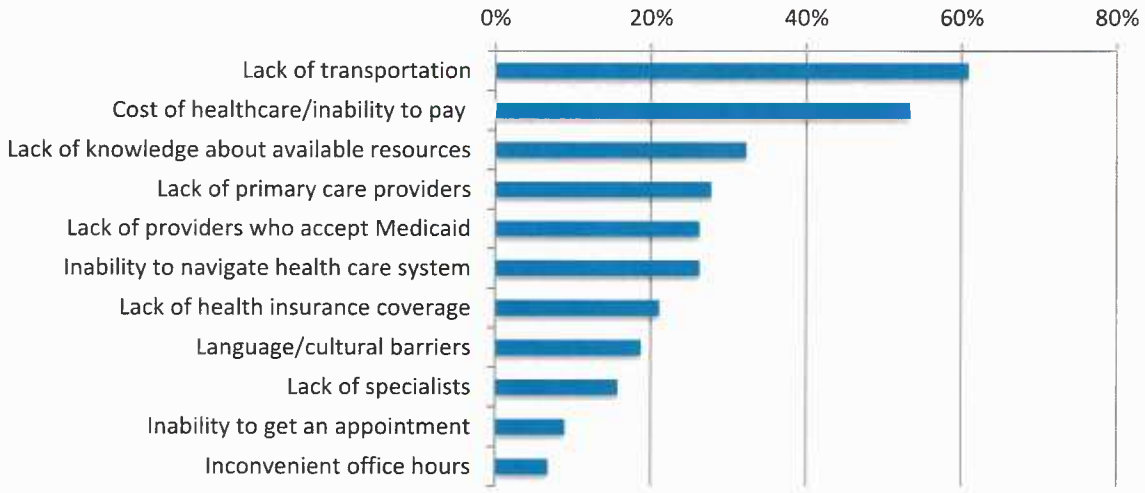


Source: FCH Community Stakeholder Survey, 2014.

Health Care Access

Due to its multi-faceted nature, access to health care was explored separately from overall health care concerns in the community stakeholder survey. Access was a substantial concern for respondents: 73% reported that they believed residents faced barriers to accessing health care services. Transportation and costs of health care were by far the top barriers to accessing health care according to survey respondents. (Figure 15) These concerns were consistent throughout the region and are consistent with other studies of rural health in Connecticut.[16] Over three-quarters of non-health providers reported that transportation was top barrier to accessing health care; half of health providers did so. Health providers were more likely to report lack of providers who accept Medicaid to be a barrier than non-health providers. Focus group members also reported the same top barriers to health care access.

Figure 15: Top Barriers to Health Care Access, 2014



Source: FCH Community Stakeholder Survey, 2014.

Lack of Transportation

About 60% of survey respondents reported that lack of transportation was one of three top barriers to health care access. This issue was also a topic of much conversation among focus group members; many identified lack of transportation as the most significant barriers to accessing health care as well as other services in the region. Focus group members from New York were more likely to report transportation barriers to accessing health care than those from Connecticut where residents appeared to have greater access to private cars. Additionally, at the time of the focus groups, the Fresh Town supermarket in Dover Plains had just closed and transportation was very much a top-of-mind issue

> "Transportation is a huge problem: some people are unable to drive and some have to travel long distances. Cancer patients, for example, have to find rides to Torrington 5 days a week."
>
> - Service Provider

[16] Holt, Wexler & Farnum, LLP. (June 2006). *Rural Community Health in Connecticut: Challenges and Opportunities.*

for residents affected by this. They shared concerns about how far they would have to travel to get food and how much it would cost in gas.

Several focus group members stated that they or people they knew delayed or went without health care due to transportation constraints. Transportation was reported to be a substantial struggle for those who have to see many providers or those suffering from diseases such as cancer who have to see providers frequently and who do not have private transportation. Non-English speakers also face substantial transportation challenges according to focus group members. Hispanic focus group members reported that lack of transportation not only affects their ability to access to health care and other services but also their ability to find employment. A recent survey examining immigrants' health care found that among the one third of immigrant survey respondents in Eastern Dutchess who reported difficulty getting to a doctor, 97% reported that the difficulty was due to lack of transportation.[17] Finally, senior residents in the region who can no longer drive also face transportation challenges. According to focus group respondents, family members are often too far away to drive seniors to appointments. Seniors were also reported to be less aware of other transportation services or if they are aware, are more reluctant to use these services because they are unfamiliar. As a result, they miss appointments or delay seeking medical care.

Transportation constraints in the area have been documented in recent studies. A 2007 study of non-emergency medical transportation in upper Litchfield County found that services are more "patchwork" and "opportunistic" rather than more comprehensive constrained by different eligibility requirements and funding sources.[18] Additionally, barriers include rising transportation costs that are not met with concurrent increases in funding and resident lack of awareness and/or willingness to access transportation services.

When asked about transportation options in the region, focus group members most often mentioned Dial-A-Ride services which are low-cost rides to destinations including health appointments, shopping, and social events. In the FCH service area, there are several Dial-A-Ride services. Both Northwest Transit and Geer Adult Day Care operate Dial-A-Ride programs that cover all of the towns in the northwest corner of Connecticut. North East Community Center (NECC), supported in part by FCH, provides free transportation to people in Northeast, Millerton, Amenia, and Dover through its volunteer-staffed Care Car and works closely with North East Transit to advertise and assist the residents of these towns in accessing the regional Dial-A-Ride service. One concern about these services shared by several focus group members is that they require a 2-3 day advance notice, which can be difficult for those who have unexpected medical appointments or other needs.

In addition to Dial-A-Ride services, the region has ADA Complementary Paratransit Services (for those eligible).[19] The Dutchess County Department of Social Services and Office for the Aging provides Medicaid-funded medical transportation for eligible individuals of all ages; however, until recently, Dutchess County vehicles were not able to leave the County. Hudson River Healthcare also provides transportation to patients. There are also a couple of fixed route bus systems: the Loop Bus serves every town in Dutchess County; Houstanic Area Regional Transit operates a fixed route

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[17] Schmidt, H., Waltner, A., Muller, S. (Feb 2011). *The Immigrant Health Initiative: A study of health care of recent immigrants in Dutchess County, New York.*

[18] Holt, Wexler & Farnum, LLP. (June 2007). *Assessment of Non-Emergency Medical Transportation in Upper Litchfield County.*

[19] ADA Complementary Paratransit Services are required as part of the Americans with Disabilities Act of 1990 and is available to eligible individuals who live within ¾ mile of a regularly-scheduled bus route and who cannot use the regular fixed route service.

bus system in New Milford; and the Northwest Transit Authority provides regularly scheduled service in Torrington and for some towns.

High Health Care Costs

Affordability of health care, including health insurance, was also a prevalent theme in the survey and in focus groups. About half of stakeholder survey respondents reported that the cost of healthcare was top three barrier to care. This was a top concern among respondents from all three counties. A higher proportion of non-health providers (63%) than health providers (47%) reported that cost was a barrier to accessing healthcare. A 2012 survey of residents of Dutchess and Columbia counties found that affordable health care ranked third among 17 community priorities.[20] This same survey found that 10% of Columbia County residents and 15% of Dutchess County residents reported that they had skipped a doctor's appointment in the year prior to the survey because they could not afford it; this compares to 13% of Columbia County residents and 10% of Dutchess County residents reporting this in 2007, when the survey was last done.

> "Paying for healthcare is expensive. It is hard to make a co-pays and pay out-of-pocket costs and still have money for gas and food."
>
> - Agency Client

Focus group members frequently talked about the cost of health care. They spoke about high co-pays, deductibles, and health insurance premiums as well as high medication costs as a substantial barrier to health care access. Several noted that although assistance is provided for medication payments (through FCH as well as others), there is no such support to help residents pay for doctors and co-pays. Most often, conversations revolved around the struggles families face in meeting health care costs as well as other expenses such as food, heating fuel, and gasoline. As one survey respondent wrote, *"in the Hispanic community, people share medications and use old home made remedies since they cannot get to or afford to see a doctor."*

Because this study was conducted in the early months of implementation of the Affordable Care Act (ACA), the cost and availability of health insurance was on the top of focus group members' minds. Prior to health reform, the proportion of residents without health insurance in FCH counties was similar to that for Connecticut and New York.[21] Focus group members reported mixed experiences in accessing health insurance through the new Marketplaces. Several respondents shared that they successfully obtained health insurance at reasonable cost through the Marketplace. Others, however, were not as positive. Some have found that the health insurance offered through the Marketplace is expensive (like Consolidated Omnibus Budget Reconciliation Act/COBRA rates, one reported) and that deductibles are high. Others reported paperwork and communication frustrations. As one focus group member shared, *"as of May 1st, I have no insurance. I gave them every piece of information they needed. I keep calling. I have done everything for the paperwork, but they have not given me insurance."*

Social service providers also shared their observations of the first ACA enrollment period. They reported that some clients they worked with had obtained insurance but like residents, they also

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[20] Marist College Institute for Public Opinion. *Many Voices One Valley 2012. Health Matters. A survey of Mid-Hudson Valley residents.* The top two were keeping business in the area and creating more jobs.

[21] In Dutchess, 13% of adults were uninsured in 2011-2012 and 14% in Columbia, compared to 16% for the state of New York. In Litchfield, 10% of adults were uninsured during that time frame, compared to 13% for Connecticut. Source: HRSA Area Resource File, 2011-2012 as cited in 2014 County Health Rankings.

observed that some have faced difficulty. Providers also reported confusion among patients about new health insurance options, including what is covered and where they can go for care. For example, New York Marketplace insurances cannot be used at Sharon Hospital. As one provider noted, *"people don't understand that the Marketplace Anthem is different than private."*

Data about the first ACA enrollment period in Connecticut and New York point to overall positive trends. Both states exceeded their enrollment targets. In Connecticut, 256,666 people have been enrolled through Access Health CT, 53% of whom were previously uninsured.[22] Access Health CT has been one of the nation's most successful Marketplaces.[23] In New York, 960,762 have enrolled in the Marketplace, more than 70% of whom were uninsured at the time of application.[24] A follow-up national study by the Commonwealth Fund has found that in particular, uninsurance rates among young adults and Latinos dropped significantly between July–September 2013 and April–June 2014. Uninsurance rates among those below the poverty line declined significantly in those states with Medicaid expansion but not in those without.[25] Data are not available at the local level.

Lack of Awareness of Services

About one third of survey respondents reported that lack of awareness of existing health services was a top three barrier to accessing health care. This response was consistent across the three regions. Lack of awareness of services has been documented in other studies as well. For example, studies of transportation needs in upper Litchfield and Dutchess County found that lack of awareness of transportation services and how to request these services are a barrier to access.[26]

"People have no idea that there are programs that could help with nearly every facet of health care including Medicare premiums, medication access, and help getting insurance."
- Provider

In focus groups as well members reported that they believed that there is a lack of publicity about existing services, both health services and social services, and that this prevented some residents from accessing services that they need. As one provider stated, *"part of the problem is awareness—it's not clear everyone in town is aware that we have services for example."* Indeed, during several focus groups, there were participants who reported that they had not heard of services others discussed, including Dial-A-Ride, Chore Services, senior fitness programs, and 2-1-1.[27] While lists of available services (and sometimes events calendars) are provided in several places, such as 2-1-1, town websites, and in some newspapers, respondents reported that they did not know of one place that provided a comprehensive directory of services and one that was updated regularly to reflect changes in programs/services.

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[22] http://4155l2gg5ga3d1m572z1uo2qov.wpengine.netdna-cdn.com/wp-content/uploads/2013/02/Key-stats-080614.pdf

[23] Atiga, S., Stephens, J., Rudowitz, R., Perry, M. (July 2014). *What Worked and What's Next? Strategies in Four States Leading ACA Enrollment Efforts*. The Kaiser Commission on Medicaid and the Uninsured.

[24] http://www.healthbenefitexchange.ny.gov/news/more-960000-new-yorkers-enrolled-ny-state-health

[25] Collins, S., Rasmussen, P., Doty, M. (July 2014). *Gaining Ground: American's Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*. The Commonwealth Fund.

[26] Holt, Wexler & Farnum, LLP. (June 2007). *Assessment of Non-Emergency Medical Transportation in Upper Litchfield County*. CGR. (October 2007). CGR. (October 2007) *Senior Transportation Services in Dutchess County. Challenges and Opportunities.*

[27] Spearheaded and funded by United Way, 2-1-1 is an easy-to-remember telephone number that connects callers to information about critical health and human services available in their community. http://211us.org/about.htm

Lack of Providers

Lack of providers, both in primary and specialty care, was also identified as a barrier to health care access in both the survey and in focus groups. About 25% of survey respondents reported that lack of primary care providers was a top barrier to accessing health care in the region. There are two aspects to this: an insufficient number of providers overall and the fact that a number of providers do not accept Medicare and/or Medicaid patients.

"It is hard to find good primary care providers. Some don't take different insurances and some don't take new patients."

- Senior

Several focus group members reported that they had difficulty finding providers and obtaining appointments, especially for routine care. Respondents reported that not only are there fewer providers than needed in the region, but that those who are available work part time or split their time over several locations. Quantitative data from the Health Resources and Services Administration (HRSA) indicate that, overall, the population to provider ratio relative to primary, dental, and mental health care in the three counties is higher than for New York or Connecticut overall. (Figure 16) The exception is mental health providers in Dutchess County where the ratio of population to provider is closer to the state ratio. Furthermore, Columbia County has been designated by the HRSA as a dental Health Professional Shortage Area (HPSA) and Litchfield County has been designated as a mental health HPSA.[28]

Figure 16: Ratio of Population to Providers, FCH Counties, Connecticut, and New York, 2011-2012

County/State	Primary Care Physicians	Dentists	Mental Health Providers[29]
Dutchess, NY	1,406:1	1,652:1	519:1
Litchfield, CT	1,600:1	1,795:1	806:1
Columbia, NY	2,018:1	2,587:1	840:1
New York	1,216:1	1,361:1	525:1
Connecticut	1,215:1	1,368:1	470:1

Source: Primary Care Physicians & Dentists: HRSA Area Resource File, 2011-2012 as cited in 2014 County Health Rankings. Mental Health Providers: CMS, National Provider Identification, 2013 as cited in 2014 County Health Rankings.

According to some focus group members, lower income residents and seniors face additional challenges accessing health care because some providers are not willing to accept Medicaid and Medicare. This means that lower income patients must often travel even further to access needed health care. As one focus group member noted, *"because there are already few physicians in our rural area, the fact that some do not accept Medicaid is a big issue."* The region does have Federally Qualified Health Centers (FQHCs)[30] which serve lower income residents but focus group members

[28] http://hpsafind.hrsa.gov/HPSASearch.aspx Accessed: 6/15/2014.

[29] Includes psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses who specialize in mental health care. http://www.countyhealthrankings.org/sites/default/files/resources/2014%20new%20measure%20descriptions.pdf

[30] Federally Qualified Health Centers (FQHCs) are organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. They must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Those serving the FCH region are Amenia

reported that the need for these services is higher than the facilities can meet. In response to growing demand, the Community Health and Wellness Center of Greater Torrington has undertaken an expansion expected to quadruple its capacity.[31]

The lack of access to providers has both personal and systems consequences. Focus group members reported that because it is difficult to sometimes get appointments, patients will delay seeking care which can have negative health consequences. In addition, the lack of primary care and urgent care services in the region can lead to increased use of hospital emergency rooms for health services that could be more efficiently addressed by other health providers. As one agency client reported, *"some people use the ER (emergency room) at Sharon for health care."* This creates cost challenges for the entire health care system. Some focus group members attributed this to a lack of urgent care in the region. Generally seen as providing a lower cost alternative to emergency rooms, residents reported that the closest urgent care for the region is 35-40 minutes away in Arlington, New York or Torrington, Connecticut.

It is important to note that while focus group members reported challenges to accessing health care, few mentioned concerns about the quality of the health care they receive. This is consistent with a finding from a 2012 survey of Mid-Hudson Valley residents which found that 68% of Dutchess County residents and 62% of Columbia County residents were pleased with the health care services in their communities. This is a substantial increase (about 10 percentage points) from responses when the survey was last done in 2007.[32]

Challenges Navigating the Health Care System

Although not mentioned as frequently as other challenges to accessing health care, some focus group members reported that they or people they knew faced challenges in navigating the health care system. Several service providers also shared this concern such as one who stated, *"people are constantly getting in trouble because they cannot navigate the health care system."* One component of this is navigating health insurance options—levels of coverage, which physicians accept which insurances, and co-pay and deductible requirements. For example, a couple of focus group members reported that they had made appointments with or been referred to physicians only to learn that these providers did not accept their insurance. They faced challenges as well when trying to figure this out. As one member of a seniors focus group shared, *"every time I try to get information about health insurance and what is covered, I only get people who represent the companies. I want someone to represent me."*

Suggestions to Enhance Health Care Access

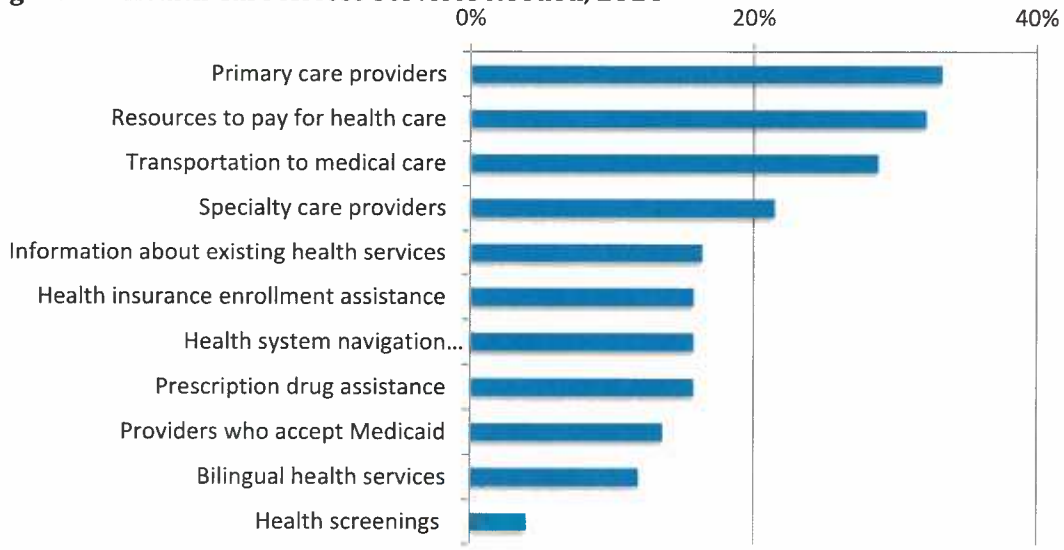
Survey respondents were asked to identify which three services they believed were most needed in the FCH service area to enhance access to care. Focus group members were also asked this question. Among survey respondents and focus group members the same services were identified: more primary care providers, resources for pay for healthcare, and transportation. (Figure 17) This was consistent across the three counties FCH serves. Additionally, more information about existing services, although not identified as prevalently in the survey, was identified as a community need in many focus groups.

Health Center, Dover Plains Health Center, and Pine Plains Health Center (all of which are operated by Hudson River Health Care) and Community Health and Wellness Center of Greater Torrington.

[31] http://www.pcdc.org/news/press-releases/torrington-closing.html

[32] Marist College Institute for Public Opinion. *Many Voices One Valley 2012. Health Matters. A survey of Mid-Hudson Valley residents.*

Figure 17: Health Care Access Services Needed, 2014



Source: FCH Community Stakeholder Survey, 2014.

Specific suggestions to enhance access included:

- *More Providers*: While respondents reported that more primary care providers were needed, they provided few suggestions about how this might be accomplished. Respondents acknowledged that health reform implementation will have a substantial impact on provider availability and provider networks—whether this will positively or negatively affect access over time is as yet unclear. Several, however, suggested that the recent passage of legislation in both New York and Connecticut allowing nurse practitioners to practice independent of physicians may help to increase access to primary care in the region. As described above, expansion of one of the region's FQHCs is also expected to increase provider capacity. One focus group member also pointed to an emerging model of Community Paramedicine as another potential strategy to enhance health care access in rural areas.[33]

- *Resources to Pay for Health-Related Costs*: Funding to help lower-income residents to access health care services was also identified as a need. There are existing funds to help with medication and related costs. Respondents saw a need for similar financial support to cover other health-related costs such as health visit co-pays, deductibles, and uncovered services such as eyeglasses and hearing aids.

- *Support for Transportation*: Existing transportation services are valued and needed by community members and demand for these services continues to rise. At the same time, respondents acknowledged that transportation in a rural region will always be a challenge. Extensive public transportation systems are unrealistic and thus, individualized services are needed. Yet these services face challenges. Funding is one of these. Dial-A-Ride services

[33] Community Paramedicine is an emerging model in which Emergency Medical Technicians (EMTs) operate in expanded roles that are integrated into local healthcare systems. www.communityparamedic.org

charge a small fee to riders but are underwritten in large part by foundations and towns. As towns have faced economic challenges in recent years, they have largely been unable to significantly increase their support for these services, even as demand among town residents has increased. Another concern is finding volunteer drivers for programs especially as current volunteers age. Although not mentioned in focus groups or by survey respondents, studies of transportation in the region point to a need for greater coordination of existing transportation services and the need to expand hours of services.[34]

- *Greater Outreach and Information about Existing Services*: Data also point to a need for more marketing of existing services. While respondents reported that 2-1-1 does an excellent job in sharing information about services, they observed that many who could benefit from this service do not know about it. Additionally, focus group members felt that a more local and regularly-updated set of information was needed in FCH communities. Comprehensiveness was seen as critical: respondents suggested information about services and programs, including when they are offered and information about eligibility requirements and financial support to pay for services (for example, local medication programs and local scholarships for youth to access camps and sports programs). Additionally, respondents saw a need for a complete (and frequently updated) list of local primary care physicians, specialists, and mental and dental providers, including what insurance they take. Dissemination of this information was seen as critical; respondents suggested that information be provided in multiple formats to reach different audiences, including in written form and on the web. To reach Hispanics in the community, dissemination in Spanish-speaking media as well as through faith and community-based organizations was suggested.

Mental Health[35]

Mental Health in the Region

Both quantitative data and focus group information collected for this study point to mental health as a significant health issue for the region. As discussed earlier in this report, mental illness was identified as the top health need in the region among respondents the community stakeholder survey; over half identified as one of the top three health concerns in the region. Mental health has been documented as a key concern nationally and in rural areas.[36]

"There is an extensive wait list for child and adolescent mental health. Medication management takes 90 days." - Provider

In focus groups, respondents expressed concerns about mental health in their families and communities. While focus group participants and survey respondents noted that mental health concerns exist among all population groups, they saw children and adolescents and Hispanics as particularly vulnerable. Respondents attributed mental health concerns among children and youth

[34] Holt, Wexler & Farnum, LLP. (June 2007). *Assessment of Non-Emergency Medical Transportation in Upper Litchfield County*. CGR. (October 2007). *Senior Transportation Services in Dutchess County. Challenges and Opportunities*.
[35] Although mental health and substance use are often co-occurring and are often discussed together as "behavioral health," for the purposes of this study, the issues were examined separately and are discussed separately.
[36] Holt, Wexler & Farnum, LLP. (June 2006). *Rural Community Health in Connecticut: Challenges and Opportunities*.

to childhood trauma, poor parenting, overmedication, and the challenges of growing up in today's world. Youth focus group members shared that many students experience anxiety due to school pressures. Untreated mental illness among children and youth were a concern among those working in schools and social service organizations. Respondents attributed this in part to a lack of mental health screening services for children and youth. Several also attributed this to a reluctance among parents to accept a diagnosis of mental illness and seek treatment for their children. As one person shared, *"this is a small community and everyone knows your business. If someone is dealing with mental illness in their families, they go far away for services, if they go anywhere at all."*

An additional barrier to accessing mental health services, according to survey respondents and focus group members, is insurance. According to respondents, many private mental health providers in the region do not accept Medicaid. This means that lower income residents must wait for appointments at the health center, travel outside the region for lower cost services, or pay for services out-of-pocket. Additionally, some health insurance places limits on the number of visits for those who are insured thereby further limiting the ability to obtain effective mental health care. As a result, respondents reported, patients do not get needed mental health services. Several shared that this may change because ACA extends treatment coverage to mental health and substance use; however, this expansion of coverage will also likely mean that existing services will face increased demand.

Respondents also reported concerns about untreated mental health issues in the Latino community. Focus group members shared a variety of reasons for this. Some reported that a lack of awareness of mental health services among minority groups means that fewer seek needed services. For some Hispanics, documentation status creates a barrier to seeking care. Cost is also a significant barrier. For Hispanic residents, the inability to communicate with mental health providers substantially constrains access to these services. While some services provide interpreters and Hudson River Healthcare has a bi-lingual mental health provider, many other services do not. Finally, a significant barrier to mental health treatment, according to Hispanic residents and community leaders in focus groups, is that stigma associated with mental illness is particularly strong in the Hispanic community. As one Latino focus group member explained, *"going to see a social worker is a big step for [Hispanic] people and it can cost money. So people don't go and it goes to the back burner."*

Available quantitative data also point to mental health concerns in the region. According to the New York State Department of Health, the age-adjusted suicide rate in Dutchess was 8.9 per 100,000 population and 10.4 per 100,000 in Columbia, higher than the rate of 7.2 per 100,000 for New York overall.[37] The suicide rate in Litchfield County was 14.3 per 100,000 in 2012 compared to 9.8 per 100,000 in the state overall.[38] As described earlier in this report, a higher number of poor mental health days were reported in the BRFSS by residents in Columbia County than in Litchfield County, Dutchess County, and the states.

Data collected by New York State through the Patient Characteristics Survey (PCS) indicates that the rate of use of public mental health services by adults between 2007 and 2011 was substantially

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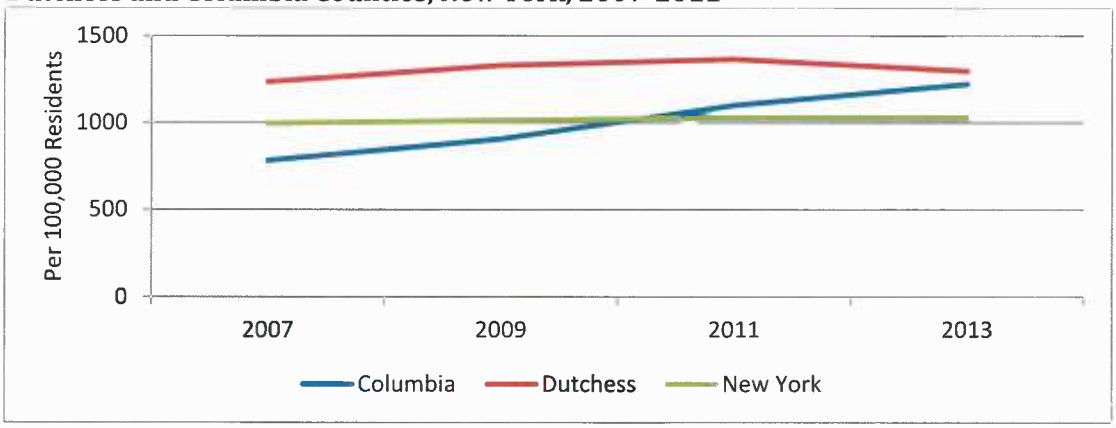
[37] New York State Department of Health, Health Indicators, 2009-2011. https://www.health.ny.gov/statistics/community/minority/county/newyorkstate.htm

[38] Presentation to Connecticut Suicide Advisory Board, September 26, 2013, by Robert Aseltine and Sara Wakai, University of Connecticut Health Center. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.ctclearinghouse.org%2Ffiles%2Fcustomer-files%2F790-CTSAB-Suicide-Data-for-General-Audiences.pptx&ei=xqo-VI3kNsz5yQTgpICgAg&usg=AFQjCNEYE4I_Ri98IN_4Ks709Gh2Qu2QxA&sig2=o7CHh9HmXUzTCItJ4ons2A&bvm=bv.77412846,d.aW

higher for Dutchess County than for Columbia County or the state overall. (Figure 18) Furthermore, the rate of use has grown faster for both Dutchess and Columbia counties over this time period than for the state overall.[39] Similar data about Litchfield are not available.

Figure 18: Use of Public Mental Health Services by Adults (18-64), per 100,000 residents, Dutchess and Columbia Counties, New York, 2007-2011



Source: New York State Office of Mental Health PCS Survey, 2007-2011.

Existing secondary data about unmet need for mental health services support the observations shared by community stakeholder survey respondents and focus group members. A 2012 survey conducted by the Dutchess County Department of Health of residents of Dutchess County found that of those residents of Eastern Dutchess who had an unmet need for mental health services, 25% reported that their needs were not met, the highest proportion among the regions studied and higher than the County average of 16%.[40] In 2013, calls to 2-1-1 about outpatient mental health care comprised the third highest number of calls to the service in FCH's towns in Litchfield—17% of total calls over the year.[41]

Secondary data collected about mental health issues among students also point to concerns. Both Dutchess County and the Region One School District in Litchfield have conducted youth surveys through the Search Institute to better understand both assets and challenges of youth in the region.[42] Data for two time periods, 2009 and 2013, were available for Region One while data for 2009 were available for Dutchess County. Due to different time frames for data collection and different grades sampled, results across the two areas cannot be compared; data on similar measures and for similar grades are also not available at the state level, thus additionally limiting

[39] PCS data compares counts and percentages of adults and children who received public mental health emergency, inpatient, outpatient, residential and support services in 2007-2011. https://my.omh.ny.gov/webcenter/faces/pcs/home?wc.contextURL=/spaces/pcs&_adf.ctrl-state=5turffdg8_414&wc.contextURL=/spaces/pcs&wc.contextURL=%2Fspaces%2Fpcs&wc.originURL=%2Fspaces%2Fpcs&_afrLoop=42855921268782

[40] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education.

[41] Data Source: Data Request to Connecticut United Way, April 2014. The top two requests were for utilities/heat services (22%) and public assistance programs (18%). It is important to note, however, that many residents may not be aware of 2-1-1 services so these numbers are likely to be underrepresented. In the past data about unmet need have been available; however, due to a new data system, that information is not available for 2013.

[42] Search Institute. (May 2010). *Developmental Assets: A Profile of Your Youth*. Prepared for Dutchess County Schools. Search Institute. (April 2014). *Developmental Assets: A Profile of Your Youth*. Prepared for Region One School District. Search Institute. (May 2009). *Developmental Assets: A Profile of Your Youth*. Prepared for Housatonic Valley Region Schools.

comparison. Similar data were not available for Columbia County schools. It is important to note that these surveys are completed by a small sample of students and thus, results should be interpreted with caution.

Data related to mental health issues show that in Region One, the proportion of sampled youth reporting mental health concerns has remained the same between 2009 and 2013. (Figure 19) In 2013, 13% of students sampled reported feeling sad or depressed in the month prior to the survey, 11% reported attempting suicide one or more times, and 19% reported engaging in bulimic or anorexic behavior. The proportion of sample students with mental health concerns tended to rise with age, with the exception of those who reported feeling sad or depressed.

Figure 19: Risk-Related Behaviors, Region One School District, 2009 and 2013

	Total 2009	Total 2013	Grade 7 2013	Grade 9 2013	Grade 11 2013
Felt sad or depressed most or all of the time in the last month	14%	13%	5%	20%	13%
Has attempted suicide one or more times	12%	11%	3%	13%	22%
Has engaged in bulimic or anorexic behavior	18%	19%	12%	23%	26%

Source: Search Institute, Developmental Assets Survey, 2009 and 2013.

In Dutchess County schools in 2009, 14% of students sampled reported feeling sad or depressed in the month prior to the survey, 10% reported attempting suicide one or more times, and 15% reported engaging in bulimic or anorexic behavior. (Figure 20) In general, the proportion of students reporting these behaviors rose with age.

Figure 20: Risk-Related Behaviors, Dutchess County Schools, 2009

	Total	Grade 8	Grade 10	Grade 12
Felt sad or depressed most or all of the time in the last month	14%	13%	15%	13%
Has attempted suicide one or more times	10%	9%	10%	13%
Has engaged in bulimic or anorexic behavior	15%	13%	16%	17%

Source: Search Institute, Developmental Assets Survey, 2009.

Data from secondary sources also point to the same concerns about mental illness and mental health service access among Hispanics in the region as shared in focus groups. The 2012 survey of Dutchess County found that 30% of Hispanic residents of the County who had a need for mental health services were not able to obtain those services, higher than the County average of 16%.[43] Additionally, a recent study of immigrants in Dutchess County found that, consistent with national trends, there are high rates of depression among newcomers to the U.S.[44]

[43] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education.

[44] Schmidt, H., Waltner, A., Muller, S. (Feb 2011). *The Immigrant Health Initiative: A study of health care of recent immigrants in Dutchess County, New York*.

Existing Mental Health Services

As described earlier, quantitative data from HRSA indicate that both Columbia and Litchfield counties have a larger population to mental health provider ratio than New York or Connecticut. Litchfield County has been designated as a mental health provider shortage area. According to focus group and survey respondents, the FCH service region lacks mental health services, especially those who work with children and who speak other languages. Respondents report that mental health services have become increasingly scarce and mental health providers in the region are closing their offices (for example, the Northwest Center is closing its Lakeville office in Fall 2014), although the need for these services is growing. As a result, residents must wait for needed services or travel long distances to get them.

Mental health services for lower-income residents of the region include Hudson Valley Mental Health and Hudson River Healthcare; however lack of sufficient providers constrains the ability of these organizations to meet the demand for services. Northwest Center for Family Service (a satellite office of Community Mental Health Affiliates, Inc.) also serves lower income residents of the region. In Connecticut, Housatonic Youth Services Bureau provides services to children and youth and in New York, Astor Services for Children and Families serves those under age 21. NAMI (National Alliance on Mental Illness) of Mid-Hudson provides family education on mental illness and some support groups locally that are largely staffed by volunteers. Women's Support Services in Sharon provides support and advocacy for those affected by domestic violence and school-based programs on bullying prevention and healthy relationships.

The lack of local emergency mental health services was raised in several focus groups. Hospital services for mental health are in the area located at Mid-Hudson Valley Regional Hospital (previously St. Francis). For residents of the FCH service region, the lack of emergency mental health services at Sharon Hospital for those other than older adults was mentioned as a growing concern. While Sharon Hospital provides psychiatric services for those over 55, others must be transported a substantial distance, often to Charlotte Hungerford Hospital, to be seen. Focus group members shared that this creates substantial challenges not only for EMS services but for patients, who must get services a distance from home and in an unfamiliar place.

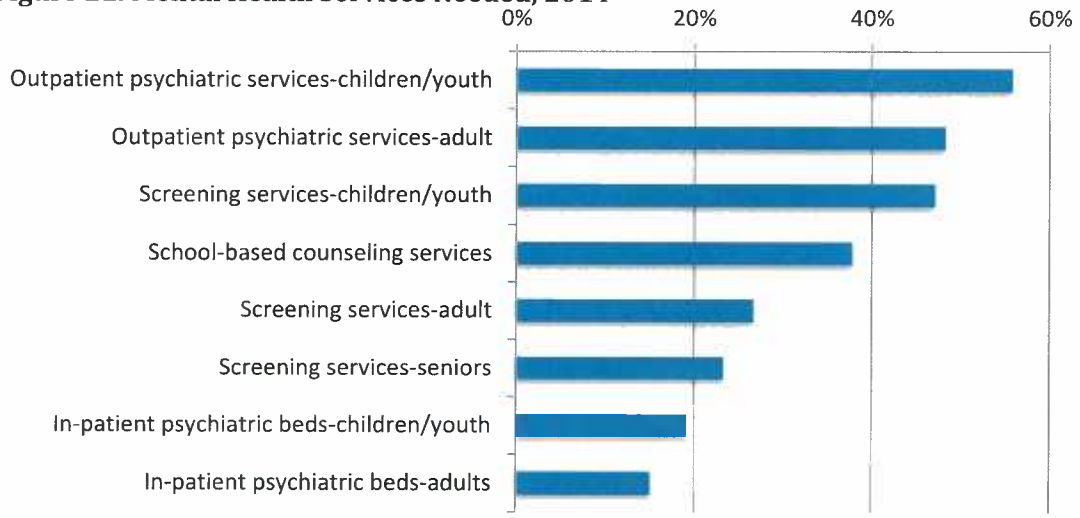
Focus group members' perceptions about the role and effectiveness of schools in addressing mental health issues among students were mixed. Some reported that schools have not been very responsive in meeting students' needs: school-based services are very limited and those that do provide services often have long waiting lists. Others, however, reported that they believed that schools are "stepping up" in response to both mental illness and substance use among students. Many acknowledged, however, that schools are also under pressure to enhance test scores, there is little funding for these types of interventions, and staff are not trained to address issues such as mental illness and substance use. As one school provider stated, *"we spend a good part of the day making sure kids are taken care of—their social-emotional well-being—but we are not equipped for that."* For this reason, several respondents pointed to partnerships such as that between the Housatonic Youth Services Bureau and the Region One High School as a promising way to enhance mental health and substance use services for youth and their families.

Suggestions to Address Mental Health Concerns in the Region

Community stakeholder survey results and focus group discussions point to a variety of needed mental health services in the region. Over half of survey respondents identified a need for outpatient services for children and youth as a top three mental health services need in the region.

(Figure 21) Screening and school-based services for children and youth were also identified as important needs. These needs were the same across the three counties.

Figure 21: Mental Health Services Needed, 2014



Source: FCH Community Stakeholder Survey, 2014.

Several specific suggestions that emerged in focus groups and surveys include:

- *More Mental Health Services/Providers:* Residents expressed concern that the availability of mental health services is decreasing as needs are increasing and are likely to continue to increase as health reform is implemented. As discussed above, local mental health offices are closing. Because accessibility to services is of concern in the region and the supply of providers is limited, several respondents suggested mobile approaches including traveling counselors who could visit community organizations such as a community centers, schools, or senior programs.

- *Enhanced Screening Services for Children and Youth:* National research points to the cost savings from prevention approaches to mental health.[45] Several respondents suggested that more be done to screen and address the need for mental health services early, when intervention is most cost-effective. They suggested more screenings in schools and in physicians' offices. Reaching young children (before they begin school) with screening was also seen as important. However, several provider respondents noted that the effectiveness of screening is limited if there are no providers to whom to refer those identified as needing mental health services. As one provider stated, *"I think the challenge remains in closing the loop between screening and making appropriate referrals for community-based mental health counseling."* Additionally, respondents noted that follow up needs to be conducted with those referred to ensure that they are actually receiving appropriate services.

- *Greater Outreach to Hispanic Residents and More Culturally Appropriate Services:* Focus group discussions with Spanish-speaking residents highlighted the need for more bi-lingual

[45] National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. Washington (DC): National Academies Press, 2009.

mental health providers and support groups, translated materials, and access to interpretation services during mental health visits. To overcome stigma associated with mental health and to encourage help seeking, focus group members suggested additional outreach and education to the Hispanic community. Trusted faith and community leaders were seen as critical partners in outreach efforts.

Substance Use

Substance Use in the Region

Closely related to the issue of mental health is substance use. Over one third of respondents identified substance use as a top three concern for the region and community challenges related to substance use were discussed in every focus group, and often extensively. Concerns about substance use also appear in other documentation. A resident survey conducted in Dutchess County in 2012 found that residents in the Eastern communities of Dutchess identified substance use as the top threat to safety in the community.[46] Additionally, all three CHNAs conducted recently have documented growing concerns about substance use in the region.[47]

"There has been a rapid increase in drug use in the community. Drug use comes from moving from prescription drugs to opiates. Stress and other mental health issues contribute to substance use. "
- Agency Client

For focus group members, substance use was of substantial concern and not limited to a single demographic group. Respondents reported substance use concerns among adults, seniors, and youth in the region. Residents expressed concerns about heroin/opiates, prescription drugs, and marijuana. Heroin was specifically singled out due to recent deaths in the community. EMS providers, for example, reported seeing more drug overdoses. Focus group members shared several reasons for the rise in the use of these substances. Some blamed our *"medication culture,"* in the words of one focus group member. The over-prescribing of medications, in the view of several respondents, has led people to become addicted and then seek cheaper alternatives. As one respondent explained, *"too many providers are prescribing Xanax, Valium, and antidepressants without proper evaluation, diagnosis, or counseling services."* Others reported that rising stress levels and increasing mental health issues have contributed to greater use of illegal substances. Availability of drugs due to the region's location off a major transit route was also seen as a factor affecting use. Finally, some reported that they perceived that lax enforcement of anti-drug laws is also an issue.

Respondents attributed drug use among youth to several factors including a lack of other things for youth to do as well as peer pressure. Focus group members shared that many activities for youth are far away: bowling and the closest movie theater for youth are in Poughkeepsie, for example. As one survey respondent wrote, *"a large number of adolescents in Dutchess County towns do not have*

[46] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education.
[47] Dutchess County Department of Health. (April 2013). *Dutchess Community Health Needs and Assessment and Community Health Improvement Plan 2013-2017.* Litchfield County Community Transformation Grant Coalition. (ND) *2012 Community Health Needs Assessment.* Columbia County Department of Health. (November 2013). *Columbia County Community Health Assessment and Community Health Improvement Plan, 2014-2017.*

access to community spaces that provide supervised gathering places....this issue arises consistently in all town forums conducted by our agency." And like mental illness, some respondents reported, many parents are not willing to acknowledge or address substance use issues among their children. In some cases, drug use is intergenerational. As one provider shared, *"kids know drugs are bad but they think it is not going to happen to them or they might have parents who use drugs and they see that."* Like mental health, the stigma of addiction also prevents people from seeking care.

Secondary data about substance use in the region corroborate the perspectives of survey respondents and focus group members. According to the CDC, in 2010, the drug poisoning deaths were 9 per 100,000 population in Dutchess and 7 in Columbia; this compares to 7 per 100,000 population for the state of New York. In Litchfield County, there were 11 drug poisoning deaths per 100,000, the same rate as for Connecticut.[48] However, Litchfield has recently been singled out for its high rate of heroin overdose deaths.[49]

Another way to look at substance use issues in the region is to examine admissions to certified rehabilitation programs. Data for Dutchess County shows that the county has the third highest rate of admissions to certified rehabilitation programs for primary substance of heroin and/or other opiates of the seven counties comprising the Hudson Valley Region, 161.0 per 10,000 population. This is substantially higher than the state rate (excluding NYC) of 96.9 per 10,000 population.[50] Between 2002 and 2011, the proportion of admissions for treatment in Columbia and Greene counties doubled for heroin use and increased from 2% to 12% for other opiate use.[51] Similar data for Litchfield are not available.

Several recent reports have documented substance use concerns in Dutchess County. The Dutchess County CHNA documented a rising trend in accidental drug overdoses in Dutchess County. While the rate of ED treatment for substance-related disorders in Dutchess County and the rest of New York State grew moderately between 2008-2010, there was a dramatic growth in the rate of hospital admissions for substance-related disorders among Dutchess County residents over this time that was not observed statewide.[52] This trend was predominantly associated with the rising use of opioids. A report by the Dutchess County Health and Human Services Cabinet also documented rising rates of prescription drug and opiate use .[53] The study's analysis shows that deaths from prescription drug overdose are more common among those ages 45 to 64 and those over age 65, while deaths due to illegal drugs are higher in the younger adult population. Similar data were not available for Columbia or Litchfield counties.

With respect to other substances, BRFSS data show that smoking rates among adults in Columbia, Dutchess, and Litchfield counties are the same as for New York and Connecticut overall, although still higher than the HP2020 target of 12%. (Figure 22) Trend data collected in Dutchess indicate that adult smoking rates have declined over time.[54] A higher proportion of adults in Columbia County reported drinking excessively than in the other two counties or the states. In discussing

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[48] Source: CDC WONDER Mortality data, 2004-2010 as cited in 2014 County Health Rankings.
[49] http://www.countytimes.com/articles/2013/12/24/opinion/doc52b9eba529c92478018424.txt
[50] New York State Office of Alcoholism and Substance Abuse Services (OASAS), from the Statewide Planning and research Cooperative System (SPARCS) Inpatient Database as cited in Dutchess County Department of Health. *Community Health Status Report. Community Health Indicators.*
[51] NYS OASAS Data Warehouse as cited in Columbia County CHNA. Data were combined for Columbia and Greene counties.
[52] New York State Department of Health, Health Commerce System, SPARCS as cited in Dutchess County CHNA.
[53] Dutchess County Health & Human Services Cabinet. (December 2013). *Confronting Prescription Drug Abuse in Dutchess County, New York: Existing and Proposed Strategies to Address the Public Health Crisis.*
[54] BRFSS, years 2009 through 2012 as cited in *Dutchess County Community Health Status Report*. (April 2013).

substance use, focus group members focused on drugs, and fewer reported concerns about alcohol or tobacco use. This is consistent with results from the community stakeholder survey in which far fewer respondents identified alcohol and tobacco abuse as top health concerns for the region compared to other substance use and mental illness.

Figure 22: Adult Substance Use Behaviors, FCH Counties, 2006-2012

	Excessive Drinking[55]	Smoking[56]
Dutchess, NY	19%	14%
Litchfield, CT	19%	17%
Columbia, NY	23%	14%
New York	17%	17%
Connecticut	19%	15%
HP2020	--	12%

Source: Behavioral Risk Factor Surveillance System, 2006-2012, as cited in 2014 County Health Rankings.

The Search Institute Developmental Assets survey provides information about substance use among youth in the region. Data for two time periods, 2009 and 2013, were available for Region One while data for 2009 were available for Dutchess County. Due to different time frames for data collection and different grades sampled, results across the two areas cannot be compared; data on similar measures and for similar grades are also not available at the state level, thus additionally limiting comparison. Similar data were not available for Columbia County schools. It is important to note that these surveys are completed by a small sample of students and thus should be interpreted with caution.

Data related to substance use in Region One show that the proportion of sampled youth reporting substance use has remained largely the same between 2009 and 2013 for most substances; reported cigarette use declined over this time period. (Figure 23) In 2013, 30% of sampled students reported using alcohol in the 30 days prior to the survey and 19% reporting getting drunk once or more in the two weeks prior to the survey. Among sampled students, 16% reported marijuana use in the 30 days prior to the survey. Not surprisingly, use of substances generally increases with age.

Figure 23: Risk-Related Behaviors, Region One School District, 2009 and 2013

	Total 2009	Total 2013	Grade 7 2013	Grade 9 2013	Grade 11 2013
Used alcohol once or more in the last 30 days	28%	30%	5%	37%	57%
Got drunk once or more in the last two weeks	17%	19%	3%	20%	44%
Smoked cigarettes once or more in the last 30 days	13%	7%	1%	7%	19%
Used marijuana once or more in the last 30 days	17%	16%	1%	18%	39%
Used heroin or other narcotics once or more in the last 12 months [57]		4%	0	9%	4%
Used other illicit drugs once or more in the past 12 months[58]	7%				

[55] Percent of adults reporting binge plus heavy drinking.
[56] Percent of adults that report smoking >= 100 cigarettes and currently smoking.
[57] Question was added in 2013 survey.
[58] Question was dropped after 2009 survey.

	Total 2009	Total 2013	Grade 7 2013	Grade 9 2013	Grade 11 2013
Rode (once or more in the last 12 months) with a driver who had been drinking	33%	28%	19%	35%	34%

Source: Search Institute, Developmental Assets Survey, 2009 and 2013.

Data related to youth substance use in Dutchess County in 2009 show that over one third of students reported using alcohol in the 30 days prior to the survey and almost one quarter reporting getting drunk once or more in the two weeks prior to the survey. (Figure 24) Over one quarter of students reported using marijuana once or more in the 12 months prior to the survey. Tobacco use was comparatively low. Reported use of substances increased with age.

Figure 24: Risk-Related Behaviors, Dutchess County Schools, 2009

	Total	Grade 8	Grade 10	Grade 12
Used alcohol once or more in the last 30 days	35%	17%	38%	51%
Got drunk once or more in the last two weeks	24%	11%	28%	35%
Smoked cigarettes once or more in the last 30 days	12%	6%	10%	21%
Used marijuana once or more in the last 12 months	28%	11%	31%	47%
Used other illicit drugs once or more in the last 12 months	8%	3%	8%	13%
Rode (once or more in the last 12 months) with a driver who had been drinking	29%	29%	26%	30%

Source: Search Institute, Developmental Assets Survey, 2009.

Existing Substance Use Services

Focus group members and survey respondents reported that, like mental health services, there are few programs and services to address substance abuse in the region. Those that do exist are economically out of reach for many or located far away according to residents. For example, Mountainside Lodge and High Watch were mentioned by many respondents, but these are private facilities. Other facilities mentioned include Trinity Glen, a long-term in-patient care facility which accepts Medicaid, and Twin County Recovery Services. Further away, the Mid-Hudson Addiction Recovery Center (MARC) operates three centers for recovery in the mid-Hudson region. The cost of substance use services and lack of providers, as with mental health, were also seen as concerns. Another concern expressed by several respondents is the lack of continuity of care. As one provider respondent shared, *"there is no prevention—the system gets [people] when there is an issue. And then once you start to get better, that is when the help ends—there is no follow up."*

Housatonic Youth Services Bureau and the Council on Addiction and Prevention Education (CAPE) were mentioned as the primary prevention and early intervention providers for youth in Connecticut and New York, respectively. Respondents reported little in terms of community education efforts around substance use. Youth and those working in schools reported that while substance issues are discussed in health classes, they are done so in a broad way and often focused

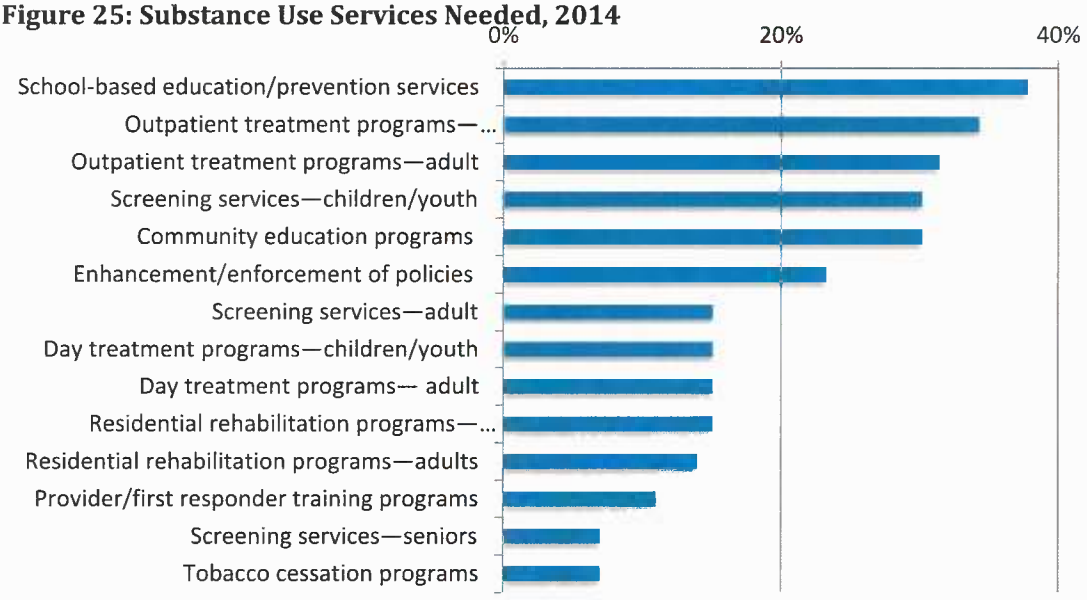
on younger students. The DARE[59] program, for example, is available for younger students but there is not a similar program for older youth.

In addition to service providers, there are several community coalitions focused on addressing substance use issues. In Dutchess County, CAPE has been working to address substance use issues through prevention and has supported community-based coalitions (encompassing Pine Plains, Webutuck, Dover, Pawling, Red Hook and Rhinebeck school districts) that are developing local strategies to address youth substance use.[60] In Litchfield, prevention efforts are led by the Northwest Corner Prevention Network that focuses on addressing substance issues among youth. Finally, agencies like the Dutchess County Drug Task Force, the Columbia-Greene Controlled Substance Task Force, and the Litchfield County Opiate Task Force, are working to address substance use at the law enforcement level.

Suggestions to Address Substance Use Concerns in the Region

Community stakeholder survey results and focus group discussions point to the need for a variety of substance use services, in particular those for children and youth. About 40% of survey respondents identified a need for school-based services for children/youth and adults as a top three need. (Figure 25) These concerns were the same across communities in all three counties. Health providers tended to see a greater need for out-patient and day treatment programs than non-health providers while non-health providers in greater numbers reported a greater need for preventive services such as screening and school-based and community education programs.

Figure 25: Substance Use Services Needed, 2014



Source: FCH Community Stakeholder Survey, 2014.

[59] Founded in 1983 by the Los Angeles Police Department, the Drug Abuse Resistance Education (DARE) is a national program that teaches students good decision-making skills to help them lead safe and responsible lives. http://www.dare.org

[60] Dutchess County Health & Human Services Cabinet. (December 2013). *Confronting Prescription Drug Abuse in Dutchess County, New York: Existing and Proposed Strategies to Address the Public Health Crisis.*

Specific suggestions from focus group members and survey respondents included:

- *More Substance Use Services/Providers:* As with mental health services, residents believed that more affordable substance use services were needed in the community. These services should address the full spectrum of the disease from prevention to early intervention to treatment and include both in- and out-patient services and programs. As discussed above, expansion of health insurance coverage to substance abuse services including screening through the ACA will likely place increasing demand on existing services.

- *More School-Based Substance Use Treatment and Prevention Services*: Focus group members and survey respondents alike saw a need for greater substance use intervention in the schools. Several mentioned that national research points to the important cost savings that come from investment in substance abuse prevention and suggested that funding for these services needs to be increased, at multiple levels.[61] Focus group members suggested more school-based counselors as, according to providers, there are wait lists for school-based services. But as with mental health services, treatment programs and services must be available to those identified in need of them.

  Additional suggestions included the use of evidence-based prevention education in the schools. However, as when discussing mental health services in the schools, respondents stressed that education mandates and other requirements placed on schools create substantial challenges to implementing substance abuse prevention education in the schools. Alternative suggestions included enhancing awareness of substance use and mental health through teacher training to help educators identify youth at risk. Those who mentioned a need for more prevention education stressed the need for young people—and their parents—to hear from youth who have personally struggled with substance use rather than substance use "experts" or school authorities. As one provider shared, *"there are kids who have turned their lives around. This is what other kids will listen to, not experts. Bring in the parents of these kids to talk about this as well."*

  Several focus group members reported, however, that education interventions are likely to be less effective for those students most at risk for substance use. They argued for deeper interventions such as mentoring programs. Finally, although not explicitly asked about in the survey, the issue of activities for young people came up in several focus groups. This was seen by some as critical to addressing substance use and other behavioral health issues among the community's young people. Suggestions to enhance options for youth included offering more community-based recreation programs (with scholarship support) and promoting those that do exist as well as opportunities for young people to participate in programs like internships and community service.

- *Enhanced Outreach and Education:* A number of survey respondents and focus group members felt that more was needed to educate all community members about the dangers of substance use especially the epidemic of opiate use. Some communities are currently working on this through events like prescription drug "take back" days and community forums. Respondents differed somewhat in how they thought this could be accomplished. Some suggested that a more intensive media approach was needed as media campaigns

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[61] National Association of State Mental Health Directors. June 2012. *Fact Sheet on Behavioral Health Conditions: Paying the Societal Toll—a Tragedy Runs Through It.*

have been shown to influence opinions and change behavior. Others suggested a more general community education approach.

- *Improving Provider Prescribing Practices*: Although it did not come up in surveys, several focus group members reported that they believed more should be done to educate providers about the dangers of overprescribing painkillers. New York has recently passed the I-STOP prescription monitoring program to track the dispensing of controlled substances. However, respondents also believed that providers should be educated about abuse of pain medication to better monitor prescribing as well as follow-up to help ensure patients do not become addicted.

Obesity and Chronic Disease

Obesity and Chronic Disease in the Region

Chronic disease and its contributors—lack of physical activity and good nutrition—was also identified as a concern for the region among survey respondents and focus group members. Over 30% of survey respondents identified chronic disease as one of the top three health concerns for the region.

"Diabetes is huge. It is epidemic. There is so much pre-diabetes. The cost of diabetes is huge—medication is expensive."

- Leader in the Latino Community

Focus group members also identified obesity as a concern for residents of the region. They attributed rising rates of obesity to a lack of access to healthy food and physical activity, a more sedentary lifestyle (the *"tech culture"* as one person stated), lack of time, and a general trend in today's culture toward highly processed foods and large serving sizes. Accessibility of healthy food was very much on the minds of many focus group respondents, especially those in Dutchess because of the recent closure of a local supermarket. Many respondents reported that healthy food was economically—and increasingly geographically—out of reach for many lower income families in the area and the closing of the supermarket exacerbated that situation.

While focus group members reported that obesity was a concern across all demographic groups, they expressed concern particularly for rising obesity in children, including very young children. Members and leaders in the Hispanic community who attended focus groups reported that diabetes rates among immigrants are rising as they adopt "American" eating habits, including consumption of sugary drinks, and become more sedentary than in their home countries. Overall, focus group members reported that they believed that rising rates of obesity were also the result of lack of knowledge about how to eat nutritionally and the importance of engaging in physical activity—across age and demographic groups. Several attributed this as well to marketing. As one focus group member shared, *"kids can go to [local convenience store] and if they buy the container they can refill their sugary drinks. Parents are not teaching their kids about healthy choices—maybe they don't know themselves."*

Data from the BRFSS show that the adult obesity rate in Columbia County is the same as for New York, while the Dutchess County rate is higher. (Figure 26) Litchfield experienced slightly lower rates than the state of Connecticut.

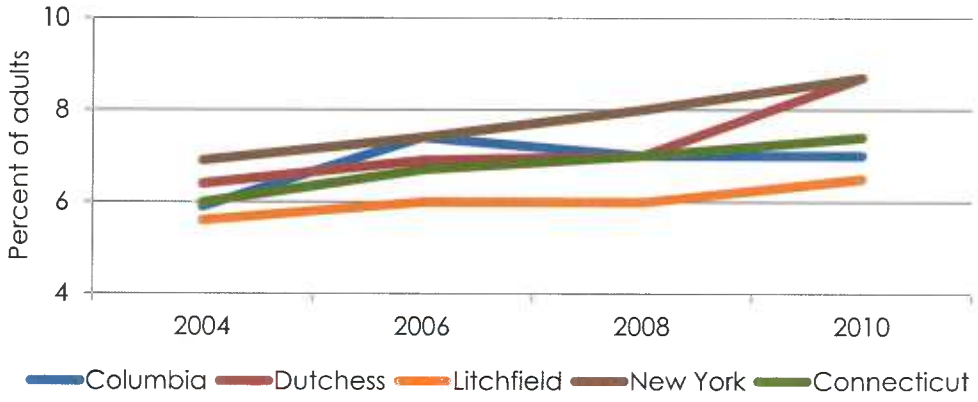
Figure 26: Adult Obesity Rates, FCH Counties, 2006-2012

County	Adult obesity rate
Dutchess	26%
Litchfield	22%
Columbia	24%
New York	24%
Connecticut	24%
HP2020	30.5%

Source: Behavioral Risk Factor Surveillance System, 2006-2012, as cited in 2014 County Health Rankings.

Data from the BRFSS show that the rate of adult diabetes is rising in the FCH counties as well as in New York and Connecticut. (Figure 27)

Figure 27: Proportion of Adults with Diabetes, FCH Counties, Connecticut, and New York, 2004-2010

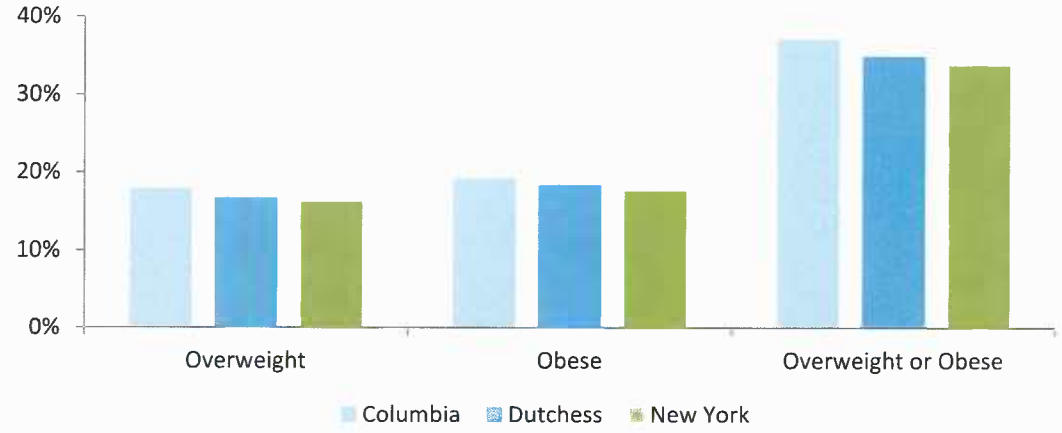


Source: Behavioral Risk Factor Surveillance System and U.S. Census Population Estimates Program, as cited in Community Commons

According to statistics collected by the New York Statewide School Health Services Center, about 37% of Columbia County students and 35% of Dutchess County students are overweight or obese. (Figure 28) In New York overall (excluding NYC) the rate of overweight or obesity among students was about 34%. Overweight and obesity rates vary across FCH towns with some towns experiencing very high rates. Among the school districts of Dutchess, the proportion of children who were overweight/obese (2010-2012) was highest in Northeast (44%), Dover (40%), Millbrook (35%), and Pine Plains (34%).[62] Among the school districts of Columbia, the proportion of children who were overweight/obese (2010-2012) in Taconic Hills (Copake and Ancram) was 33%, the fourth highest of the six school districts in the County.[63]

[62] Source: NY State Student Weight Status Reporting System, 2010-2012 as cited in Dutchess County CHNA.
[63] Source: NY State Student Weight Status Reporting System, 2010-2012 as cited in Columbia County CHNA.

Figure 28: Proportion of Public School Students who are Overweight and Obese, Columbia, Dutchess, and New York, 2010-2012



Source: New York State Department of Health, Student Weight Status Reporting System.

Data about obesity rates among youth in Litchfield County are unavailable. However, information about physical fitness among youth in the area indicate that among students in the region, fewer in North Canaan and Norfolk and fewer middle/high schoolers than elementary school students are able to pass physical fitness tests. (Figure 29)

Figure 29: Percentage of K-12 Students Passing All Four Physical Fitness Components, Litchfield School Districts, 2010-2011[64]

School District	% of K-12 Students Passing
Cornwall School District	80.5%
Kent School District	67.0%
Canaan (Falls Village) School District	65.2%
Salisbury School District	64.6%
Sharon School District	56.1%
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	35.1%
Norfolk School District	31.9%
North Canaan School District	28.7%
STATE	51.0%

Source: Connecticut Department of Education as cited in 2013 Litchfield County CHNA.

Existing Services to Support Healthy Eating and Physical Activity

Accessibility of healthy food was very much on the minds of many focus group respondents, especially those in Dutchess and Columbia. Residents of Dutchess communities reported in focus groups that the Fresh Town supermarket in Dover Plains had recently closed, creating challenges to food access, especially for those without transportation. The cost of food, including costs associated with traveling to purchase it, was a substantial concern to many residents, especially seniors and lower income residents.

[64] Tests include four areas of fitness: aerobic endurance, flexibility, muscular strength, and endurance.

In general, regardless of where they lived, focus group members reported that accessing affordable healthy food was challenging. As one focus group member shared, *"many lower income people shop for food at the dollar stores because they can get more food—it's not the healthiest but they get more for their money."* Additionally, lower income residents rely on food pantries which were reported to have limited healthy choices. Although the region does not have many fast food outlets, it also does not to have many affordable restaurants that serve healthy food options according to focus group members.

"Healthy food is far away now that the supermarket has closed. Those who used to walk there have it hard – they have to find other places to go and it won't be easy."

- Agency Client

There was substantial discussion in focus groups about accessibility of fresh and locally-grown food. There are several community gardens in the region at local churches and at Webutuck High School. Many towns have farmer's markets but not all do; however efforts are underway to expand farmer's markets to new towns. Perceptions about the affordability of food sold at farmer's markets varied across focus group members. Some reported that it was too expensive while others reported it was not substantially more than supermarket prices.

When asked about options for physical activity in the region, focus group members shared that there are many opportunities including parks, playgrounds, and a rail trail. However, access is largely limited to those with private transportation. Additionally, the rurality of the region means that there is limited infrastructure to support active transportation such as biking or walking including lack of sidewalks, streetlights, and bike lanes. New England winters also constrain outdoor activities for many. Focus group respondents reported that there are also community-based programs for physical activity, although these are limited. Community centers offer exercise classes for seniors and others. In addition, the Hotchkiss School makes its pool available for free and also offers exercise classes for a fee.

When asked about opportunities for youth, focus group respondents mentioned that youth have opportunities to participate in sports through school teams or club-based programs, although some programs cost money to participate. This can be prohibitive for some families. As one focus group member shared, *"the town has an active youth sports program—soccer, t-ball. But they all cost money. There is scholarship money but many families are not aware of that. And then transportation might be an issue."*

Secondary data point to similar themes relative to accessibility of healthy food and places to be physically active as shared by focus group members. According to business mapping information, a smaller proportion of residents in all three FCH counties have access to exercise opportunities compared to other residents in the states, especially those in Litchfield County. About 85% of residents in Dutchess have access to exercise opportunities, compared to 89% of New York residents overall. Only 47% of residents in Columbia have access to exercise opportunities. In Connecticut, 91% of residents have access to exercise opportunities, while only 81% of Litchfield residents do.[65]

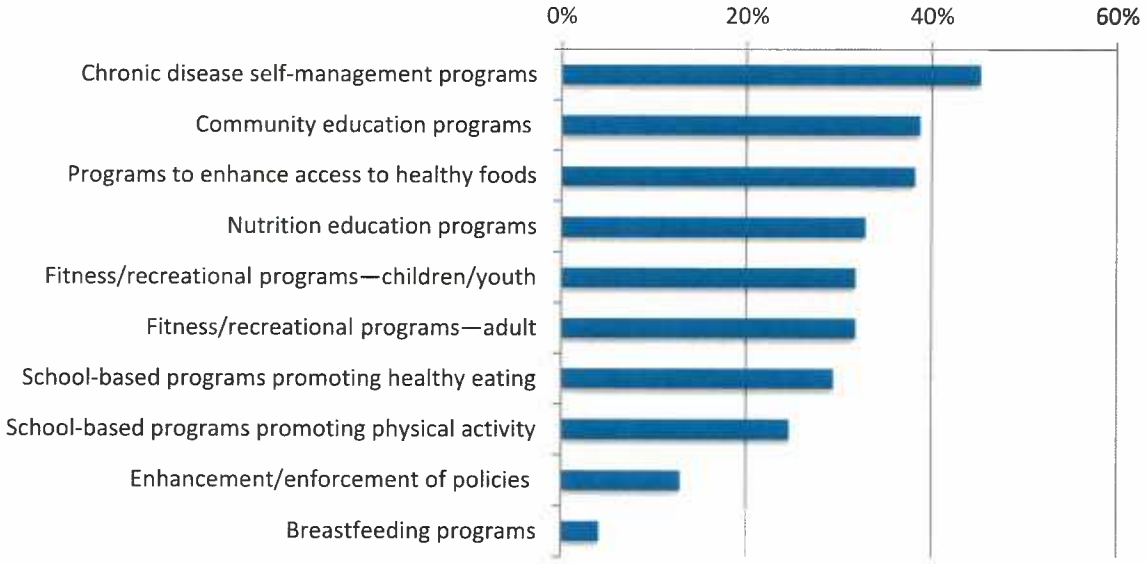
[65] OneSource Global Business Browser, Delorme map data, ESRI, & US Census Tigerline Files, 2010 & 2012, as reported in 2014 County Health Rankings.

The proportion of the population with limited access to healthy food is 6% in Dutchess and 5% in Columbia, a higher rate than for the state of New York (2%), the state of Connecticut (4%) and Litchfield County (2%).[66] According to the 2012 Dutchess County resident survey, 12% of respondents reported that they had difficulty buying healthy foods.[67] Among those who reported difficulty, cost was the predominant reason (87%) followed by lack of availability in places where the respondents shopped (31%) and too far to get to (28%).

Suggestions to Address Obesity and Chronic Disease Concerns in the Region

Review of survey responses about needed services to address chronic disease shows that aside from chronic disease self-management programs, which over 40% of respondents reported as a top three need in the region, respondents were more mixed in their views of what services were needed to address the complex issue of obesity and lifestyle behaviors. Almost half of stakeholder survey respondents reported that there was a need for chronic disease self-management programs. (Figure 30) Other suggestions related to enhanced education and programs that increase access to healthy foods and physical activity.

Figure 30: Chronic Disease Services Needed, 2014



Source: FCH Community Stakeholder Survey, 2014

Specific suggestions from focus group members and survey respondents included:

- *Promotion of Chronic Disease Self-Management Programs*: Provider survey respondents overwhelmingly reported a need to enhance chronic disease self-management programs with a particular focus on implementing those that have been proven to work (are evidence-based). As one survey respondent stated, *"I believe evidence-based interventions like the Stanford Chronic Disease Self-Management Program provide the tools needed for organizations and individuals to have sustainable and measureable health outcomes."* While

[66] Source: USDA Food Environment Atlas, 2012, as reported in 2014 County Health Rankings.
[67] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education.

this suggestion was not raised in focus groups, when asked whether such type of support would help those with chronic illnesses, many focus group members agreed that it would.

- *More Education About Healthy Lifestyles*: Both survey respondents and focus group members noted that community education was needed to increase healthy behaviors among residents and reduce obesity rates. What was especially needed, according to residents in focus groups, was nutrition education. Few focus group participants reported that they had seen a nutritionist or dietician as part of their health care, although they believed this would be helpful in educating patients about proper nutrition. Residents also stated that more written materials and in-person education/training was needed especially in topics such as what comprises a balanced meal, how to read food labels, how to purchase healthy foods on a budget, and how to prepare quick but healthy meals. They stressed that multiple outlets for information are needed because attendance at "classes" or community forums is often lower than expected. They suggested that more written materials about nutrition for parents be sent home with students and shared through food pantries and food programs such as the BackPack Program.[68] Spanish-speaking focus group members suggested that ESL classes were an ideal place to share such information with non-English speaking residents (while simultaneously enhancing English language skills) and several mentioned that this has been tried with success in Dutchess County through a partnership with Cooperative Extension.

- *Greater Access to Affordable and Healthy Food*: Focus group participants reported that efforts to raise awareness about nutrition among residents, especially those with lower incomes, will only be successful if healthy food is affordable. One respondent mentioned that the region is currently piloting a Health Bucks program at local farmer's markets. Health Bucks is a program begun in New York City to enhance healthy eating through paper vouchers that can be used by electronic benefit transfer (EBT) consumers to purchase fresh fruits and vegetables at participating farmers markets. For every $5 a customer spends using EBT, s/he receives one $2 Health Buck coupon to be used for additional healthy food.[69] Several respondents also suggested that more be done to create community gardens and to promote farmer's markets to lower income residents of the region.

- *Enhanced Access to Physical Activity Classes*: Relative to physical activity, respondents suggested that more opportunities for physical activity be offered and that such opportunities be affordable. They also suggested that more be done to raise awareness of those opportunities that are currently available, including financial support such as scholarships for summer camps and youth sports programs. Several senior residents believed that parks and trails could be improved through the addition of benches. Finally, a couple of focus group members mentioned that community fitness challenges have proven successful in the past and could be promoted in the future.

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[68] The BackPack Program, run by the Food Bank of the Hudson Valley addresses childhood hunger, especially on weekends when school breakfast and lunch programs are not offered, provides bags filled with food that are discreetly distributed to participating children at 11 regional schools on Friday afternoons.

[69] http://www.grownyc.org/greenmarket/ebt/healthbucks

Other Health Needs

In the final survey question, community stakeholder survey respondents were asked about other health concerns in the region, beyond those already discussed in this report. Of the top three concerns highlighted early childhood services such as home visiting and family support were identified by the most respondents (48%) followed by geriatric care services (42%).

Oral Health

Although oral health was not identified as a top overall health concern in the region by many completing the community stakeholder survey, it was identified as a top "other health" concern among respondents.[70] Additionally, the topic was discussed in several focus groups. As shared earlier in this report, the region has a high patient to dental provider ratio.[71] In addition, focus group members reported that many dentists do not accept Medicaid. Both of these make it difficult to access oral health care according to focus group members. Focus group members also reported that specialty dentistry, like root canal, was very difficult to obtain and required travel out of the region. The 2012 resident survey conducted in Dutchess County found that access to dental care was the top unmet need for health care services: 20% of survey respondents reported that they needed dental care, and 61% of these respondents reported that they did not receive it.[72] The unmet need for dental services was significantly higher among younger adults (ages 18-21) and declined with age. According to BRFSS data, however, the proportion of adults with a dental visit in the past year was similar for the FCH counties as for the two states. (Figure 31)

Figure 31: Proportion of Adults With Dental Visits in the Past Year, FCH Counties, Connecticut, and New York

County	
Dutchess	72.3%
Litchfield	83%
Columbia	69.6%
New York	71.1%
Connecticut	81%

Source: Dutchess and NYS: BRFSS 2008-2009 as cited in Dutchess County CHNA. Columbia: BRFSS 2008-2009 as cited in Columbia County CHNA. Litchfield and CT: BRFSS 2007-2010 as cited in Litchfield County CHNA.

[70] In the last question of the survey, respondents were asked to identify the top three other health and health-related services needed from the following list: dental services, community education programs to prevent vector-borne illness, provider education programs to prevent vector-borne illness, end-of-life/hospice services, geriatric care services, early childhood services, sexually transmitted disease screening programs, and women's health services. 42% of respondents selected dental services. However, when asked to identify top three overall health concerns in the region, 15% of respondents identified dental/oral health as one of these.

[71] The ratio of population to dental providers in New York and Connecticut was about 1,300 to 1 while the ratio in the FCH service area ranged from 1,652:1 in Dutchess to 2,587:1 in Columbia.

[72] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education. Data specific to Eastern Dutchess communities not provided. Question was asked as follows: "At any time in the past year, did you or any member of your immediate household need but not receive any of the following healthcare services?"

Affordability of dental care was also a big concern for residents. Many lower income residents reported that they obtained dental care on a sliding fee scale from Hudson River Health Care (FQHC located in Amenia) or the Greater Torrington Community Health and Wellness Center but wait times were reported to be long. The cost of dental care was found to be a significant barrier to accessing dental services for immigrant populations in Eastern Dutchess County.[73]

Overall, focus group members shared positive views about dental services for children. Several reported that their children received preventative oral health services in school and got dental services when needed. Many schools in the region provide school-based oral health services including sealants which are seen as a critical intervention for good oral health among children. Data collected about this work indicate positive improvement over time. According to data cited in the 2013 CHNA for Dutchess County, the proportion of 3rd grade children with evidence of untreated tooth decay declined from 32.1% in the 2002-2004 to 20.5% in 2009-2011.[74] In Columbia, 21.2% of children had untreated tooth decay in 2009-2011.[75] Data from six Connecticut schools with sealant programs show that proportion of children with one or more decayed teeth declined from 34% in the 2006-2007 school year to 12% in the 2010-2011 school year.[76]

Communicable Diseases

Although quantitative data point to high rates of Lyme Disease in FCH counties, this issue was not often mentioned in focus groups or surveys. (Figure 32) However, both the Columbia County CHNA and the Dutchess County CHNA identified arthropod-borne illness as a key health concern and have included prevention efforts in their updated Community Health Improvement Plans.

Figure 32: Lyme Cases per 100,000 population, FCH Counties, Connecticut, and New York

County	
Dutchess, NY	150
Litchfield, CT	116.9
Columbia, NY	824.8
New York	66.2
Connecticut	122

Source: NY: 2008-2010 NYSDOH as cited in Columbia and Dutchess County CHNAs. CT and Litchfield: 2009, Connecticut Department of Public Health as cited in Litchfield County CHNA.

Rates of sexually-transmitted infections were substantially lower in FCH counties than in the states of New York and Connecticut overall. Chlamydia infections are among the most commonly-reported notifiable disease in the U.S. and they are among the most prevalent of all sexually transmitted infections (STIs).[77] The Chlamydia rate in Dutchess was 245 per 100,000 population in 2011 and 160 in Columbia, much lower than the New York rate of 530 per 100,000. Litchfield's rate of 137

[73] Schmidt, H., Waltner, A., Muller, S. (Feb 2011). *The Immigrant Health Initiative: A study of health care of recent immigrants in Dutchess County, New York.*
[74] Bureau of Dental Health, New York State Department of Health as cited in Dutchess County CHNA.
[75] New York State Department of Health as cited in Columbia County CHNA.
[76] Kwatra, J. (Sept 2013) *Evaluation of School Based Oral Health Promotion Program.* Study conducted for the Foundation for Community Health.
[77] Dutchess County Department of Health, *Community Health Assessment 2014-2017.*

was far lower than the Connecticut rate of 381 per 100,000 population.[78] However, Chlamydia rates in Dutchess were reported to be rising, as they are nationwide and in the state.[79]

Asthma

Mortality and morbidity statistics shared earlier in this report indicate a higher rate of asthma deaths and hospitalizations in FCH counties than the states. However, data about asthma-related ED visits, for both young children and those of all ages, indicate that rates are lower in Columbia and Dutchess than in New York. (Figure 33) Data for Litchfield are unavailable.

Figure 33: Asthma ED Visits, per 10,000 population, Columbia, Dutchess, New Year, 2008-2010

	New York (excl. NYC)	Columbia	Dutchess
ED Visits (0-4 yrs)	221.4	112.3	84.3
ED Visits (all ages)	83.7	41.5	51.7

Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2008-2010.

Maternal and Child Health

Maternal and child health concerns were not prominent themes in most focus groups and interviews. Quantitative data additionally indicate that FCH communities are similar to or better than on key measures of maternal and child health and have met key HP2020 targets in this area. (Figure 34)

Figure 34: Maternal and Child Health Indicators, FCH Counties, Connecticut, and New York, 2005-2011

County	Low Birthweight	Infant Mortality[80]	Teen Birthrate[81]
Dutchess, NY	7.2%	5	13
Litchfield, CT	7.2%	4	12
Columbia, NY	7.5%	10	24
New York	8.2%	6	24
Connecticut	8.0%	6	21
HP2020	7.8%	6	NA

Source: Low Birthweight and Teen Birth Rate: National Center for Health Statistics, 2005-2011 as cited in 2014 County Health Rankings. Infant Mortality: Health Indicators Warehouse as cited in 2014 County Health Rankings.

Another measure of maternal and child health is access to adequate prenatal care. According to the New York State Department of Health, the percent of pregnant women with adequate prenatal care

[78] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2011 as reported in 2014 County Health Rankings.
[79] Dutchess County Department of Health, *Community Health Assessment 2014-2017*.
[80] Rate of all infant deaths (within 1 year), per 1,000 live births
[81] Teen birth rate per 1,000 female population, ages 15-19

was 68% in Dutchess County and 63% in Columbia County compared to 68% in New York State (excluding NYC).[82]

Screening and Prevention

Screening was not a prevalent theme in either survey results or focus groups and quantitative data indicate that screening levels in FCH counties are similar to those for the states. (Figure 35) Screening rates for diabetes are slightly higher in Dutchess County than in Litchfield, Columbia, and the states. Mammogram screening rates are higher in Dutchess and Columbia counties than in New York overall.

Figure 35: Screening Rates, FCH Counties, 2005-2011

County	Diabetes Screening	Mammogram
Dutchess	88%	66%
Litchfield	86%	66%
Columbia	85%	66%
New York	85%	63%
Connecticut	85%	68%

Source: Medicare/Dartmouth Institute, 2011 as cited in 2014 County Health Rankings.

Health Needs of Sub-Populations

This section discusses more specifically the health needs of two populations in the region that respondents identified as facing unique health challenges and needs, Hispanics and seniors. Children and youth and those of lower income were also reported to face challenges and these groups are discussed throughout this report.

Hispanics

Hispanics are the largest non-White population group in the FCH service region, comprising 6% of the total population. The number of Hispanics in the region is also growing according to recent community health needs assessments. The health disparities experienced by racial and ethnic minorities have been extensively documented.[83] Due to the small number of Hispanics in the region, statistical data about health disparities in FCH communities are unavailable. However, secondary data show that:[84]

- In Columbia and Dutchess counties, a higher proportion of Hispanics experience premature death when compared to non-Hispanic Whites.[85] It is important to note that premature death rates are highest among non-Hispanic Blacks.

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[82] New York State Department of Health, Health Indicators, 2009-2011, https://www.health.ny.gov/statistics/community/minority/county/newyorkstate.htm

[83] Although many sources can be cited, a good recent summary of health disparities experienced by racial and ethnic minorities can be found in the U.S. Department of Health and Human Services *Plan to Reduce Racial and Ethnic Health Disparities:* http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[84] Due to low sample size, some of the data about Hispanics in Columbia are unstable.

[85] Litchfield: Connecticut Department of Public Health, 2012. Vital Records Mortality Files, 2005-2009 cited in Litchfield County CHNA. Columbia: NYSDOH County Health Indicators, 2008-2010, as cited in Columbia County CHNA. Premature

- While Hispanics in Litchfield, Dutchess, and Columbia experience lower rates of mortality and hospitalization due to heart disease, stroke, and cancer compared to non-Hispanic Whites, they experience higher rates of mortality and hospitalization due to diabetes.[86] It is important to note that death and hospitalization rates due to many of these conditions is highest among non-Hispanic Blacks.
- Obesity rates are higher for Hispanic populations compared to non-Hispanic Whites nationally. Based on data from National Health and Nutrition Examination Survey, the White non-Hispanic population had the lowest rate of obesity, 33.4% of adults aged 20 years and over (age adjusted) whereas the black non-Hispanic and Hispanic populations had rates of 48.6% and 40.5% (age adjusted), respectively.[87]
- Data available at the state level indicate that Hispanics have lower rates of screening than their non-Hispanic White counterparts, including screening for diabetes and cholesterol.[88]
- Data for Dutchess and Columbia counties indicate that Hispanic residents are less likely to access dental and mental health services than non-Hispanic Whites.[89]
- Fewer Hispanic women in Columbia and Dutchess counties receive prenatal care compared to non-Hispanic White women.[90]
- Hispanic residents of the Mid-Hudson Valley were more likely than their non-Hispanic White counterparts to experience a gap in health insurance and skip a doctor's visit or medication due to cost.[91]

According to focus group members as well as other data, the primary barriers to health care access encountered by Hispanic residents in the area include lack of health insurance, language, cost, and availability and awareness of services.[92] Additionally, undocumented Hispanics are particularly vulnerable. Fear of deportation leads to reluctance among illegal immigrants to seek out services from agencies and health providers, thus negatively affecting their health. Suggestions by focus group members and survey respondents to address these barriers and improve health outcomes among Hispanics in the community included:

- *Enhanced Language Access*: A recurring topic among focus group members who were Spanish speakers was the issue of language access. While many shared that communication access at community health centers, where many get services, and community-based organizations serving Hispanics is very good due to bi-lingual providers and in-person interpreters, that is not the case at all provider locations and social service agencies. Results

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death defined as death before 75 years. Dutchess: NYSDOH Community Health Indicators, 2008-2010 as cited in Dutchess County CHNA. Premature death defined as death before 65 years.

[86] Litchfield: mortality data from Connecticut Department of Public Health, 2012. Vital Records Mortality Files, 2005-2009, hospitalization data from Connecticut Department of Public Health, 2012. CHIME Hospital Discharge Data Set, 2005-2009. Both cited in Litchfield County CHNA. Columbia: NYSDOH County Health Indicators, 2008-2010, as cited in Columbia County CHNA. Mortality data for Hispanics in Columbia suppressed due to low numbers. Dutchess: NYSDOH Community Health Indicators, 2008-2010 as cited in Dutchess County CHNA.

[87] http://healthypeople.gov/2020/lhi/nutrition.aspx?tab=data#NWS-9 Data from 2009-2012.

[88] Connecticut Department of Public Health. (2011) *The Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report* and Connecticut Department of Public Health. (2011) *The Burden of Diabetes in Connecticut, 2010 Surveillance Report.*

[89] Wheeler, K., and Waltner, A. (June 2013) *Dutchess County ICA Community Health Survey 2012*. Prepared for the Dutchess County Department of Health, Division of Health Planning and Education. Marist College Institute for Public Opinion. *Many Voices One Valley 2012. Health Matters. A survey of Mid-Hudson Valley residents.*

[90] Columbia: NYSDOH Health Indicators Reports, 2008-2010, as cited in Columbia County CHNA. Dutchess: NYSDOH Community Health Indicators, 2008-2010 as cited in Dutchess County CHNA.

[91] Schmidt, H., Waltner, A., Muller, S. (Feb 2011). *The Immigrant Health Initiative: A study of health care of recent immigrants in Dutchess County, New York.*

[92] Ibid.

from a survey of immigrants conducted in Dutchess County found that immigrants from eastern Dutchess County were significantly more likely to bring their own interpreters than those in Poughkeepsie who were more likely to use medical interpreters.[93] Enhancing the number of bi-lingual providers and interpretation services especially in services such as mental health, dental health, and other specialties, was frequently mentioned as a strategy for enhancing access and improving outcomes for Hispanics. Focus group members also expressed a need for more translated information including instructions for follow-up care and medication. As one Spanish speaking focus group member stated, *"results of tests come in English and that is hard."*

- *More Culturally Appropriate Mental Health Services*: As discussed earlier in this report, lack of mental health services, including both prevention and treatment services, is a concern for the entire region. Spanish-speaking focus group members reported that they face substantial challenges in accessing mental health services due to communication barriers and cost. Focus group members suggested enhancing access to free and language-appropriate screenings as well as the formation of Spanish-speaking mental health support groups in the area.

- *Enhanced Health Literacy*: Another challenge mentioned by focus group members was health literacy. They shared that a lack of information about healthy behaviors and available health and social services creates a barrier to good health for non-English speakers. Focus group respondents saw a need for extended outreach to Hispanic members of the community through partnerships with existing programs such as ESL classes. Outreach through media such as Spanish TV and radio was also suggested as a strategy for reaching Hispanic residents with information. Several respondents also reported that support for community health workers (discussed below) is an important strategy to enhance health literacy in the community.

- *Support the Use of Community Health Workers*: Community health workers (CHWs), also called Promotoras or peer health educators, are lay community members (volunteers or paid staff) who work with health care systems to improve the health and well-being of community residents. CHWs often offer interpretation and translation services, provide culturally-appropriate health education and information, assist people in receiving the care they need, and give informal counseling and guidance on health behaviors.[94] CHWs are seen as particularly effective because they usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Although CHWs were not mentioned by many respondents, a couple of providers participating in focus groups mentioned that such supports can be effective in meeting the needs of more vulnerable populations.

Essential to any successful strategy to reach Hispanic residents, according to focus group members, is the engagement of trusted community leaders such as those who are from the church and local community providers. As one Hispanic focus group member explained *"building trust is key, especially for undocumented people—you need to work through facilitators in the community, key leaders in faith and community services."*

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[93] Ibid.

[94] U.S. Department of Health and Human Services. HRSA Office of Rural Health Policy. (August 2011). *Community Health Workers Evidence-Based Models Toolbox.*

Seniors

Given the large senior population in the FCH service region, it is not surprising that seniors' health and well-being emerged as a topic of concern among focus group members and survey respondents. According to population estimates, the proportion of residents over the age of 65 is expected to rise in the three counties served by FCH. By 2030, about one third of Columbia County residents, 20% of Dutchess County residents, and 40% of upper Litchfield County residents will be over age 65.[95]

"I've seen seniors wait to get health care because they are afraid of high costs or can't get to care and then by the time you get to them, they've broken a hip."

- Service Provider

Because of the large number of seniors in the region and in order to gather a more complete picture of seniors' needs (little secondary data exist), two of the focus groups conducted for this study involved residents who are seniors. These conversations focus on several concerns for seniors in the region:

- Many seniors are on fixed incomes. Seniors in focus groups reported that they face multiple expenses including food, heating, and transportation, and rising costs of each create economic hardships for them. While seniors rely on Medicare to cover health expenses and some have supplemental insurance, they also face health-related costs such as co-pays and deductibles as well as expenses for services such as eyeglasses and dentures that are often not covered. This can also result in delays in getting needed healthcare.
- Transportation is a substantial challenge for seniors who no longer drive. Focus group members reported challenges in getting to health appointments as well as shopping and social activities. Several also observed that the loss of the ability to drive can lead to social isolation and depression among seniors. Transportation challenges related to meeting seniors' needs were shared by those in other focus groups as well. For example, seniors are more likely to need door-to-door transportation services and services that can manage wheelchairs or otherwise address seniors' mobility and health challenges. Seniors who are transitioning from a "car culture" face challenges in understanding how public transportation systems work as well as a reluctance to use public systems. Since Medicare does not pay for taxis to medical services, seniors who do not drive must rely on friends and family for transportation or use services such as Paratransit or Dial-A-Ride which require some advance notice.
- Seniors reported that social isolation is a concern among seniors in the region. Many focus group members reported that they do not have family in the area and thus, must rely on friends and area programs to get out. Lack of transportation adds an additional burden. As one senior stated, *"in a rural area, getting out is really important."* Several providers reported that they are increasingly concerned about seniors who may need help but are not known to providers. This is compounded, several respondents suggested, by a decline in a "neighbors checking in on neighbors" spirit in many communities. As a result, one provider observed, "*there are a lot of forgotten people."*

[95] Columbia: Cornell University Cooperative Extension, Program on Applied Demographics. (2013) *Columbia County Profile 2013*. Dutchess: Cornell University Cooperative Extension, Program on Applied Demographics. (2013) *Dutchess County Profile 2013*. Litchfield: Holt, Wexler & Farnum, LLP. (June 2007). *Assessment of Non-Emergency Medical Transportation in Upper Litchfield County*. Note that Litchfield rate is only for upper Litchfield County.

- The ability to maintain their homes was another concern shared by seniors. While several seniors reported that they have used Chore Services, others had not heard of this service.[96]
- Lack of awareness of services was reported among seniors. This was also apparent in focus group discussions in which several members reported that they did not know about services such as Dial-A-Ride or Chore Services. In addition to lack of awareness, however, several respondents commented that some seniors may have an "independence" mindset and may not be willing to accept help from agencies or those who they do not know well.

There was substantial discussion in focus groups about health care and seniors. Several shared that, for a variety of reasons, including cost, transportation barriers, the beginnings of memory loss, and pride, seniors may not be effectively connected to health services that can help them to maintain their health and help identify serious issues before they happen. For example, one focus group member explained that, *"the biggest 'frequent flyers' for Emergency Medical Services (EMS) are those with congestive heart failure—they don't need EMS, they need some doctor intervention."* Several focus group members also reported that insufficient follow-up care after a hospital stay was also a concern among seniors and providers who work with them. Some felt that many seniors are released too soon from the hospital, often without sufficient home supports to maintain and improve their health or identify emerging issues. While visiting nurses successfully fill this role, according to respondents, they are not able to reach all patients who need support. In part, according to respondents, this has been in part a systemic constraint: until recently, VNAs from Connecticut and Massachusetts could not serve patients in New York which created challenges to access for the northern rural communities of New York.

Suggested services that focus group members provided included:

- *Enhanced home-based health and related services*: Focus group members reported that the region needs more in-home services to help seniors maintain their homes and "age in place." They suggested expansion of VNA and home health aide services and support to help seniors pay for these services. One respondent suggested that telehealth approaches such as home monitoring devices and videoconferencing have also been shown to be effective in promoting good health, particularly in rural settings.[97] Community paramedicine, as described earlier, can also help to address this need.

- *Programs to Reduce Social Isolation.* While a variety of social and physical activity programs are offered to seniors in the region (the American Legion Hall and programs offered through NECC were most often mentioned), seniors reported that these should be expanded because they play an important role in helping seniors to maintain social connections and be active. Closely related this, several seniors suggested that intergenerational programs be implemented in the area. Ideas included programs in which seniors read to children and programs in which young people help with chores at seniors' homes for community service credit.

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[96] Chore Services provides a variety of services to seniors and handicapped individuals needing support, such as housekeeping, shopping, laundry, cooking, yard maintenance and minor home repair. Financial assistance is available and client contributions are supplemented by grants and donations.

[97] Telehealth/telemedicine refers to the remote delivery of healthcare services and information using telecommunications technology. Such approaches have been shown to be effective in delivering a variety of health services including medication management, health monitoring, and treatment. http://www.raconline.org/topics/telehealth/faqs#improve-access

- *Enhance and Raise Awareness About Programs for Seniors:* As discussed earlier in this report, there is a need to raise awareness of existing services in the region through a more local and regularly-updated set of information. Reaching seniors with this information is important. Senior focus group members suggested this should be done through both technology (on the web) but also in hard copy such as directories, flyers, newsletters, and newspapers.

SUMMARY OF FINDINGS

Relying on secondary data about the region, a community stakeholder survey, and ten focus group discussions with community residents and providers, this report provides an overview of the social and economic environment of the towns FCH serves, the health conditions and behaviors that affect residents, and perceptions of health and health care needs. Several overarching themes emerge from this analysis:

Mental health was identified as an important health concern by focus group and survey participants, and current services were largely seen as insufficient to meet the need. Consistent with national and state trends, mental health was identified as a top concern in the FCH region by both focus group members and survey respondents. The use of mental health services in the region has increased over time. Rising and untreated mental illness among children and youth and Hispanic residents were of particular concern to community residents. Challenges to improved mental health include lack of mental health screening services, cost of care, few mental health providers in the region and few private providers willing to accept Medicaid, and insurance constraints that limit mental health visits and services. Stigma associated with mental illness also creates barriers to care. Respondents reported a need for more mental health providers—and those who are more accessible, including available in schools and who can serve non-English speakers. More screening and prevention services, including those based in schools, physicians' offices, and community organizations are also needed. Finally, education and outreach was seen as needed to overcome stigma associated with mental illness and promote help-seeking behaviors.

Access to health care, including primary, behavioral, and oral health, is a substantial concern in the region and is constrained by transportation, cost burdens, and lack of providers. As a rural region, the FCH service area faces the same challenges as other rural areas do. Lack of providers, across all health needs, is a fundamental constraint to health care access in the region. The region lacks a sufficient number of providers and lower income residents face additional challenges because some providers do not accept Medicaid. The lack of providers and services for mental health and substance use issues was reported of particular concern because of the rising concern about these issues in the community. As in many rural areas, transportation barriers were identified as a substantial barrier to health care access in the FCH service area as well as a barrier to accessing other services. Lack of access to transportation can lead to delayed or unobtainable health care, inefficient use of emergency services, and reduced access to social and recreational opportunities and healthy food. Cost of health care was also a common concern in the region. The continued implementation of the health insurance marketplaces and Medicaid expansion will have implications for the health system in some substantial ways, including costs of health insurance, access to services, and the workforce. Currently, however, some of the region's residents face barriers to paying for health care, including premiums, co-pays, devices, and deductibles.

Substance use, especially the use of painkillers and opiates, is a pressing concern for community residents. Rising substance abuse rates in the region were a top-of-mind issue for

residents in the FCH service area. As nationally and in New York and Connecticut, abuse of prescription drugs and cheaper opiate substitutes, were of great concern. Existing services to identify and treat those with substance use issues were seen as inadequate and underfunded. In addition, issues of substance abuse and mental health are intricately intertwined, creating further challenges for the health system. Additional barriers to addressing substance use issues in the community include lack of screening services, cost of treatment, and stigma. Respondents reported a need for more affordable substance use services, enhanced school-based services including deeper intervention with those youth considered most at risk of substance abuse, enhanced community education, and improved provider prescribing practices.

Obesity, especially among children and youth, is a concern for the region and is seen as linked to a lack of opportunities for physical activity and healthy eating. While obesity rates for adults and children/youth in the FCH service area are similar to those of surrounding communities and the state of New York and Connecticut, there are some communities that experience higher rates. Additionally, residents expressed concern about affordable healthy food and fitness opportunities, where secondary data show lower levels of access for FCH communities than others. Lack of knowledge about healthy food and lack of access to healthy food emerged as a key challenge, especially as a local supermarket has recently closed. Suggestions to address obesity and related chronic diseases included more chronic disease self-management programs, greater access to healthy and affordable food and physical fitness opportunities, and more outreach and education about healthy lifestyles.

Hispanics, who comprise the region's largest non-White population, encounter additional difficulties that negatively affect their health. State, county, and national data point to health disparities among non-White populations. Survey and focus group feedback collected for this study indicate that barriers to good health and well-being for the region's Hispanic population include many of the challenges facing other vulnerable populations including transportation, cost, and lack of awareness of services. Hispanic residents face additional barriers including communication access barriers such as the lack of bi-lingual providers, interpreters, and translated materials, particularly for mental health, oral health, and specialty services. Suggestions to address these barriers and improve health outcomes among Hispanics in the community included increasing communication access, providing more culturally appropriate mental health services, efforts to enhance health literacy, and employment of community health workers.

The aging of the region's population was noted by many and concerns about seniors were prominent. The FCH region has a higher proportion of seniors than other communities and the states of New York and Connecticut. As baby boomers age, seniors are expected to comprise an ever increasing proportion of the population in the region. Concerns about seniors were prominent in focus groups and surveys. Challenges to seniors' health include health care costs, transportation challenges, social isolation, memory loss, and lack of awareness of services and/or reluctance to accept services. Insufficient follow-up care after a hospital stay was also a concern among seniors and providers who work with them. Suggestions to address the health needs of an aging population included enhanced home-based health and related services, programs to reduce social isolation, and more outreach to seniors about existing services.

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APPENDIX A: SURVEY INSTRUMENT

FOUNDATION FOR COMMUNITY HEALTH
COMMUNITY NEEDS SURVEY

Thank you for completing this survey. Your feedback will help the Foundation for Community Health to identify the most important health needs in the region. Please answer the questions as thoroughly and honestly as you can—your responses are confidential.

1. Which of the following best describes your organization or affiliation? (choose one)
   - ☐ Health care provider
   - ☐ Public health organization
   - ☐ Mental/behavioral health organization
   - ☐ Non-profit social service organization
   - ☐ Faith-based organization
   - ☐ Cultural/civic organization
   - ☐ Education/youth services organization
   - ☐ Government
   - ☐ Business sector
   - ☐ Community member/resident
   - ☐ Other (specify): _____

2. Which of the following counties does your organization serve? (check all that apply)
   - ☐ Columbia County
   - ☐ Dutchess County
   - ☐ Litchfield County

The Foundation for Community Health serves the following 17 towns served by Sharon Hospital: Ancram, Copake, Amenia, Dover, Northeast, Pine Plains, Stanford, Washington, Canaan, Cornwall, Goshen, Kent, Norfolk, North Canaan, Salisbury, Sharon, and Warren. When answering the following questions, please consider ONLY those towns your organization serves that are included in this list.

Of the list below, what do you consider to be the **top three** health concerns for the residents of the town(s) you serve? (select three)

- ☐ Access to primary care services
- ☐ Access to specialty health care services
- ☐ Chronic disease (i.e., diabetes, heart disease, asthma, cancer)
- ☐ Obesity/overweight
- ☐ Dental/oral health
- ☐ HIV/Sexually transmitted diseases
- ☐ Lack of awareness of health and social services available in the community
- ☐ Lyme disease and other tick-borne illness
- ☐ Maternal/infant health
- ☐ Depression
- ☐ Other mental health/mental illness
- ☐ Alcohol abuse
- ☐ Tobacco use/smoking
- ☐ Other substance abuse
- ☐ Unintentional injuries (i.e., car crashes, falls)
- ☐ Other (specify): _____

3. Are there particular populations/groups in the town(s) you serve that you think are more affected by these health concerns than others?

   ☐ YES ☐ NO

   If YES, which populations/groups you think are more affected by these health concerns than others? (select all that apply)

   - ☐ Children/youth
   - ☐ Low-income people
   - ☐ Racial/ethnic/linguistic minorities
   - ☐ People with disabilities
   - ☐ Seniors
   - ☐ Other (specify):_____

4. Are there barriers to accessing health care services in the town(s) you serve?

   ☐ YES ☐ NO ☐ DON'T KNOW

   IF YES, what do you see as the **top three** barriers to accessing health care services in the town(s)? (select three)

   - ☐ Lack of primary care providers
   - ☐ Lack of specialists
   - ☐ Lack of providers who accept Medicaid
   - ☐ Inability to get an appointment
   - ☐ Inconvenient office hours
   - ☐ Inability to navigate health care system
   - ☐ Cost of healthcare/inability to pay out-of-pocket expenses
   - ☐ Lack of knowledge about available resources, including social services
   - ☐ Lack of health insurance coverage
   - ☐ Lack of transportation
   - ☐ Language/cultural barriers
   - ☐ Other (specify): _____

   If you have any comments or wish to elaborate on your answers above, please do so here:

5. A composite analysis of recent community health needs assessments has identified mental health, substance use, access to health care, obesity and chronic disease, and tick-borne illness as key health concerns for the region. The following questions ask for your perceptions about the need for services to address these health concerns as well as several others. Please skip any questions you feel you are unable to answer.

Of the following **mental health services**, please identify the **three** you think are most needed at this time in the town(s) you serve: (choose only three)

- ☐ Screening services-children/youth
- ☐ Screening services-adult
- ☐ Screening services-seniors
- ☐ School-based counseling services
- ☐ Outpatient psychiatric services-children/youth
- ☐ Outpatient psychiatric services-adult
- ☐ In-patient psychiatric beds-children/youth

- ☐ In-patient psychiatric beds-adults
- ☐ Other: _____

If you have any comments or clarifications about your selections, please provide them here:

Of the following **substance use services**, please identify the **three** you think are most needed at this time in the town(s) you serve: (choose only three)

- ☐ Screening services—children/youth
- ☐ Screening services—adult
- ☐ Screening services—seniors
- ☐ School-based education/substance use prevention services
- ☐ Tobacco cessation programs
- ☐ Provider/first responder training programs
- ☐ Enhancement/enforcement of policies that prevent/discourage substance use
- ☐ Community education programs to prevent/discourage substance use
- ☐ Outpatient treatment programs—children/youth
- ☐ Outpatient treatment programs—adult
- ☐ Day treatment programs—children/youth
- ☐ Day treatment programs— adult
- ☐ Residential rehabilitation programs— children/youth
- ☐ Residential rehabilitation programs—adults
- ☐ Other: _____

If you have any comments or clarifications about your selections, please provide them here:

Of the following **health care services**, please identify the **three** you think are most needed at this time in the town(s) you serve: (choose only three)

- ☐ Primary care providers
- ☐ Specialty care providers
- ☐ Providers who accept Medicaid
- ☐ Bilingual health services
- ☐ Health insurance enrollment assistance
- ☐ Health screenings (mammogram, pap smear, prostate, etc.)
- ☐ Information about existing health services
- ☐ Health system navigation programs/health navigators
- ☐ Transportation to medical care
- ☐ Prescription drug assistance
- ☐ Resources to pay for health care
- ☐ Other: _____

If you have any comments or clarifications about your selections, please provide them here:

Of the following **obesity and chronic disease prevention services**, please identify the **three** you think are most needed at this time in the town(s) you serve: (choose only three)

- ☐ Chronic disease self-management programs
- ☐ Fitness/recreational programs— children/youth

- ☐ Fitness/recreational programs—adult
- ☐ Nutrition education programs
- ☐ School-based programs that promote physical activity
- ☐ School-based programs that promote healthy eating
- ☐ Programs to enhance access to healthy foods
- ☐ Breastfeeding programs
- ☐ Enhancement/enforcement of policies that encourage healthy behaviors
- ☐ Community education programs to encourage healthy behaviors
- ☐ Other: _____

If you have any comments or clarifications about your selections, please provide them here:

Of the following **other services**, please identify the **three** you think are most needed at this time in the town(s) you serve: (choose only three)

- ☐ Dental services— children/youth
- ☐ Dental services—adult
- ☐ Community education programs to prevent vector-borne illness
- ☐ Provider education programs to enhance diagnosis and care of patients with vector-borne illness
- ☐ End-of-life care/hospice services
- ☐ Geriatric care services
- ☐ Early childhood services such as family support and home visiting
- ☐ Sexually transmitted disease (STD) screening programs
- ☐ Women's health services
- ☐ Other: _____

If you have any comments or clarifications about your selections, please provide them here:

6. Are there other health or related services needed in the town(s) you serve that are not listed above?

7. If you have any suggestions about what else could be done or is needed to improve the health of residents in the town(s) you serve, please provide those here:

8. If you have any other comments or suggestions, please provide those here:

Thank you very much for responding to this survey.

APPENDIX B: FOCUS GROUP PROTOCOL

Please tell the group your first name and the town you live in.

1. We're going to talk specifically about the towns served by the Foundation for Community Health. These are: Ancram, Copake, Amenia, Dover, Northeast, Pine Plains, Stanford, Washington, Canaan, Cornwall, Goshen, Kent, Norfolk, North Canaan, Salisbury, Sharon, and Warren. I am wondering if you could share a few words about what living in this area is like.

2. So let's talk a bit about health. What would you say are the biggest health issues or concerns in your community? [PROBES: Mental Health/Substance Use; Chronic Disease; Access to Care; Transportation to Care; Cost of Healthcare; Lack of Awareness of Services; Dental Care; Obesity; Bilingual services]

3. Do you think these health concerns affect some groups of people more than others? If so, which groups of people?

4. Let's talk about a few of the issues you mentioned. [SELECT TOP HEALTH CONCERNS]

    a. What programs/services are you aware of in your community that currently focus on these health issues?

    b. What's missing? Are there programs or services that are not available that you think should be?

5. [If not brought up in earlier questions] Have you or anyone you know ever faced challenges in getting health care when you need it?

    a. If so, what kinds of challenges? [PROBES: Insurance coverage, copays, availability of providers, transportation, cost, language/ cultural barriers, accessibility, navigating the system, and awareness of services]

    b. What do you think can be done about these challenges?

6. Is there anything else that you would like to mention that we didn't discuss today?

APPENDIX C: COMMUNITY SURVEY RESULTS

TOP THREE HEALTH CONCERNS

Top Health Concerns by Towns[98]

	Overall	Columbia	Dutchess	Litchfield
Other mental health/mental illness	40.4%	39.0%	35.9%	44.7%
Access to primary care services	36.6%	54.2%	41.3%	38.6%
Chronic disease	35.0%	25.4%	34.8%	32.5%
Lack of awareness of health and social services available in the community	32.8%	27.1%	29.3%	33.3%
Other substance abuse	27.9%	20.3%	28.3%	24.6%
Access to specialty health care services	25.1%	28.8%	26.1%	25.4%
Obesity/overweight	18.6%	16.9%	17.4%	18.4%
Depression	18.6%	15.3%	19.6%	18.4%
Dental/oral health	15.3%	15.3%	20.7%	10.5%
Lyme disease and other tick-borne illness	12.0%	11.9%	14.1%	8.8%
Alcohol abuse	11.5%	8.5%	10.9%	13.2%
Maternal/infant health	4.4%	8.5%	6.5%	7.0%
Tobacco use/smoking	4.4%	5.1%	5.4%	3.5%
HIV/Sexually transmitted diseases	0.5%	0.0%	1.1%	0.9%
Unintentional injuries (i.e., car crashes, falls)	0.0%	0.0%	0.0%	0.0%

Top Health Concerns by Provider/Non-Provider[99]

	Overall	Health Provider	Non-Health Provider
Other mental health/mental illness	40.4%	46.9%	40.7%
Access to primary care services	36.6%	45.3%	35.2%
Chronic disease	35.0%	35.9%	37.0%
Lack of awareness of health and social services available in the community	32.8%	18.8%	44.4%
Other substance abuse	27.9%	28.1%	29.6%
Access to specialty health care services	25.1%	29.7%	25.0%
Depression	18.6%	26.6%	15.7%
Obesity/overweight	18.6%	15.6%	22.2%
Dental/oral health	15.3%	10.9%	19.4%
Lyme disease and other tick-borne illness	12.0%	6.3%	16.7%
Alcohol abuse	11.5%	10.9%	13.0%
Maternal/infant health	4.4%	9.4%	1.9%
Tobacco use/smoking	4.4%	6.3%	3.7%
HIV/Sexually transmitted diseases	0.5%	1.6%	0.0%
Unintentional injuries (i.e., car crashes, falls)	0.0%	0.0%	0.0%

[98] Response Rates: Overall=195; Columbia=59; Dutchess=92; Litchfield=114.
[99] Response Rates: Health Provider=64; Non-Health Provider=108. Health provider includes mental, oral, and long-term care providers.

BARRIERS TO ACCESSING HEALTHCARE

Barriers by Towns[100]

	Overall	Columbia	Dutchess	Litchfield
Lack of transportation	60.9%	47.8%	58.0%	55.7%
Cost of healthcare/inability to pay out-of-pocket expenses	53.4%	47.8%	50.7%	57.0%
Lack of knowledge about available resources, including social services	32.3%	28.3%	33.3%	30.4%
Lack of primary care providers	27.8%	32.6%	24.6%	31.6%
Lack of providers who accept Medicaid	26.3%	28.3%	27.5%	35.4%
Inability to navigate health care system	26.3%	21.7%	29.0%	19.0%
Lack of health insurance coverage	21.1%	28.3%	27.5%	22.8%
Language/cultural barriers	18.8%	15.2%	26.1%	10.1%
Lack of specialists	15.8%	17.4%	15.9%	20.3%
Inability to get an appointment	9.0%	4.3%	8.7%	7.6%
Inconvenient office hours	6.8%	6.5%	7.2%	5.1%

Barriers by Provider/Non-Provider[101]

	Overall	Health Provider	Non-Health Provider
Lack of transportation	60.9%	53.1%	72.4%
Cost of healthcare/inability to pay out-of-pocket expenses	53.4%	46.9%	63.2%
Lack of knowledge about available resources, including social services	32.3%	30.6%	36.8%
Lack of primary care providers	27.8%	34.7%	25.0%
Inability to navigate health care system	26.3%	30.6%	27.6%
Lack of providers who accept Medicaid	26.3%	44.9%	15.8%
Lack of health insurance coverage	21.1%	20.4%	23.7%
Language/cultural barriers	18.8%	12.2%	25.0%
Lack of specialists	15.8%	14.3%	19.7%
Inability to get an appointment	9.0%	12.2%	7.9%
Inconvenient office hours	6.8%	6.1%	7.9%

[100] Response Rates: Overall=133 73% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region.; Columbia=46 79% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region.; Dutchess=69 76% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region; Litchfield=79 70% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region.

[101] Response Rates: Health Provider=49 77% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region; Non-Health Provider=76 71% responded "yes" to the question of whether there are barriers to accessing health care for residents of the region. Health provider includes mental, oral, and long-term care providers.

MENTAL HEALTH SERVICES NEEDED

Mental Health Services Needed by Town[102]

	Overall	Columbia	Dutchess	Litchfield
Outpatient psychiatric services-children/youth	55.8%	60.0%	56.0%	57.8%
Outpatient psychiatric services-adult	48.3%	50.9%	52.4%	51.4%
Screening services-children/youth	47.1%	38.2%	41.7%	45.9%
School-based counseling services	37.8%	40.0%	39.3%	35.8%
Screening services-adult	26.7%	25.5%	29.8%	26.6%
Screening services-seniors	23.3%	21.8%	22.6%	24.8%
In-patient psychiatric beds-children/youth	19.2%	16.4%	20.2%	17.4%
In-patient psychiatric beds-adults	15.1%	12.7%	19.0%	13.8%

Mental Health Services Needed by Provider/Non-Provider[103]

	Overall	Health Provider	Non-Health Provider
Outpatient psychiatric services-children/youth	55.8%	64.4%	55.9%
Outpatient psychiatric services-adult	48.3%	57.6%	47.1%
Screening services-children/youth	47.1%	42.4%	54.9%
School-based counseling services	37.8%	28.8%	47.1%
Screening services-adult	26.7%	28.8%	27.5%
Screening services-seniors	23.3%	18.6%	29.4%
In-patient psychiatric beds-children/youth	19.2%	28.8%	15.7%
In-patient psychiatric beds-adults	15.1%	10.2%	19.6%

[102] Response Rates: Overall=172; Columbia=55; Dutchess=84; Litchfield=109.

[103] Response Rates: Health Provider=59; Non-Health Provider=102. Health provider includes mental, oral, and long-term care providers.

SUBSTANCE USE SERVICES NEEDED

Substance Use Services Needed by Town[104]

	Overall	Columbia	Dutchess	Litchfield
School-based education/substance use prevention services	37.8%	26.8%	39.1%	33.9%
Outpatient treatment programs—children/youth	34.3%	33.9%	31.0%	38.5%
Outpatient treatment programs—adult	31.4%	26.8%	31.0%	35.8%
Screening services—children/youth	30.2%	33.9%	32.2%	26.6%
Community education programs to prevent/discourage substance use	30.2%	19.6%	24.1%	33.0%
Enhancement/enforcement of policies that prevent/discourage substance use	23.3%	26.8%	25.3%	22.9%
Screening services—adult	15.1%	19.6%	12.6%	14.7%
Day treatment programs—children/youth	15.1%	14.3%	17.2%	14.7%
Day treatment programs— adult	15.1%	19.6%	14.9%	16.5%
Residential rehabilitation programs—children/youth	15.1%	14.3%	14.9%	12.8%
Residential rehabilitation programs—adults	14.0%	8.9%	16.1%	13.8%
Provider/first responder training programs	11.0%	14.3%	10.3%	11.0%
Screening services—seniors	7.0%	10.7%	6.9%	7.3%
Tobacco cessation programs	7.0%	8.9%	9.2%	6.4%

Substance Use Services Needed by Provider/Non-Provider[105]

	Overall	Health Provider	Non-Health Provider
School-based education/substance use prevention services	37.8%	28.1%	48.5%
Outpatient treatment programs—children/youth	34.3%	45.6%	31.7%
Outpatient treatment programs—adult	31.4%	45.6%	26.7%
Community education programs to prevent/discourage substance use	30.2%	17.5%	41.6%
Screening services—children/youth	30.2%	29.8%	34.7%
Enhancement/enforcement of policies that prevent/discourage substance use	23.3%	22.8%	26.7%
Screening services—adult	15.1%	17.5%	15.8%
Day treatment programs—children/youth	15.1%	21.1%	13.9%
Day treatment programs— adult	15.1%	22.8%	12.9%
Residential rehabilitation programs—children/youth	15.1%	15.8%	16.8%
Residential rehabilitation programs—adults	14.0%	10.5%	16.8%
Provider/first responder training programs	11.0%	14.0%	10.9%
Screening services—seniors	7.0%	8.8%	6.9%
Tobacco cessation programs	7.0%	14.0%	4.0%

[104] Response Rates: Overall=172; Columbia=56; Dutchess=87; Litchfield=1094.

[105] Response Rates: Health Provider=56; Non-Health Provider=101. Health provider includes mental, oral, and long-term care providers.

HEALTH CARE SERVICES NEEDED

Health Care Services Needed by Town[106]

	Overall	Columbia	Dutchess	Litchfield
Primary care providers	33.3%	35.7%	33.0%	37.3%
Resources to pay for health care	32.2%	32.1%	34.1%	35.5%
Transportation to medical care	28.8%	30.4%	31.8%	23.6%
Specialty care providers	21.5%	21.4%	23.9%	21.8%
Information about existing health services	16.4%	30.4%	18.2%	16.4%
Health insurance enrollment assistance	15.8%	19.6%	17.0%	20.0%
Health system navigation programs/health navigators	15.8%	16.1%	17.0%	15.5%
Prescription drug assistance	15.8%	12.5%	14.8%	16.4%
Providers who accept Medicaid	13.6%	8.9%	9.1%	16.4%
Bilingual health services	11.9%	5.4%	13.6%	8.2%
Health screenings (mammogram, pap smear, prostate, etc.)	4.0%	3.6%	4.5%	2.7%

Health Care Services Needed by Provider/Non-Provider[107]

	Overall	Health Provider	Non-Health Provider
Primary care providers	33.3%	41.9%	31.4%
Resources to pay for health care	32.2%	21.0%	41.9%
Transportation to medical care	28.8%	6.5%	45.7%
Specialty care providers	21.5%	25.8%	21.9%
Information about existing health services	16.4%	8.1%	23.8%
Health insurance enrollment assistance	15.8%	17.7%	16.2%
Health system navigation programs/health navigators	15.8%	6.5%	21.9%
Prescription drug assistance	15.8%	8.1%	21.9%
Providers who accept Medicaid	13.6%	8.1%	17.1%
Bilingual health services	11.9%	1.6%	19.0%
Health screenings (mammogram, pap smear, prostate, etc.)	4.0%	0.0%	6.7%

[106] Response Rates: Overall=177; Columbia=56; Dutchess=88; Litchfield=110.

[107] Response Rates: Health Provider=62; Non-Health Provider=105. Health provider includes mental, oral, and long-term care providers.

CHRONIC DISEASE PREVENTION SERVICES NEEDED

Chronic Disease Prevention Services Needed by Town[108]

	Overall	Columbia	Dutchess	Litchfield
Chronic disease self-management programs	45.3%	43.4%	48.8%	44.9%
Community education programs to encourage healthy behaviors	38.8%	32.1%	35.7%	45.8%
Programs to enhance access to healthy foods	38.2%	37.7%	33.3%	40.2%
Nutrition education programs	32.9%	37.7%	39.3%	36.4%
Fitness/recreational programs— children/youth	31.8%	20.8%	29.8%	26.2%
Fitness/recreational programs—adult	31.8%	20.8%	31.0%	29.0%
School-based programs that promote healthy eating	29.4%	35.8%	28.6%	29.0%
School-based programs that promote physical activity	24.7%	32.1%	23.8%	24.3%
Enhancement/enforcement of policies that encourage healthy behaviors	12.9%	18.9%	15.5%	12.1%
Breastfeeding programs	4.1%	9.4%	6.0%	2.8%

Chronic Disease Prevention Services Needed by Provider/Non-Provider[109]

	Overall	Health Provider	Non-Health Provider
Chronic disease self-management programs	45.3%	55.9%	42.6%
Community education programs to encourage healthy behaviors	38.8%	42.4%	41.6%
Programs to enhance access to healthy foods	38.2%	35.6%	44.6%
Nutrition education programs	32.9%	37.3%	32.7%
Fitness/recreational programs— children/youth	31.8%	20.3%	40.6%
Fitness/recreational programs—adult	31.8%	25.4%	38.6%
School-based programs that promote healthy eating	29.4%	20.3%	37.6%
School-based programs that promote physical activity	24.7%	33.9%	21.8%
Enhancement/enforcement of policies that encourage healthy behaviors	12.9%	22.0%	8.9%
Breastfeeding programs	4.1%	8.5%	2.0%

[108] Response Rates: Overall=170; Columbia=53; Dutchess=84; Litchfield=107.

[109] Response Rates: Health Provider=59; Non-Health Provider=101. Health provider includes mental, oral, and long-term care providers.

OTHER HEALTH AND HEALTH-RELATED SERVICES NEEDED

Other Health and Health-Related Services Needed by Town[110]

	Overall	Columbia	Dutchess	Litchfield
Early childhood services such as family support and home visiting	47.6%	40.0%	44.8%	52.4%
Geriatric care services	42.4%	45.5%	37.9%	41.0%
Dental services—adult	42.4%	47.3%	42.5%	38.1%
Dental services— children/youth	41.2%	49.1%	48.3%	32.4%
Women's health services	22.9%	21.8%	25.3%	24.8%
Community education programs to prevent vector-borne illness	18.8%	20.0%	20.7%	21.0%
End-of-life care/hospice services	18.8%	20.0%	17.2%	23.8%
Provider education programs to enhance diagnosis and care of patients with vector-borne illness	18.2%	14.5%	19.5%	17.1%
Sexually transmitted disease (STD) screening programs	11.8%	12.7%	12.6%	12.4%

Other Health and Health-Related Services Needed by Provider/Non-Provider[111]

	Overall	Health Provider	Non-Health Provider
Early childhood services such as family support and home visiting	47.6%	53.3%	49.5%
Geriatric care services	42.4%	43.3%	46.5%
Dental services—adult	42.4%	38.3%	48.5%
Dental services— children/youth	41.2%	35.0%	48.5%
Women's health services	22.9%	20.0%	28.3%
Community education programs to prevent vector-borne illness	18.8%	26.7%	16.2%
Provider education programs to enhance diagnosis and care of patients with vector-borne illness	18.2%	23.3%	17.2%
End-of-life care/hospice services	18.8%	20.0%	21.2%
Sexually transmitted disease (STD) screening programs	11.8%	15.0%	11.1%

[110] Response Rates: Overall=170; Columbia=55; Dutchess=87; Litchfield=105.

[111] Response Rates: Health Provider=55; Non-Health Provider=99. Health provider includes mental, oral, and long-term care providers.

EXHIBIT J

Title:	Number/Type:
Financial Assistance Policy	I-0002
Owner: Gary Zmrhal Senior Vice President, Chief Financial Officer	**Effective Date:** *01.01.2016*
For use at: *HQ Medical Practice, HQ Urgent Care, HQ Home Care, Heart Center, Hudson Valley Newborn Physician Services, Ulster Radiation Oncology Center, Northern Dutchess Hospital, Putnam Hospital Center, **Vassar Brothers Medical Center***	

POLICY/PURPOSE

Policy: It is the policy of Health Quest to provide the level of financial aid necessary to provide emergency, urgent, and medically necessary treatment to the greatest number of patients who reside in New York, as well as residents out of New York State, residing in the Health Quest's primary service area. A "medically necessary" treatment is a treatment that is a covered health service or a treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice. Services provided that are not medically necessary (e.g., cosmetic surgery, sleep study services) and/or discretionary charges, such as private rooms, private nursing are not covered by this policy. In addition The Thompson House is not covered by this policy.

Health Quest does not take into account race, gender, age, sexual orientation, religious affiliation, social or immigrant status when making an eligibility determination. Health Quest will provide, without discrimination, care for emergency conditions regardless of a patient's financial status, in accordance with EMTALA regulations.

Patients who are uninsured, underinsured, ineligible for government assistance programs, or unable to pay based on their individual financial situation are eligible for financial assistance. Determinations for eligibility are made upon review of the financial application and may require appointments or discussion with hospital's Customer Service Dept. Financial assistance is provided only after all third party payment possibilities available to the patient have been exhausted or denied.

Uninsured Patients. For uninsured self-pay patients or patients who have exhausted their healthcare benefits, Health Quest will limit the patient payment to the amount generally billed or allowed under the Prospective Medicare Payment System (PPS). This discounted amount is considered "Tier 1" of our Financial Assistance Policy. Balances may be eligible for further discounts pursuant to this policy. The Prospective Medicare reimbursement rate is based on the Medicare fee schedule, APC or DRG calculations. If in the event there is not a Medicare service/fee, the Medicaid fee schedule will be used to determine the uninsured self-pay rate.

Insured Patients. For patients with insurance, financial assistance is not provided for co–payments, or for amounts that are due after insurance if the patient fails to get the necessary referrals or approvals as required by the insurer. Financial assistance will be provided to insured patients only if allowed under the patient's insurance carrier's contract with Health Quest. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a

Health Reimbursement Arrangement or a Flexible Spending Account, will be expected to use the account funds prior to being granted financial assistance.

Services provided in qualifying Health Quest sites but delivered by healthcare providers not employed by Health Quest may not be covered under this policy (see Appendix I for a list of providers not covered under this policy).

Health Quest will make reasonable efforts to explain the benefits of Medicaid and other available public and private coverage programs to patients and to assist patients to apply for such benefits. Patients identified as potentially eligible will be expected to apply for such programs. Patients choosing not to cooperate in applying for programs may be denied financial assistance. If a patient is applying for Medicaid, he/she may also apply for financial assistance. The application will be placed on hold until the Medicaid process is completed.

Patients are requested, but not required, to complete a financial assistance application. However, in order to qualify for financial assistance, patients must comply with Health Quest's requests to verify income, family size and residency status. Financial assistance is granted only when patients are found to have met all financial criteria based on the disclosure of proper information and documentation. The financial assistance application can be found on the Health Quest website.

There may be circumstances under which a patient's qualification for financial assistance is established without completing the formal assistance application, in which case Health Quest may utilize other sources of information which will enable Health Quest to make an informed determination of financial need.

Health Quest shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy. The following guideline applies: Patients may be expected to contribute payment for care based on their individual financial situation (Example: New York State Medicaid spend down requirements).

Procedure:

No patient is to be screened for financial assistance or payment information prior to receiving medical treatment in emergency situations. Collection actions that discourage people from seeking emergency medical care, such as demanding upfront payments or permitting debt collection activities that interfere with the provision of emergency medical care, are prohibited under the Health Quest policy.

Patients will be informed of the financial assistance policy and the application process. Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement. Patients have a responsibility to cooperate by providing information on family size, residency status and documentation of income as required under this policy.

No patient accounts may be forwarded to collection while an application for financial assistance is pending.

Health Quest shall issue either an approval or denial within thirty (30) days after receiving all information necessary to make a determination. If a patient application is missing documentation, the patient will be notified of the information needed to complete the application and will have thirty (30) days to supply Health Quest with the missing documentation.

Any patient who provides all requested information and is denied under this policy shall be entitled to appeal such decision in writing to the System Business Office at Health Quest, 1351 Route 55, Suite 104, LaGrangeville, New York 12540. The denial letter shall include information concerning the appeal process available to the patient. The denial letter will include the phone number to the Dept. of Health. Every appeal will be assigned to the Customer Service Supervisor for re-consideration. A written determination of an appeal will be sent to the patient within thirty (30) days of receipt of the patient's written request for appeal.

Health Quest financial assistance policy information will be available in English, Spanish and other languages to the extent they are the primary language spoken by at least 1,000 residents within the Health Quest service area or 5% of the residents in the Health Quest service area (whichever is less).

A patient that has been denied financial assistance may resubmit an application if there has been a change of income or financial circumstances. No payments made up to the time of resubmitting an application will be refunded if eligibility is granted based on a re-determination due to such a change.

Application Documentation:
When applying for Financial Assistance, a patient must cooperate with Health Quest to explore available third party coverage. A patient must complete the Health Quest Financial Assistance application and provide the following documents:

Proof of Identify (supply at least ONE from the list below for each person listed on the application)

- Passport
- Permanent Resident Alien Card (Green Card)
- Birth Certificate for all members in the family including children under 21 years old
- Employment Authorization Card
- Driver License
- Photo ID for Spouse / Common-Law Partners

Proof of Address/Residency-Home Address (bring at least TWO from list below

- Utility bills
- Cell phone bills
- Cable television bill
- Rent receipt, copy of lease, or mortgage papers

- Letter from person you reside with or letter from landlord (must be notarized)

Proof of Income (bring at least ONE from the list below)

- Last four weekly pay stubs or two biweekly pay stubs
- Letter from employer **on company letterhead** , letter should be signed by employee's Manager and include the employee's gross income
    - If no letterhead, bring a **notarized** letter from the employer
- Award letter from Social Security Administration / Pension /Annuities
- Last unemployment benefit check
- Letter of support
    - If a patient is being wholly supported by someone else, bring a **notarized letter** from that person which states that they are supporting the patient in the absence of income
- If unemployed, explanation of support required
    - Please clarify in a letter how the patient is being supported (i.e. bank savings, etc.)
- Income from rental of property, room, etc.
- Provide documentation of child support income
- V.A. Benefits or Worker's Compensation Income

Other

- Proof of school attendance

No patient will be denied assistance based on failure to provide information or documentation not described in this Policy or on the application. The financial assistance applications and required documentation are to be submitted to the following office: Health Quest, System Business Office, 1351 Route 55, Suite 104, LaGrangeville, New York 12540.

Level of Financial Assistance Based on Financial Resources:

Uninsured self-pay patients, or patients who have exhausted their healthcare benefits and provide documentation that their family income is at or below 200% of the federal poverty line are eligible for a 100% discount on any patient balance.

Uninsured self-pay patients, or patients who have exhausted their healthcare benefits and provide documentation demonstrating that their family income is between 201% and 300% of the federal poverty line are eligible for a 50% discount on any patient balance.

Uninsured self-pay patients with family income exceeding the 300% of the federal poverty line may still be eligible for discounts if the medical bills prove to be a hardship on the family. Health Quest will review these cases on an individual basis, taking into account extenuating circumstances.

Insured patients who provide documentation that their family income is at or below 150% of the federal poverty line are eligible for a 100% discount on eligible balances.

Insured patients with family income exceeding the 150% of the federal poverty line may still be eligible for discounts if the medical bills prove to be a hardship on the family. Health Quest will review these cases on an individual basis, taking into account extenuating circumstances.

Health Quest will limit the amounts charged to all patients eligible for assistance under this policy who receive emergency or medically necessary care. Please see Appendix II

Qualification Period: If a patient is determined eligible, financial assistance will be granted for a period of six months. Financial assistance will apply to all charges incurred in the specific visit patient is applying for if within the 240 days of the first statement.

Payments made by a patient on approved accounts will be refunded if the payment made for the patient portion is in excess of the amount owed, based on the financial assistance received (50% or 100%), unless this payment amount was less than $5.00. Should Health Quest grant financial assistance on accounts older than 240 days, any payments made on those accounts up to the date that assistance has been granted will not qualify for refund(s). This is consistent with the Health Quest Self Pay Credit Balance policy.

During the 240 day application period Health Quest will engage in collection actions against the individual. However, Health Quest will still accept and process a Financial Assistance Application if one is submitted. (See Billing, Collection and Litigation Policy for details. A copy of this policy may be obtained by contacting Health Quest Customer Service Department, Customer Service Director at 845-475-9983 and/or Supervisor at 845-475-9956 or Health Quest, System Business Office, Attn: Customer Service Supervisor, 1351 Route 55, Suite 104, LaGrangeville, New York 12540).

Receipt of a complete Financial Assistance Application will suspend collection activity, pending determination of eligibility.

Presumptive Eligibility: Health Quest realizes that certain patients may be non-responsive to the financial assistance application process. Under these circumstances other sources of information may be used to make an individual assessment of financial need. This information will allow for an informed decision on the financial need of these non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

A presumptive eligibility process will be used by Vassar Brothers Medical Center, Northern Dutchess Hospital and Putnam Hospital Center for uninsured patients only, for any balances greater than $100.00. Prior to classifying a debt as bad debt, Health Quest will utilize healthcare industry-recognized software programs that incorporate public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity and will assess a patient's eligibility for financial aid based on the same standards and historical approvals for Health Quest financial assistance under the traditional application process. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

When electronic enrollment is used as the basis for presumptive eligibility, a 100% discount will be granted for eligible services for the specific account in the file. If a patient does not qualify under the electronic enrollment process, the patient may apply for assistance by submitting an application through the standard financial assistance application process.

Patient accounts granted presumptive eligibility will be classified as financial assistance. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their electronic eligibility qualification, and will not be included in the hospital's bad debt expense.

Limitation on Charges for Patients Eligible for Financial Assistance: Health Quest has elected to use the Prospective Medicare Payment System (PPS) to determine the discount applied to accounts for patient's eligible for financial assistance. Health Quest will determine the amount generally billed for any emergency or other medically necessary care provided to an eligible patient by using the billing and coding process used if the patient were a Medicare fee-for-service beneficiary and discounting the bill to the amount billed for the care equal to the total amount Medicare would allow for the care. The amount expected to be paid for eligible services by patients eligible for assistance under this policy will not exceed the amount that would be reimbursed by Medicare and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles.

Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under financial assistance policy. Questions concerning amount generally billed should be directed to Health Quest Customer Service Department at 845-475-9940.

Collection Practices for Financial Assistance Patients:
Internal and external collection policies and procedures will take into account the extent to which a patient is qualified for financial assistance or discounts. In addition, patients who qualify for partial discounts are required to make a good faith effort to honor payment agreements with Health Quest, including payment plans and discounted hospital bills. Health Quest is committed to working with patients to resolve their accounts, and at its discretion, may provide extended payment plans to eligible patients.

Payment Plans: If a patient, after receiving a 50% Financial Assistance adjustment, requires a payment plan, monthly installments can be made interest free, and installments are capped at 10% of a patient's gross income (Payment Plan Policy). A patient's or guarantor's failure to comply with a payment plan agreement will result in referral to bad debt collection.

For more information on Health Quest bad debt collection practices, please refer to the Credit and Collections Policies.

Payment Criteria

Account Balance	Maximum Payment Term
$1.00 - $100.00	Payment in Full
$101.00 - $500.00	6 months
$501.00 - $1,999	12 months
$2,000 - $10,000	24 months
> $10,000	60 months

If a patient cannot commit to the above guidelines, but responds with a reasonable offer (1-3 months past normal guidelines) a payment option can be approved. If the account has already been referred to the collection agency, the account will be reviewed with the collection agency for a payment plan.

Communication of Patient Financial Assistance Program:
Health Quest communicates the availability and terms of its financial assistance program to all patients, through means which include, but are not limited to:

- Posted signs within waiting rooms, registration desks, emergency departments and financial services departments.
- Notifications on patient bills or statements with a direct link to the Financial Assistance Application (healthquest.org/financialassistance).
- Brochures given to patients by hospital team members or with other paperwork.
- Reference within Health Quest patient handbook.
- Designated staff knowledgeable on the financial assistance policy to answer patient questions or who may refer patients to the program.
- Requests can be made by patient, their family members, friend or associate, but will be subject to applicable privacy laws.
- Patients concerned about their ability to pay for services or would like to know more about financial assistance should be directed to the System Business Office at 845-475-9940.

REFERENCES/SOURCES
1. New York Public Health Law §2807-k(9-a)("Hospital Financial Assistance Law")
2. Internal Revenue Code §501(r)

ATTACHMENTS
Appendix I (listing of the providers non-participating with HQ Financial Asst. Policy)
Appendix II (Gross Income Criteria and Schedule)

POLICY HISTORY:
Supersedes: Hospital Financial Assistance Policy
Original implementation date: *10.04.2012*
Date Reviewed: 03.4.2014
Date Revised: 1.1.2015

APPROVAL:_____ _____
Gary Zmrhal, Senior Vice President, Chief Financial Officer Date:

EXHIBIT K

Health Quest Systems, Inc. and Subsidiaries

Consolidated Financial Statements and Consolidating Information
December 31, 2015 and 2014

Health Quest Systems, Inc. and Subsidiaries
Index
December 31, 2015 and 2014

Independent Auditor's Report

To the Board of Trustees of
Health Quest Systems, Inc. and Subsidiaries

We have audited the accompanying consolidated financial statements of Health Quest Systems, Inc. and Subsidiaries (the "Company"), which comprise the consolidated balance sheets as of December 31, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

pwc

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Health Quest Systems, Inc. and Subsidiaries at December 31, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position and results of operations of the individual companies.

PricewaterhouseCoopers LLP

New York, New York
April 29, 2016

Health Quest Systems, Inc. and Subsidiaries
Consolidated Balance Sheets
December 31, 2015 and 2014

(in thousands)

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 109,359	$ 75,458
Restricted cash	722	708
Investments	198,240	200,560
Assets whose use is limited, required for current liabilities		
Externally restricted	2,013	2,014
Patient accounts receivable, less allowance for uncollectible accounts of $27,272 and $30,951 in 2015 and 2014, respectively	92,048	85,004
Supplies and prepaid expenses	27,057	25,524
Other current assets	7,540	10,018
Amounts due from third-party payors	8,664	9,749
Total current assets	445,643	409,035
Assets whose use is limited, net of current portion		
Externally restricted	21,595	54,756
Investments held by captive	28,076	28,059
Long-term investments	8,853	9,032
Property, plant and equipment, net	412,080	362,182
Goodwill	30,747	5,264
Other assets	38,691	44,057
Total assets	$ 985,685	$ 912,385
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt	$ 17,648	$ 13,669
Accounts payable and accrued expenses	116,298	103,080
Amounts due to third-party payors	7,673	5,899
Captive insurance loss reserve payable	8,147	7,626
Total current liabilities	149,766	130,274
Long-term debt, net of current portion	192,581	188,166
Post-retirement benefit obligations	75,521	75,124
Amounts due to third-party payors and other liabilities	118,782	111,913
Total liabilities	536,650	505,477
Net assets		
Unrestricted	419,234	379,374
Temporarily restricted	24,417	22,145
Permanently restricted	5,384	5,389
Total net assets	449,035	406,908
Total liabilities and net assets	$ 985,685	$ 912,385

The accompanying notes are an integral part of these consolidated financial statements.

Health Quest Systems, Inc. and Subsidiaries
Consolidated Statements of Operations
Years Ended December 31, 2015 and 2014

(in thousands)

	2015	2014
Operating revenue		
Net patient service revenue	$ 868,893	$ 793,489
Provision for bad debts	(25,591)	(30,352)
Net patient service revenue less provision for bad debts	843,302	763,137
Other revenue	27,493	33,500
Net assets released from restrictions used for operations	54	83
Total operating revenue	870,849	796,720
Operating expenses		
Salaries and fees	395,322	362,348
Employee benefits	112,560	107,814
Supplies	131,573	119,389
Other expenses	136,650	133,962
Interest	9,391	8,460
Depreciation and amortization	47,934	46,161
Total operating expenses	833,430	778,134
Operating income	37,419	18,586
Investment (loss) income	(4,900)	12,061
(Gain) loss on sale of property plant and equipment	252	(22)
Excess of revenue over expenses	32,771	30,625
Pension related changes other than net periodic pension costs	4,271	(28,016)
Grant revenue for capital expenditures	203	197
Net assets released from restrictions for capital expenditures	2,615	2,254
Increase in unrestricted net assets	$ 39,860	$ 5,060

The accompanying notes are an integral part of these consolidated financial statements.

Health Quest Systems, Inc. and Subsidiaries
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2015 and 2014

(in thousands)

	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total Net Assets
December 31, 2013	$ 374,314	$ 20,220	$ 5,391	$ 399,925
Change in net assets				
Excess of revenue over expenses	30,625	-	-	30,625
Pension related changes other than net periodic pension costs	(28,016)	-	-	(28,016)
Contributions		4,262	(2)	4,260
Grant revenue for capital expenditures	197	-	-	197
Net assets released from restrictions used for operations and capital expenditures	2,254	(2,337)	-	(83)
Total change in net assets	5,060	1,925	(2)	6,983
December 31, 2014	379,374	22,145	5,389	406,908
Change in net assets				
Excess of revenue over expenses	32,771	-	-	32,771
Pension related changes other than net periodic pension costs	4,271	-	-	4,271
Contributions	-	4,941	(5)	4,936
Grant revenue for capital expenditures	203	-	-	203
Net assets released from restrictions used for operations and capital expenditures	2,615	(2,669)	-	(54)
Total change in net assets	39,860	2,272	(5)	42,127
December 31, 2015	$ 419,234	$ 24,417	$ 5,384	$ 449,035

The accompanying notes are an integral part of these consolidated financial statements.

Health Quest Systems, Inc. and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended December 31, 2015 and 2014

(in thousands)

	2015	2014
Cash flows from operating activities		
Change in net assets	$ 42,127	$ 6,983
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	47,934	46,161
Provision for bad debts	25,591	30,352
Loss on extinguishment of debt	-	-
Restricted contributions for capital	(2,615)	(2,254)
Pension related changes other than net periodic pension costs	(4,271)	28,016
Change in realized and unrealized (gain) / loss on investments	9,820	(4,228)
Changes in operating assets and liabilities		
Patient accounts receivable	(32,635)	(35,441)
Supplies and prepaid expenses	(1,533)	(2,287)
Other current assets	2,514	(5,198)
Other assets	4,965	3,158
Accounts payable and accrued expenses	11,233	9,532
Amounts due to third-party payors and other liabilities	2,219	722
Post-retirement benefit obligations	4,668	755
Insurance loss reserve payable	521	3,749
Net cash provided by operating activities	110,538	80,020
Cash flows from investing activities		
Acquisitions of property, plant and equipment	(83,502)	(49,569)
Cash paid for radiology acquisition	(6,500)	-
Purchases of investments and assets whose use is limited	(49,778)	(133,975)
Sales of investments and assets whose use is limited	75,602	85,227
Net cash used in investing activities	(64,178)	(98,317)
Cash flows from financing activities		
Proceeds from the issuance of long term debt	-	54,615
Payments for bond issuance costs	-	(629)
Repayments of long-term debt	(15,074)	(25,035)
Restricted contributions for capital	2,615	2,254
Net cash (used in) provided by financing activities	(12,459)	31,205
Net increase in cash and cash equivalents	33,901	12,908
Cash and cash equivalents		
Beginning of year	75,458	62,550
End of year	$ 109,359	$ 75,458
Supplemental information and noncash transactions		
Cash paid for interest, net of amounts capitalized	$ 7,815	$ 8,077
Capital lease obligations incurred	-	237
Note payable for radiology acquisition	23,468	-
Increase in asset retirement obligation	7,509	-

The accompanying notes are an integral part of these consolidated financial statements.

(in thousands)

1. Organization

Health Quest Systems, Inc. (the "Company" or "Health Quest") is a not-for-profit corporation that is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code.

A summary of subsidiaries, in which the Company is the sole member, is as follows:

Vassar Brothers Medical Center ("VBMC") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. VBMC provides general acute care with a full range of inpatient and outpatient services for residents of the Mid-Hudson Valley. Included within VBMC is One Columbia Street, LLC, a limited liability company, which provides real estate oversight management and holds title to certain real estate interests and Healthserve, LLC, a limited liability for-profit company providing limited technology services to non-affiliated healthcare organizations.

The Foundation for Vassar Brothers Medical Center (the "Foundation for VBMC") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Foundation for VBMC's principal activity is the solicitation, receipt, holding, investment and administration of contributions on behalf of VBMC and other Section 501(c)(3) entities affiliated with VBMC.

Putnam Hospital Center ("PHC") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. PHC provides general acute care with a full range of inpatient and outpatient services for residents of the Mid-Hudson Valley.

Putnam Hospital Center Foundation, Inc. ("PHC Foundation"), is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Foundation's principal activity is the solicitation, receipt, holding, investment, and administration of contributions on behalf of PHC. The Foundation actively solicits contributions from the public through direct mailings, fund-raising programs and other activities.

Northern Dutchess Hospital ("NDH") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. NDH provides general acute care with a full range of inpatient and outpatient services for residents of the Mid-Hudson Valley.

Northern Dutchess Hospital Foundation ("NDH Foundation") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. NDH Foundation's principal activity is the solicitation, receipt, holding, investment and administration of contributions on behalf of NDH, Northern Dutchess Residential Health Care Facility, Inc. and other community organizations. NDH Foundation actively solicits contributions from the public through direct mailings, fund-raising programs and other activities.

VBH Insurance Co. Ltd. (the "VBH Insurance"), is a captive insurer incorporated under the laws of Barbados. The captive insurer, licensed under the Exempt Insurance Act, Cap. 308A of the laws of Barbados, provides various levels of medical malpractice insurance for VBMC, PHC, NDH, Health Quest Medical Practice and Health Quest Urgent Care Practice.

(in thousands)

Northern Dutchess Residential Health Care Facility, Inc. (the "Nursing Home") is a not-for-profit corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code. The Nursing Home operates and maintains a residential healthcare facility for the care and treatment of persons who require medical care and related services.

Riverside Diversified Services, Inc. ("RDSI") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. RDSI is the beneficial owner of various physician practices that provide emergency and neonatal services for residents of the Mid-Hudson Valley.

Health Quest Medical Practice, PC ("HQMP") is a not-for-profit corporation, exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. HQMP is the beneficial owner of various physician practices that provide a full range of hospital and outpatient services for residents of the Mid-Hudson Valley.

Health Quest Urgent Medical Care Practice, PC ("HQUMCP") is a not-for-profit corporation, exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. HQUMCP is the beneficial owner of two urgent care centers that provide walk-in urgent care services for the residents of the Mid-Hudson Valley.

Hudson Valley Cardiovascular Practice, PC ("HVCP") is a not-for-profit corporation, exempt from Federal income taxes under Section 501©(3) of the Internal Revenue Code. HVCP provides invasive and noninvasive cardiovascular, diagnostic and therapeutic services and is located throughout Dutchess and Orange counties.

Health Quest Home Care, Inc. (Licensed) and Health Quest Home Care, Inc. (Certified) ("HQHC") are not-for-profit corporations exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. HQHC was formed to operate a home health care services business, serving residents of the Mid-Hudson Valley.

Wells Manor Housing Development Fund Corporation ("Wells Manor") is a private foundation incorporated as a 501(c)(3) organization and is exempt from Federal income tax under Section 509(a) of the Internal Revenue Code. Wells Manor operates an apartment complex of 75 units under Section 202 of the National Housing Act of 1959 and Section 8 of the National Housing Act of 1937, regulated by the U.S. Department of Housing and Urban Development.

Alamo Ambulance Service, Inc. ("Alamo") is a not-for-profit corporation exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Alamo's assets were sold in September 2009, however, it has maintained its license to provide transport and emergency medical services to sick, disabled, or injured persons, generally within Dutchess, Orange, Ulster and Putnam Counties, New York.

HQ Lab Support Services, LLC. is a limited liability company which provides diagnostic laboratory services to the Health Quest affiliated organizations.

(in thousands)

Riverside Management Services, Inc. ("RMSI") was incorporated under Section 402 of the Business Corporation Law of the State of New York and manages Hillside Renovations, Inc., a renovation and construction company and Riverside Ambulance, which was created in 1992 to maintain a note receivable and payable related to the purchase of Alamo. This corporation is currently dormant.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries. All significant intercompany accounts and transactions are eliminated in consolidation. The consolidation of the for-profit entities and not-for-profit entities is not necessarily indicative of the legal extent of assets available to settle the liabilities of the individual entities.

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of patient revenues and expenses during the reported period. The most significant estimates relate to patient accounts receivable allowances, amounts due from or due to third party payors, self-insurance reserves and assumptions related to post-retirement benefit obligations. Actual results may differ from those estimates. The consolidated statements of operations for the years ended December 31, 2015 and 2014 reflect estimated changes of approximately a decrease of $3,671 and an increase of $400, respectively.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid financial instruments with original maturities of three months or less from date of acquisition, excluding amounts whose use is limited and those amounts in investments held for reinvestment.

Restricted Cash

In October 2005, PHC terminated its agreement with DaVita, Inc. for renal dialysis services. As part of the termination agreement, PHC agreed to set aside all cash received for renal dialysis services provided prior to the termination of the agreement into a separate cash account. The funds are to be used to pay any costs associated with the program, including Medicare cost report settlements.

Inventories

The Company values its inventories, included in supplies and prepaid expenses, at current cost.

(in thousands)

Investments
The Company has determined that all investments reported in the consolidated balance sheets are considered trading securities. Investments in equity securities with readily determinable fair values and investments in debt securities are measured at fair value in the consolidated balance sheets. Fair value is determined based on closing price on primary market or quotes of similar securities. Investments in equity and bond funds are measured at fair value based on the net asset value per share at year end. Investment income (including realized and unrealized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Investments not traded on national exchanges are measured at net asset value, as provided by investment managers.

Long-Term Investments
Long-term investments include donor-restricted endowment gifts, other restricted funds and accumulated investment income on those funds.

Assets Whose Use is Limited
Assets whose use is limited includes externally controlled funds under bond indenture agreements and investments held by the Company's insurance captive. Amounts required to meet current liabilities of the Company have been classified as current assets in the consolidated balance sheets at December 31, 2015 and 2014.

Property, Plant and Equipment
Property, plant and equipment, including certain revenue producing equipment purchases, are carried at cost and those acquired by gifts and bequests are carried at appraised or fair market value established at date of contribution. Depreciation is provided on the straight-line method over the estimated useful lives of the assets:

Land improvement	20 years
Building and building improvement	40 years
Major moveable and equipment	3 – 15 years

Equipment under capital leases is recorded at present value at the inception of the leases and is amortized on the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. The amortization of assets recorded under capital leases is included in depreciation and amortization expense in the accompanying consolidated statements of operations. When assets are retired or otherwise disposed of, the cost and the related depreciation are reversed from the accounts, and any gain or loss is reflected in current operations. Repairs and maintenance expenditures are expensed as incurred.

Asset Retirement Obligations
The Company accounts for asset retirement obligations, including asbestos related removal costs, in accordance with authoritative guidance. The Company accrues for asset retirement obligations in the period in which they are incurred if sufficient information is available to reasonably estimate the fair value of the obligation. In 2015, management updated its asset retirement obligation estimates based on new information. Over time, the liability is accreted to its settlement value. Upon settlement of the liability, the Company will recognize a gain or loss for any difference between the settlement amount and liability recorded. As of December 31, 2015 and 2014, $9,444 and $2,005, respectively, of conditional asset retirement obligations are included within amounts due to third-party payors and other liabilities in the consolidated balance sheets.

(in thousands)

Capitalized Interest
Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets. These costs are amortized over the life of the related capital assets constructed.

Deferred Financing Costs
Deferred financing costs (approximately $3,685 and $4,153 at December 31, 2015 and 2014, respectively, included in other assets in the consolidated balance sheets) represent costs incurred to obtain financing for construction and renovation projects at VBMC, PHC and NDH. These costs are amortized over the life of the related debt. Amortization expense was approximately $468 and $442 for the years ended December 31, 2015 and 2014, respectively.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Company has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Company in perpetuity.

Donor-Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Charity Care
Effective January 1, 2007, the New York State Public Health Law required all hospitals to implement financial aid policies and procedures. The law also requires hospitals to develop a summary of its financial aid policies and procedures that must be made publicly available. All standards set forth in the law are minimum standards.

The Company provides a significant amount of partially or totally uncompensated patient care to patients who are unable to compensate the Company for their treatment either through third-party coverage or their own resources. Patients who meet certain criteria under the Company's charity care policy are provided care without charge or at amounts less than established rates. Because charity care amounts are not expected to be paid, they are not reported as revenue.

Performance Indicator
The consolidated statements of operations include excess of revenue over expenses, which is the performance indicator. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include pension related changes other than net periodic pension costs, net assets released from restriction for capital expenditures and contributions of long-lived assets.

(in thousands)

The Company differentiates its operating activities through the use of operating income as an intermediate measure of operations. For the purposes of display, investment income and other transactions, which management does not consider to be components of the Company's operating activities, are excluded from operating income and reported as non-operating revenues in the consolidated statements of operations.

Acquisition
On October 16, 2015, VBMC entered into an asset purchase agreement with DRA Imaging, P.C., to purchase the technical side of their business, in order to enhance the Radiology Department within VBMC. The total purchase price for the acquisition was $31,000 payable to DRA Imaging, P.C. over five years. The first installment of $6,500 was paid at the closing date of the transaction.

The fair value of the assets acquired was Property, Plant, and Equipment for $4,000 and Inventory for $50. The remainder of the consideration paid was allocated to Goodwill as there were no other intangible assets identified. The goodwill arising from the acquisition consists largely of the synergies from including the technical side of radiology within VBMC.

Goodwill
Intangible assets with indefinite useful lives, including goodwill, are not amortized, but are tested for impairment at least annually and more frequently if events or changes in circumstances indicate that an asset may be impaired. If fair value is less than carrying value, an impairment loss is recorded in the consolidated statements of operations. Management tested goodwill for impairment and concluded that no impairment existed as of December 31, 2015. In 2015, VBMC purchased the assets of a radiology practice, of which $25,916 was recorded as goodwill.

New Accounting Pronouncements
In February 2016, the Financial Accounting Standards Board ("FASB") issued the new standard, *Leases* (ASC 842). Under this guidance, lessees will need to recognize virtually all of their leases on the balance sheet, by recording a right-of-use asset and lease liability. This new standard is effective for fiscal years beginning after December 15, 2019, with early application permitted. The Company is evaluating the impact that this will have on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-1, Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities. This guidance supersedes the guidance to classify equity securities with readily determinable fair values into different categories, and requires equity securities to be measured at fair value with changes in the fair value recognized through net income. This guidance, among other things, removes the requirement to disclose the methods used to calculate the fair value of debt and allows equity investments without readily determinable fair values to be remeasured at fair value either upon the occurrence of an observable price change or upon identification of an impairment and requires additional disclosures regarding these investments. This guidance is effective for fiscal years beginning on January 1, 2019, with early adoption permitted. The Company is evaluating the impact of adopting this guidance on the consolidated financial statements.

In May 2015, the FASB issued ASU No. 2015-07, Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or its Equivalent) which amends disclosure requirements of Accounting Standards Codification Topic 820, Fair Value Measurement, for reporting entities that measure the fair value of an investment using the net asset value per share (or its equivalent) as a practical expedient. The amendments remove the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The ASU is effective for fiscal years beginning after December 15, 2016, with

(in thousands)

early application permitted. The Company is evaluating the impact that this will have on the consolidated financial statements.

In May 2014, the FASB issued a standard on Revenue from Contracts with Customers. This standard implements a single framework for recognition of all revenue earned from customers. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services by allocating transaction price to identified performance obligations and recognizing revenue as performance obligations are satisfied. Qualitative and quantitative disclosures are required to enable users of financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2018. The Company is evaluating the impact that this will have on the consolidated financial statements.

In April 2015, the FASB issued a standard on Simplifying the Presentation of Debt Issuance Costs. This standard requires all costs incurred to issue debt to be presented in the balance sheet as a direct deduction from the carrying value of the associated debt liability. The standard is effective for fiscal years beginning after December 15, 2015. The Company is evaluating the impact this will have on the consolidated financial statements beginning in fiscal year 2016.

3. Net Patient Service Revenue, Accounts Receivable and Allowance for Uncollectible Accounts

The Company has agreements with third-party payors that provide for payments to the Company at amounts different from its established rates (i.e., gross charges). Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments.

Billings relating to services rendered are recorded as net patient service revenue in the period in which the service is performed, net of contractual and other allowances that represent differences between gross charges and the estimated receipts under such programs. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Patient accounts receivable are also reduced for allowances for uncollectible accounts.

The process for estimating the ultimate collection of receivables involves significant assumptions and judgments. The Company has implemented a monthly standardized approach to estimate and review the collectability of receivables based on the payor classification and the period from which the receivables have been outstanding. Past due balances over 90 days from the date of billing and over a specified amount are considered delinquent and are reviewed for collectability. Account balances are written off against the allowance when management feels it is probable the receivable will not be recovered. Historical collection and payor reimbursement experience is an integral part of the estimation process related to reserves for doubtful accounts. In addition, the Company assesses the current state of its billing functions in order to identify any known collection or reimbursement issues and assess the impact, if any, on reserve estimates. The Company believes that the collectability of its receivables is directly linked to the quality of its billing processes, most

(in thousands)

notably those related to obtaining the correct information in order to bill effectively for the services it provides.

A summary of the payment arrangements with major third-party payors follows:

- *Medicare:* Inpatient acute care services and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors.
- *Non-Medicare Payments*: The New York Health Care Reform Act of 1996, as updated, governs payments to hospitals in New York State. Under this system, hospitals and all non-Medicare payors, except Medicaid, workers' compensation and no-fault insurance programs, negotiate hospital payment rates. If negotiated rates are not established, payors are billed at hospital's established charges. Medicaid, workers' compensation and no-fault payors pay hospital rates promulgated by the New York State Department of Health on a prospective basis. Adjustment to current and prior years' rates for these payors will continue to be made in the future.

There are also various other proposals at the Federal and State level that could, among other things, reduce payment rates. The ultimate outcome of these proposals, regulatory changes, and other market conditions cannot presently be determined.

The Company has established estimates, based on information presently available, of amounts due to or from Medicare and non-Medicare payors for adjustments to current and prior years' payment rates, based on industry-wide and hospital-specific data. Additionally, certain payors' payment rates for various years have been appealed by the Company. If the appeals are successful, additional income applicable to those years will be realized.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Revenue from the Medicare and Medicaid programs accounted for approximately 49% and 13%, respectively, of the Company's net patient service revenue for the year ended December 31, 2015, and 47% and 15%, respectively, of the Company's net patient service revenue, for the year ended December 31, 2014.

VBMC's Medicare cost reports have been audited through December 31, 2013 and finalized by the Medicare fiscal intermediary through December 31, 2012, with the exception of fiscal year ended December 31, 2003. PHC's Medicare cost reports have been audited and finalized by the Medicare fiscal intermediary through December 31, 2013. NDH's Medicare cost reports have been audited through December 31, 2013 and finalized by the Medicare fiscal intermediary through December 31, 2012.

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Company analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data for these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Company analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and

(in thousands)

copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Company records a provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors and others for services rendered and includes estimated retroactive revenue adjustments due to future audits, reviews and investigations. Federal and state regulations provide for certain retrospective adjustments to current and prior years' payment rates based on industry wide and hospital-specific data. The Company has estimated the potential impact of such retrospective adjustments based on information presently available and adjustments are accrued on an estimated basis in the period the services are rendered and are adjusted in future periods as additional information becomes available or final settlements are determined.

The Company has implemented a discount policy and provides financial assistance discounts to uninsured patients. Under this policy, the discount offered to uninsured patients is reflected as a reduction to net patient service revenue at the time the uninsured billings are recorded.

Federal and state law requires that hospitals provide emergency services regardless of a patient's ability to pay. Uninsured patients seen in the emergency department, including patients subsequently admitted for inpatient services, often do not provide information necessary to allow the Company to qualify such patients for charity care. Uncollectible amounts due from such uninsured patients represent the substantial portion of the provision for bad debts reflected in the accompanying consolidated statements of operations. Charity care and uncompensated care is as follows for the years ended December 31:

	2015	2014
Charity care, at estimated cost	$ 15,683	$ 13,461
Uncompensated care reported as provision for bad debts, net	25,591	30,352
Total uncompensated care provided	$ 41,274	$ 43,813

The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Company's total expenses (less bad debt expense) divided by gross patient service revenue.

(in thousands)

The Company grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor arrangements. The mix of receivables (net of contractual allowances and advances from certain third-parties) from patients and third-party payors at December 31, 2015 and 2014 is as follows:

	2015	2014
Medicare	25 %	23 %
Medicaid	5	6
Blue Cross	15	14
Managed care and other	46	47
Patients	9	10
	100 %	100 %

4. Promises to Give

Unconditional promises to give that are expected to be collected in more than one year are discounted to the net present value of their estimated future cash flows. The discount rate on new pledges was 1.76% and 1.65% at December 31, 2015 and 2014, respectively. These amounts are included in other assets in the consolidated balance sheets as of December 31, 2015 and 2014.

The composition of unconditional promises to give, at December 31, 2015 and 2014 is as follows:

	2015	2014
Pledges due in less than one year	$ 2,433	$ 2,534
Pledges due in one to five years	5,948	5,681
Pledges due in more than five years	1,231	1,443
	9,612	9,658
Unamortized discount	390	377
	9,222	9,281
Allowance for uncollected pledges	614	1,359
	$ 8,608	$ 7,922

5. Concentration of Credit Risk

The Company routinely invests its surplus operating funds in money market funds. These funds generally invest in highly liquid U.S. government and agency obligations. Investments in money market funds are not insured or guaranteed by the U.S. government.

At December 31, 2015 and 2014, the Company had cash and investment balances in financial institutions that exceeded Federal depository insurance limits. Management believes that the credit risk related to these deposits is minimal. The investment balances are held at primarily one institution.

(in thousands)

6. Investments and Assets Whose Use is Limited

Investments, stated at fair value at December 31, 2015 and 2014, consist of the following:

	2015	2014
Cash and cash equivalents	$ 479	$ 699
Equity securities	8,600	9,440
Mutual funds - Equity securities	133,688	154,220
Mutual funds - Bonds	63,042	44,533
Short term investments	1,284	700
	$ 207,093	$ 209,592

The composition of assets whose use is limited, stated at fair value at December 31, 2015 and 2014, consists of the following:

	2015	2014
Externally restricted by bond indenture agreements		
Cash and cash equivalents	$ 13,063	$ 45,239
Short term investments	481	780
U.S. treasury obligations	10,064	10,751
	23,608	56,770
Less: Current portion	2,013	2,014
	$ 21,595	$ 54,756

	2015	2014
Externally restricted by captive insurer		
Equity securities	$ 904	$ 994
Mutual funds - Equity securities	11,392	11,336
Mutual funds - Bonds	15,780	15,729
	$ 28,076	$ 28,059

Investment income (loss) for the years ended December 31, 2015 and 2014 consists of the following:

	2015	2014
Interest and dividend income	$ 5,023	$ 7,971
Net realized gains on sale of securities	317	1,310
Change in unrealized gains/(losses)	(10,138)	2,918
Management fees	(102)	(138)
Investment income (loss)	$ (4,900)	$ 12,061

(in thousands)

The Company follows accounting guidance for fair value measurements. This guidance defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and requires disclosures about fair value measurements. Fair value is defined under this guidance as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement data.

The guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value under the guidance must maximize the use of observable inputs and minimize the use of unobservable inputs. The standard describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Company for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 - Quoted prices in active markets for identical assets or liabilities.
- Level 2 - Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the whole term of the assets or liabilities.
- Level 3 - Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques noted in the guidance. The three valuation techniques are as follows:

- Market approach - Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- Cost approach - Amount that would be required to replace the service capacity of an asset (i.e. replacement cost); and
- Income approach - Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Categorization in hierarchy is based on lowest level of input that is significant to the determination of fair value.

(in thousands)

The categorization of investments and assets whose use is limited within the fair value hierarchy defined by the accounting guidance is as follows at December 31, 2015 and 2014:

		Fair Value at December 31, 2015			Valuation
	Total	Level 1	Level 2	Level 3	Technique
Cash and cash equivalents	$ 13,541	$ 9,036	$ 4,505	$ -	Market
Equity securities	9,504	9,504	-	-	Market
Mutual Funds - Equity securities	145,080	-	145,080	-	Market
Mutual Funds - Bond funds	78,822	-	78,822	-	Market
U.S. treasury obligations	10,066	10,066	-	-	Market
Short term investments	1,764	1,764	-	-	Market
Total	$ 258,777	$ 30,370	$ 228,407	$ -	

		Fair Value at December 31, 2014			Valuation
	Total	Level 1	Level 2	Level 3	Technique
Cash and cash equivalents	$ 45,938	$ 41,079	$ 4,859	$ -	Market
Equity securities	10,434	10,434	-	-	Market
Mutual Funds - Equity securities	165,556	-	165,556	-	Market
Mutual Funds - Bond funds	60,262	-	60,262	-	Market
U.S. treasury obligations	10,751	10,751	-	-	Market
Short term investments	1,480	1,480	-	-	Market
Total	$ 294,421	$ 63,744	$ 230,677	$ -	

The Company's assets with a fair value estimate using net asset value per share as a basis at December 31, 2015 and 2014 are as follows:

	Fair Value Estimated Using Net Assets Value Per Share				
	Fair Value December 31, 2015	Fair Value December 31, 2014	Unfunded Commitment	Settlement Terms	Redemption Frequency
Mutual Funds - Equity securities	$ 36,969	$ 38,415	$ -	Redemptions occur at NAV	T-2 days notification for redemption or contributions
Total	$ 36,969	$ 38,415			

(in thousands)

7. Property, Plant and Equipment

Property, plant and equipment, at cost, and accumulated depreciation and amortization at December 31, 2015 and 2014 consisted of the following:

	2015	2014
Land	$ 7,133	$ 7,133
Land improvements	9,320	8,543
Buildings and fixed equipment	430,990	409,072
Major movable equipment	459,535	431,122
	906,978	855,870
Less: Accumulated depreciation and amortization	554,291	509,140
	352,687	346,730
Construction in progress	59,393	15,452
Net property, plant and equipment	$ 412,080	$ 362,182

Depreciation and amortization expense for the years ended December 31, 2015 and 2014 was $47,934 and $46,161, respectively. Included in construction in progress is capitalized interest of $7,039 and $5,414 at December 31, 2015 and 2014, respectively.

Construction in progress is comprised of certain projects started but not completed at December 31, 2015. The estimated cost to complete these projects is approximately $16,619, at December 31, 2015. Included in construction in progress is a building project for NDH. NDH contracted to build an approximately 87,000 square foot, four story addition on its hospital campus. The building opened in February 2016. Also included in the construction in progress is the property acquisition costs and architectural drawings for the new VBMC patient pavilion project.

VBMC's patient pavilion project is for the construction of a new 696,000 square foot patient bed tower for the adult patient population and will replace its current adult medical surgical beds (reduction from 276 to 264) and its adult critical care units (increase from 24 to 30). The project will also include the replacement and expansion of the emergency department and the replacement of the operating rooms and interventional suites. Additionally, an expanded and modernized central plant and appropriate conference rooms and capabilities will provide enhanced physician, visitor and employee amenities within the new building. This project is expected to start in June 2016 with an expected completion date of January 2019. The total estimated cost of the project is $466 million, which will be funded through cash and bond financing.

As of December 31, 2015 and 2014, there was approximately $3,799 and $1,814 of property, plant and equipment in accounts payable.

(in thousands)

8. Long-term Debt

A summary of long-term debt and capital lease obligations at December 31, 2015 and 2014 is as follows:

	2015	2014
Health Quest Systems, Inc. Obligated Group Dormitory Authority of the State of New York Revenue Bonds, Series 2007, varying rates from 4.5% to 5.0% at December 31, 2015, principal payments due in varying annual payments until 2037, collateralized by a lien on a facility mortgage and gross receipts (a)	$ 53,410	$ 55,984
Health Quest Systems, Inc. Obligated Group Dutchess County Local Development Corporation, Series 2010, varying rates from 5.0% to 6.82% at December 31, 2015, principal payments due in varying annual payments until 2040, collateralized by a lien facility mortgage and gross receipts (b)	40,291	43,642
Health Quest Systems, Inc. Obligated Group Dutchess County Local Development Corporation, Series 2012, a refinancing of the VBH 1997 Series bonds varying rates from 1.75% to 3.80% at December 31, 2015, principal payments due in varying annual payments until 2025, collateralized by a lien facility mortgage and gross receipts (c)	20,148	21,906
Health Quest Systems, Inc. Obligated Group Dutchess County Local Development Corporation, Series 2014, varying rates from 1.65% to 5.0% at December 31, 2015, principal payments due in varying annual payments until 2044, collateralized by a lien facility mortgage and gross receipts (d)	54,853	56,616
Vassar Brothers Medical Center Civic Facility Bonds, Series 2011, a refinancing of the 2005 Series bonds, varying rates of 4.25% to 5.50% at December 31, 2015, principal payments due in varying annual payments until 2034, collateralized by a lien on a facility mortgage and gross receipts (e)	15,177	15,638
Vassar Brothers Medical Center note payable, payable in 4 installments, until October 2019	23,468	
PHC's Bank of New York Bond at varying rates (Series 1999A), average 0.80%, due 2019; collateralized by certain Hospital property, paid in full in 2015	-	1,700
PHC's promissory notes payable to Comprehensive Support Services, monthly principal installments, paid in full in July 2015, interest rate of 8.25%	-	77
PHC's 6% mortgage note, monthly installments due until April 2021, collateralized by the Romolan building located on PHC's property	156	184
Wells Manor mortgage note payable in monthly installments through 2027, interest at 9.25%, collateralized by the Wells Manor project and insured by HUD	1,936	2,048
Health Quest Systems, Inc. $8 million loan with TD Bank North, interest rate based on one month LIBOR rate (1.17% at December 31, 2015), plus fixed rate of 2.5%, due in monthly installments until June 2016, collateralized by equipment	651	1,925
Health Quest Systems, Inc. Obligated Group Dormitory Authority of the State of New York and TD Equipment Finance TELP ("Tax Exempt Leasing Program") loan payable, paid in full in October 2015, interest rate of 2.7% (f)	-	1,878
Capital lease obligation, collateralized by leased equipment	139	237
	210,229	201,835
Less: Current portion	17,648	13,669
Long-term debt	$ 192,581	$ 188,166

(in thousands)

a. During 2007, the Company formed the Health Quest Systems, Inc. Obligated Group ("Obligated Group"), which consists of Health Quest, VBMC, PHC and NDH. On September 5, 2007, the Obligated Group issued $69,335 in debt through the Dormitory Authority of the State of New York ("DASNY") as Revenue Bonds, insured by Assured Guaranty Corp. These bonds were allocated as follows: VBMC - $17,980; PHC - $35,740; NDH - $15,615. The purpose of the bonds was to refund certain existing debt for VBMC and NDH, fund the PHC building project and to purchase certain medical equipment.

b. On December 14, 2010, the Dutchess County Local Development Corporation issued $55,055 Health Quest Systems, Inc. Obligated Group Revenue Bonds, Series 2010 for the purpose of providing funds to the Obligated Group for construction, furnishing, installation, equipping and improvement of new facilities and to refinance existing VBMC Series 2004 debt. These bonds were allocated 100% to VBMC.

c. On October 1, 1997, Vassar Brothers Hospital Insured Revenue Bonds, Series 1997 ("Series 1997"), with proceeds of $58,500 were issued to VBMC to refund outstanding debt and to finance a major renovation and construction project. The Dormitory Authority of the State of New York sponsored the issuance of the Series 1997. On December 5, 2012, these bonds were refinanced, Series 2012, for the balance of $27,320 with the Dutchess County Local Development Corporation.

d. On May 14, 2014, the Dutchess County Local Development Corporation issued $54,615 Health Quest Systems, Inc. Obligated Group Revenue Bonds, Series 2014 for the purpose of providing funds to the Obligated Group for construction, furnishing, installation, equipping and improvement of new facilities and to refinance existing VBMC debt. These bonds were allocated as follows: VBMC - $18,045 and NDH - $36,570.

e. On June 28, 2005, the Dutchess County Industrial Development Agency issued $19,975 Civic Facility Revenue Bonds, Series 2005 bonds to VBMC for the purpose of providing funds for the construction, acquisition, furnishing, installation, equipping and improvement of new and existing facilities. These bonds were refinanced in 2011 with the Dutchess County Local Development Corporation.

f. On October 1, 2010, VBMC, PHC and NDH entered into a master lease and sublease agreement with the Dormitory Authority of the State of New York and TD Equipment Finance Inc. under the Tax Exempt Leasing Program ("TELP") in the amount of $10,665. The lease was paid back in full in October 2015.

In accordance with certain bond agreements, the Obligated Group is required to maintain specified amounts in a debt service reserve fund, a renewal fund and a bond fund. These assets, along with the unspent proceeds from the issuances of other debt issued by VBMC, PHC and NDH, are recorded in assets whose use is limited, externally restricted in the accompanying consolidated balance sheets.

These debt agreements also place limits on the incurrence of additional borrowing and requires that the Obligated Group satisfy certain measures of financial requirements (i.e. day's cash on hand, debt to capitalization, debt service coverage) as long as the debt remains outstanding. Under the Obligated Group, there is a cross guaranteed repayment of the outstanding debt in the event any of the members default.

(in thousands)

Health Quest has a $4,800 letter of credit with JP Morgan Chase, associated with workers compensation self-insurance and a $24,500 letter of credit, associated with the purchase of a radiology practice.

Scheduled principal payments on all long-term debt for the next five years and thereafter, are as follows:

Year	Total
Long Term Debt and Capital Lease Obligations	
2016	$ 17,648
2017	16,980
2018	16,783
2019	15,481
2020	11,735
Thereafter	131,602
	210,229
Less: Current portion	17,648
Long-term debt	$ 192,581

The Company estimates the fair value of long-term debt using quoted market prices or estimates using discounted cash flow analyses, based on the Company's incremental borrowing rates for similar types of borrowing arrangements. The fair value of the Company's long-term debt, based on quoted market prices, at December 31, 2015 and 2014 was approximately $223,259 and $217,000, respectively, compared to the carrying value of $210,229 and $201,835, respectively, and is classified as level 2, as defined in Note 6.

9. Benefit Plans

Vassar Brothers Medical Center

VBMC maintains a noncontributory defined benefit plan (the "Vassar Brothers Plan") covering employees of VBMC who are part of the collective bargaining unit with New York State Nurses Association ("NYSNA") who have completed 5 years of service and attained 21 years of age. Contributions to the Vassar Brothers Plan are based on actuarial valuations. Benefits under the Vassar Brothers Plan are based on years of service and compensation. VBMC's policy is to contribute amounts sufficient to meet funding requirements under the Employee Retirement Income Security Act of 1974.

VBMC sponsors a health care plan that provides post-retirement medical benefits to its nonunion retired employees. Nonunion employees hired prior to January 1, 1993, retiring from VBMC on or after attaining age 60 who have rendered at least 20 years of service, are entitled to post-retirement health care coverage. VBMC funds post-retirement benefit costs on a cash basis.

(in thousands)

The measurement date for the two plans is December 31. The following tables provide a reconciliation of the changes in each of the plan's benefit obligations and fair value of assets for the years ended December 31, 2015 and 2014 and a statement of the funded status of the plans as of December 31, 2015 and 2014:

	Noncontributory Defined Benefit Plan		Post-retirement Medical Benefits Plan	
	2015	2014	2015	2014
Changes in benefit obligation				
Benefit obligation, at beginning of year	$ (118,939)	$ (98,855)	$ 450	$ (457)
Service cost	(6,642)	(5,804)	21	18
Interest cost	(4,796)	(4,944)	8	11
Actuarial gain (loss)	7,179	(11,668)	(889)	846
Benefits paid	2,972	2,332	37	32
Benefit obligation, at end of year	(120,226)	(118,939)	(373)	450
Changes in plan assets				
Fair value of plan assets, at beginning of year	67,270	61,474	-	-
Actual return on plan assets	(504)	3,573	-	-
Contributions	3,941	4,649	37	32
Benefit payments	(2,990)	(2,426)	(37)	(32)
Fair value of plan assets, at end of year	67,717	67,270	-	-
Funded status	$ (52,509)	$ (51,669)	$ (373)	$ 450

Amounts recognized in the consolidated balance sheets consist of:

Noncurrent assets	$ -	$ -	$ -	$ 450
Current liabilities	-	-	(17)	-
Noncurrent liabilities	(52,509)	(51,669)	(356)	-
	$ (52,509)	$ (51,669)	$ (373)	$ 450

Amounts recognized in unrestricted net assets consist of:

	Noncontributory Defined Benefit Plan		Post-retirement Medical Benefits Plan	
	2015	2014	2015	2014
Gain (loss)	$ (20,170)	$ (23,810)	$ (7)	$ 930

As of December 31, 2015 and 2014, the accumulated benefit obligation with respect to the defined benefit plan is $100,825 and $99,749, respectively.

(in thousands)

The following table provides the components of the net periodic benefit cost (income) for the plans for the years ended December 31, 2015 and 2014:

	Noncontributory Defined Benefit Plan		Post-retirement Medical Benefits Plan	
	2015	2014	2015	2014
Net periodic benefit cost				
Service cost	$ 6,642	$ 5,804	$ (22)	$ (18)
Interest cost	4,796	4,944	(8)	(11)
Expected return on plan assets	(4,408)	(4,537)	-	-
Amortization of net (gain) loss	1,391	70	(48)	(56)
Net periodic benefit cost	8,421	6,281	(78)	(85)
Other changes in plan assets and benefit obligations recognized in unrestricted net assets				
Net (gain) loss	(2,248)	12,725	889	(845)
Less: Amortization of net (gain) loss	1,391	70	(48)	(56)
Total recognized in unrestricted net assets	(3,639)	12,655	937	(789)
Total recognized in net periodic benefit cost and unrestricted net assets	$ 4,782	$ 18,936	$ 859	$ (874)

The calculation of the VBMC plans' funded status and amounts recognized in the consolidated balance sheets as of December 31, 2015 and 2014, respectively, were based upon actuarial assumptions as follows:

	Noncontributory Defined Benefit Plan		Post-retirement Medical Benefits Plan	
	2015	2014	2015	2014
Discount rate	4.43 %	4.03 %	4.01 %	4.24 %
Average rate of salary increases	3.50 %	3.50 %	0.0 %	0.0 %
Initial trend	-	-	5.60 %	4.00 %
Ultimate trend	-	-	4.40 %	4.40 %
Year ultimate trend is achieved	-	-	2080	2080

	Noncontributory Defined Benefit Plan	Post-retirement Medical Benefits Plan
Amount in unrestricted assets expected to be recognized in 2016		
Amortization of unrecognized net (loss)	$ (845)	$ 0

(in thousands)

The calculation of the net benefit costs for the years ended December 31, 2015 and 2014, respectively, were based upon actuarial assumptions as follows:

	Noncontributory Defined Benefit Plan		Post-retirement Medical Benefits Plan	
	2015	2014	2015	2014
Discount rate	4.03 %	5.11 %	4.24 %	5.11 %
Expected return on plan assets	6.50 %	7.25 %	-	-
Average rate of salary increases	3.50 %	5.50 %	-	-
Projected retiree health care	-	-	5.60 %	4.00 %
Ultimate retiree health-care cost trend	-	-	4.40 %	4.40 %
Year ultimate trend is achieved	-	-	2080	2080

In 2015, the effect on the post-retirement medical benefits plan of a 1% change in health care cost trend rate is as follows:

	2015 1% Increase	2015 1% Decrease
Effect on total of service and interest cost components	$ (16)	$ 12
Effect on postretirement benefit obligation	(31)	24

The expected long-term rate of return on plan assets assumption is based upon a building-block method, whereby the expected rate of return on each asset class is broken down into three components: (1) inflation, (2) the real risk-free rate of return (i.e., the long-term estimate of future returns on default-free U.S. government securities), and (3) the risk premium for each asset class (i.e., the expected return in excess of the risk-free rate). All three components are based primarily on historical data, with modest adjustments to take into account additional relevant information that is currently available. For the inflation and risk-free return components, the most significant additional information is that provided by the market for nominal and inflation-indexed U.S. Treasury securities. That market provides implied forecasts of both the inflation rate and risk-free rate for the period over which currently-available securities mature. The historical data on risk premiums for each asset class is adjusted to reflect any systemic changes that have occurred in the relevant markets; e.g., the higher current valuations for equities, as a multiple of earnings, relative to the longer-term average for such valuations.

Assumed health care cost trend rates have a significant effect on the amounts reported for the postretirement medical benefits plan; however, because VBMC has frozen its employer subsidy at 1993 amounts, no future trend is used in the valuations for 2015 and 2014.

Contributions
VMBC expects to contribute approximately $3,900 to the defined benefit pension plan and postretirement medical benefits plan for fiscal year 2016.

(in thousands)

Benefit Payments
The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid out of the plan as follows:

Year	Noncontributory Defined Benefit Plan Payments	Post-retirement Medical Benefits Plan Payments
2016	$ 2,932	$ 17
2017	3,336	18
2018	3,667	21
2019	4,053	23
2020	4,409	27
2021–2025	28,901	151

Plan Assets
No post-retirement medical benefits plan assets were held for investment as of December 31, 2015 and 2014. Defined benefit plan assets are held in a trust fund. The weighted-average asset allocation at December 31, 2015 and 2014, by asset category are as follows:

	Noncontributory Defined Benefit Plan	
	2015	2014
Asset category		
Cash and cash equivalents	2 %	- %
Equity securities	58	60
Bond funds	40	40
	100 %	100 %

Objective
The plan's investment objectives seek a positive long-term total rate of return after inflation to meet VBMC's current and future plan obligations. The asset allocations for the plan combine tested theory and informed market judgments to balance investment risks with the need for high returns. The target allocation of plan investments is approximately 60% equity and 40% bonds.

The following table presents the VBMC plans' financial instruments as of December 31, 2015 and 2014, measured at fair value on a recurring basis using the fair value hierarchy defined in Note 6:

	Total	Fair Value at December 31, 2015 Level 1	Level 2	Level 3	Valuation Technique
Cash and cash equivalents	$ 19	$ 19	$ -	$ -	Market
Equity securities	2,625	2,625	-	-	Market
Mutual Funds - Equity securities	36,683	-	36,683	-	Market
Mutual Funds - Bond funds	27,247	-	27,247	-	Market
Short term investments	1,143	1,143	-	-	Market
Total	$ 67,717	$ 3,787	$ 63,930	$ -	

(in thousands)

	Total	Fair Value at December 31, 2014 Level 1	Level 2	Level 3	Valuation Technique
Cash and cash equivalents	$ 23	$ 23	$ -	$ -	Market
Equity securities	2,800	2,800	-	-	Market
Mutual Funds - Equity securities	37,159	-	37,159	-	Market
Mutual Funds - Bond funds	27,138	-	27,138	-	Market
Short term investments	150	150	-	-	Market
Total	$ 67,270	$ 2,973	$ 64,297	$ -	

Certain employees of VBMC, who have completed two years of service, participate in a defined contribution retirement plan whereby contributions are made on an annual basis equal to 6% of the employees' qualifying salary. Costs related to this plan were approximately $1,169 and $1,384 for the years ended December 31, 2015 and 2014, respectively.

Putnam Hospital Center

PHC maintains a noncontributory defined benefit plan (the "Putnam Plan") covering substantially all employees who have completed 5 years of service and attained 21 years of age. The Putnam Plan provides benefits based on the participants' year of service and compensation. PHC's policy is to fund amounts intended to provide for benefits attributed to service to date and those expected to be earned in the future. Effective December 31, 2007, the Plan was frozen.

The measurement date for the Plan is December 31, 2015 and 2014, respectively. The following table provides a reconciliation of the changes in the Plan's benefit obligation and fair value of assets for the years ended December 31, 2015 and 2014, and a statement of the funded status of the Plan as of December 31, 2015 and 2014:

	2015	2014
Changes in benefit obligation		
Benefit obligation, at beginning of year	$ (83,930)	$ (67,030)
Service cost	(522)	(328)
Interest cost	(3,176)	(3,332)
Actuarial gain (loss)	3,107	(16,009)
Benefits paid and expected expenses	3,038	2,769
Benefit obligation, at end of year	(81,483)	(83,930)
Changes in plan assets		
Fair value of plan assets, at beginning of year	60,475	58,217
Actual return on plan assets	(353)	3,222
Contributions	1,756	1,874
Benefits paid and actual expenses	(3,051)	(2,838)
Fair value of plan assets, at end of year	58,827	60,475
Funded status	$ (22,656)	$ (23,455)
Amounts recognized in the consolidated balance sheets consist of		
Noncurrent liabilities	$ (22,656)	$ (23,455)
Amounts recognized in unrestricted net assets consist of		
Gain (loss)	$ (29,502)	$ (31,022)

At December 31, 2015 and 2014, the accumulated benefit obligation is $81,483 and $83,930, respectively.

(in thousands)

The following table provides the components of the net periodic benefit cost for the Putnam Plan for the years ended December 31, 2015 and 2014:

	2015	2014
Net periodic benefit cost		
Service cost	$ 522	$ 328
Interest cost	3,176	3,332
Expected return on assets	(3,875)	(4,167)
Amortization of net loss	2,654	817
Net periodic benefit cost	2,477	310
Other changes in plan assets and benefit obligations recognized in unrestricted net assets		
Net (gain) loss	1,134	17,022
Less: Amortization of net (gain) loss	2,654	816
Total recognized in unrestricted net assets	(1,520)	16,206
Total recognized in net periodic benefit cost and unrestricted net assets	$ 957	$ 16,516

The calculation of the Putnam Plan's funded status and amounts recognized in the consolidated balance sheets as of December 31, 2015 and 2014 were based upon the actuarial assumptions as follows:

	2015	2014
Discount rate	4.19 %	3.84 %

The calculation of the net periodic benefit cost for the years ended December 31, 2015 and 2014 were based upon actuarial assumptions as follows:

	2015	2014
Discount rate	3.84 %	5.11 %
Expected return on plan assets	6.50 %	7.25 %

Amount in unrestricted assets expected to be recognized in 2016	
Amortization of net loss	$ (2,759)

(in thousands)

The expected long-term rate of return on plan assets assumption is based upon a building-block method, whereby the expected rate of return on each asset class is broken down into three components: (1) inflation, (2) the real risk-free rate of return, (i.e., the long-term estimate of future returns on default-free U.S. government securities), and (3) the risk premium for each asset class (i.e., the expected return in excess of the risk-free rate). All three components are based primarily on historical data, with modest adjustments to take into account additional relevant information that is currently available. For the inflation and risk-free return components, the most significant additional information is that provided by the market for nominal and inflation-indexed U.S. Treasury securities. That market provides implied forecasts of both the inflation rate and risk-free rate for the period over which currently-available securities mature. The historical data on risk premiums for each asset class is adjusted to reflect any systemic changes that have occurred in the relevant markets; e.g., the higher current valuations for equities, as a multiple of earnings, relative to the longer-term average for such valuations.

Contributions
Expected contribution to the plan for fiscal year 2016 is $1,600.

Benefit Payments
The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid out of the plan as follows:

Year	Pension Benefits
2016	$ 3,461
2017	3,757
2018	3,983
2019	4,243
2020	4,557
2021–2025	24,264

Plan Assets
PHC's weighted-average asset allocation at December 31, 2015 and 2014, by asset category are as follows:

Asset Category	Plan Assets at December 31, 2015	2014
Equity securities	55 %	56 %
Met Life assets	7	7
Bond funds	38	37
	100 %	100 %

Objective
The Putnam Plan's investment objectives seek a positive long-term total rate of return after inflation to meet PHC's current and future obligations. The asset allocations for the plan combines tested theory and informed market judgment to balance investment risks with the need for higher returns. The target allocation is approximately 60% equity and 40% fixed income securities.

(in thousands)

The following table presents the Putnam Plans' financial instruments as of December 31, 2015 and 2014, measured at fair value on a recurring basis using the fair value hierarchy defined in Note 6:

	Total	Fair Value at December 31, 2015 Level 1	Level 2	Level 3	Valuation Technique
Cash and cash equivalents	$ 57	$ 57	$ -	$ -	Market
Equity securities	2,237	2,237	-	-	Market
Mutual funds - Equity securities	30,236	-	30,236	-	Market
Mutual funds - Bond funds	22,191	-	22,191	-	Market
Met Life assets	3,953	-	3,953	-	Market
Short term investments	153	153	-	-	Market
Total	$ 58,827	$ 2,447	$ 56,380	$ -	

	Total	Fair Value at December 31, 2014 Level 1	Level 2	Level 3	Valuation Technique
Cash and cash equivalents	$ 62	$ 62	$ -	$ -	Market
Equity securities	2,399	2,399	-	-	Market
Mutual funds - Equity securities	31,382	-	31,382	-	Market
Mutual funds - Bond funds	22,326	-	22,326	-	Market
Met Life assets	4,205	-	4,205	-	Market
Short term investments	101	101	-	-	Market
Total	$ 60,475	$ 2,562	$ 57,913	$ -	

Certain employees of PHC, who have completed two years of service, participate in a defined contribution retirement plan whereby contributions are made on an annual basis equal to 6% of the employees' qualifying salary. Costs related to this plan were approximately $2,230 and $2,577 for the years ended December 31, 2015 and 2014, respectively.

Multi-employer Benefit Plan

VBMC and PHC participate in multi-employer defined benefit pension plans. VBMC and PHC make cash contributions to these plans under the terms of collective-bargaining agreements that cover its union employees based on a fixed rate and hours of service per week worked by the covered employees. The risks of participating in these multi-employer plans are different from other single-employer plans in the following aspects: (1) assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of other participating employers, (2) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers and (3) if VBMC or PHC chooses to stop participating in some of its multiemployer plans, VBMC or PHC may be required to pay those plans an amount based on the underfunded status of the plan, referred to as a withdrawal liability. VBMC or PHC has contributed cash and recorded expenses for the multi-employer plans noted in the table below. The measurement dates for the following plans are as of December 31, 2015 and 2014, respectively.

Pension Fund	2015	2014
1199 SEIU Health Care Employees Pension Fund	$ 4,684	$ 4,447

VBMC and PHC contributions to the 1199 SEIU Health Care Employees Pension Fund represent approximately 0.4% of total plan contributions.

(in thousands)

The 1199 SEIU Health Care Employees Pension Fund covers employees of both VBMC and PHC and while it is only one plan, VBMC and PHC each have a separate EIN / Pension plan number. The following table includes additional disclosure information as it relates to the Pension Funds for VBMC and PHC, respectively:

EIN/Pension Plan Number	Pension Protection Act Zone Status 2015	2014	FIP/RP Status Pending/ Implemented	Surcharge Imposed	Expiration Date of Collective-Bargaining Agreement
14-1338586	Green	Green	No	No	September 30, 2018
14-6019179	Green	Green	No	No	September 30, 2018

The Pension Protection Act zone status indicates the plan's funded status of either at least 80% funded (green) or less than 80% funded (red). A zone status of red requires the plan sponsor to implement a Funding Improvement Plan (FIP) or Rehabilitation Plan (RP).

Northern Dutchess Hospital
NDH maintains a defined contribution plan covering all full-time employees who have completed two years of service. NDH's pension contribution is 6% of eligible payroll for 2015 and 2014. Pension expense for the years ended December 31, 2015 and 2014 was $1,048 and $1,141, respectively.

Health Quest
Health Quest maintains a defined contribution plan covering all full-time employees who have completed two years of service. Health Quest's pension contribution is 6% of eligible payroll for 2015 and 2014. Pension expense for the years ended December 31, 2015 and 2014 was $5,887 and $5,987, respectively.

Health Quest
Health Quest has active 457B and 457F deferred compensation plans which are offered to select management based on title (Physicians and AVP or higher level). The employee contributions are capped at the annual Federal limit for deferred compensation and the employer portion does not carry a limit, however there are substantial risk of forfeitures which apply. In addition, there is a closed KEYSOP plan for deferred compensation which had been offered to executive employees of Health Quest, VBMC and RDSI. NDH currently has a liability for a deferred compensation plan for the previous administrators prior to the formation of Health Quest. This plan is currently closed. The assets related to these plans are included in other assets and amounted to $4,771 and $6,154 as of December 31, 2015 and 2014, respectively. The assets primarily consist of money market funds and other marketable securities which are considered Level 1 based on the fair value hierarchy described in Note 6. The liabilities that relate to these plans are included in estimated amounts due to third party payors and other liabilities and are $4,785 and $6,207 as of December 31, 2015 and 2014, respectively.

(in thousands)

10. Professional Liabilities

During 1988, Health Quest (then known as VBH Corporation) established VBH Insurance, a captive insurance company ("the Captive") to provide and augment the professional liability coverage for VBMC. Beginning August 1, 2005, PHC and NDH purchased insurance from the Captive. The Captive has provided various levels of coverage since inception to the three hospitals. On July 1, 2013, the Captive began to provide professional liability coverage for employed physicians. The hospitals and HQMP purchase commercial insurance to supplement the coverage provided by the Captive.

The hospitals purchased primary coverage through a commercial insurer through July 31, 2011. Effective August 1, 2011, the primary coverage is through the Captive with excess coverage through a commercial insurer. VBMC, PHC and NDH accrue premiums payable to the Captive based on the estimated ultimate cost of losses payable by the Captive at a discount rate of 2.5% at December 31, 2015 and 2014, respectively.

VBH Insurance loss reserves comprise estimates for known reported losses and loss expenses plus a provision for losses incurred but not reported. Losses are valued by an independent actuary retained by VBH Insurance and are based on the loss experience of the insured. In management's opinion recorded reserves are adequate to cover the ultimate net cost of losses incurred to date however, the provision is based on estimates and may ultimately be settled for a significantly greater or lesser amount. The actuarially determined estimated loss reserve payable at December 31, 2015 and 2014 was $31,929 and $28,518, respectively.

The Nursing Home purchases commercial insurance for professional liabilities on a claims made basis and HQHC purchases coverage through a commercial insurer on an occurrence basis. The balance of employed physicians is covered under an individual policy purchased through commercial carriers.

Total amounts accrued under these programs approximate $49,511 and $51,278 at December 31, 2015 and 2014, respectively, and are included in estimated amounts due to third-party payors and other liabilities in the consolidated balance sheets. Amounts recognized as anticipated insurance recoveries related to the claims approximate $23,119 and $26,860 at December 31, 2015 and 2014, respectively, and are included in other assets in the consolidated balance sheets. Insurance recoveries are measured on the same basis as the liability subject to the need for valuation allowance for uncollectible amounts.

11. Workers' Compensation Insurance

The Company is self-insured for workers' compensation claim losses and expenses effective April 1, 2006. Included in amounts due to third-party payors and other liabilities at December 31, 2015 and 2014 are accruals of $12,107 and $10,976, respectively for specific incidents to the extent that they have been asserted or are probable of assertion and can be reasonably estimated. This liability has been discounted at 2.5% at December 31, 2015 and 2014.

12. Medical Benefits

Effective January 1, 2006, the Company provides employee health and welfare benefits under a self-insured program. Included in other liabilities at December 31, 2015 and 2014 are accruals of $4,040 and $3,870, respectively, for claims that have been incurred but not reported.

(in thousands)

13. Functional Expenses

The Company provides health care services to residents within their geographic areas including general acute care with a full range of inpatient and outpatient services. Expenses related to providing these services for the years ended December 31, 2015 and 2014 are as follows:

	2015	2014
Health care services	$ 637,646	$ 586,713
General and administrative	195,784	191,421
	$ 833,430	$ 778,134

14. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets at December 31, 2015 and 2014 are for the following purposes:

	2015	2014
Capital asset acquisition	$ 21,364	$ 18,810
Health care services	2,890	3,172
Health education	163	163
	$ 24,417	$ 22,145

Permanently restricted net assets are restricted at December 31, 2015 and 2014 to:

	2015	2014
Investments to be held in perpetuity, the income from which is expendable to support health care services (reported as nonoperating income)	$ 5,384	$ 5,389

In September 2010, New York State enacted its version of the Uniform Prudent Management of Institutional Funds Act ("UPMIFA"). The Company has interpreted UPMIFA as requiring the preservation of the value of the original gift of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Company classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts donated to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Company in a manner consistent with the standard of prudence prescribed by UPMIFA.

(in thousands)

15. Commitments and Contingencies

On June 23, 2015, the Company received a Civil Investigative Demand ("CID") from the Department of Justice ("DOJ") related to HQMP operations. The CID (which has been adjourned) identified nine areas of review, of which four matters remain under current review. In cooperation with the DOJ's request, the Company is performing additional audits related to the four matters. At December 31, 2015, the Company recorded an estimated liability for potential overpayments related to the four areas, however it is reasonably possible that a change in this estimate will occur in the future and the change could be material to the consolidated financial statements.

On April 15, 2016, the DOJ asserted that it would be pursuing investigation into two matters that were subjects of the Company's self-disclosure efforts (self-disclosures were filed by the Company in March 2016). The two matters relate to contracts entered into between VBMC and PHC and two separate physician groups. At December 31, 2015, the Company recorded an estimated liability for these two matters based on the self-disclosure process; however the ultimate resolution of the investigation is unknown. It is reasonably possible that a change in these estimates will occur in the future and the change could be material to the consolidated financial statements.

The Company is involved in litigations arising in the course of business. While the outcome of these suits cannot be determined at this time, management, based on the advice from legal counsel, currently believes that any loss which may arise from these actions will not have a material adverse effect on the Company's financial position or results of operations. The liabilities, if accrued, might be subject to change in the future based on new developments, or changes in circumstances, which could have a material impact on the Company's results of operations, financial position, and cash flows.

The health care industry is subject to numerous laws and regulations of Federal, state and local governments. Recently, government activity has increased with respect to investigations concerning possible violations by health care providers of fraud and abuse statutes and regulations. Compliance with such laws and regulations are subject to future government review and interpretations as well as potential regulatory actions.

The Company leases various equipment and facilities under operating leases. Total rent expense in 2015 and 2014 for all operating leases was approximately $10,883 and $9,609, respectively.

The following is a schedule by year of future minimum lease payments under operating leases as of December 31, 2015, that have initial or remaining lease terms in excess of one year.

Year	Amount
2016	$ 8,913
2017	7,527
2018	6,707
2019	5,684
2020	5,339
Thereafter	20,627
Total	$ 54,797

(in thousands)

16. Subsequent Events

Subsequent events have been evaluated through April 29, 2016, the date the consolidated financial statements were issued.

Supplemental Information

Health Quest Systems, Inc. and Subsidiaries
Consolidating Balance Sheet
December 31, 2015

(in thousands)

	HQ Obligated Group	VBH Insurance	Foundation for VBMC	PHC Foundation	NDH Foundation	NDRHCF	RDSI	HQ Med Practice	HQUMCP	HV Cardio Practice	Alamo	HQ Homecare	Wells Manor	RMSI	Total	Total Eliminations	Consolidated
Assets																	
Current assets																	
Cash and cash equivalents	$ 90,936	$ 1,280	$ 4,444	$ 4,819	$ 3,265	$ 1,405	$ 152	$ 1,550	$ 542	$ 609	$ -	$ 353	$ 4	$ -	$ 109,359	$ -	$ 109,359
Restricted cash	633	-	-	-	27	38	-	-	-	-	-	-	24	-	722	-	722
Investments	163,026	-	25,293	6,483	3,438	-	-	-	-	-	-	-	-	-	198,240	-	198,240
Assets whose use is limited and required for current liabilities																-	
Externally restricted	2,013	-	-	-	-	-	-	-	-	-	-	-	-	-	2,013	-	2,013
Patient accounts receivable, net	81,513	-	-	-	-	789	473	6,205	503	1,816	-	749	-	-	92,048	-	92,048
Supplies and prepaid expenses	23,724	-	5	11	9	23	54	2,959	79	182	-	11	-	-	27,057	-	27,057
Other current assets	872	18,214	1,001	251	882	1	-	134	-	716	-	-	15	-	22,086	(14,546)	7,540
Amounts due from third party payors	8,664	-	-	-	-	-	-	-	-	-	-	-	-	-	8,664	-	8,664
Interest in Foundation, current	2,134	-	-	-	-	-	-	-	-	-	-	-	-	-	2,134	(2,134)	-
Due from affiliates, current portion	39,532	-	363	3	-	11	1,989	6,976	164	268	-	3	-	-	49,329	(49,329)	-
Total current assets	413,047	19,494	31,106	11,567	7,621	2,267	2,668	17,824	1,288	3,611	-	1,116	43	-	511,652	(66,009)	445,643
Interest in Foundation	25,512	-	-	-	-	-	-	-	-	-	-	-	-	-	25,512	(25,512)	-
Assets whose use is limited																	
Externally restricted	21,595	-	-	-	-	-	-	-	-	-	-	-	-	-	21,595	-	21,595
Investments held by captive	-	28,076	-	-	-	-	-	-	-	-	-	-	-	-	28,076	-	28,076
Long-term investments	8,447	-	-	-	406	-	-	-	-	-	-	-	-	-	8,853	-	8,853
Property, plant and equipment, net	396,379	-	60	5	17	2,271	5	8,940	1,778	1,416	-	91	1,117	-	412,080	-	412,080
Goodwill	26,039	-	-	-	-	-	-	1,068	-	3,342	-	298	-	-	30,747	-	30,747
Other assets	16,189	-	2,705	433	3,335	-	540	14,198	-	755	-	-	556	-	38,691	-	38,691
Due from affiliates, net of current	34,212	-	-	-	-	49	-	-	-	-	-	-	-	-	34,261	(34,261)	-
Total assets	$ 941,420	$ 47,570	$ 33,871	$ 12,005	$ 11,379	$ 4,587	$ 3,213	$ 42,030	$ 3,066	$ 9,124	$ -	$ 1,506	$ 1,696	$ -	$ 1,111,467	$ (125,782)	$ 985,685
Liabilities and net assets																	
Current liabilities																	
Current portion of long-term debt	$ 17,428	$ -	$ -	$ -	$ -	$ -	$ -	$ 98	$ -	$ -	$ -	$ -	$ 122	$ -	$ 17,648	$ -	$ 17,648
Accounts payable and accrued expenses	99,386	6,079	118	15	6	1,007	307	8,514	421	5,678	33	440	120	-	122,104	(5,806)	116,298
Amounts due to third-party payors	7,417	-	-	-	-	255	-	1	-	-	-	-	-	-	7,673	-	7,673
Captive insurance loss reserve payable	-	8,147	-	-	-	-	-	-	-	-	-	-	-	-	8,147	-	8,147
Due to affiliates, current portion	10,844	-	1,698	1,971	995	1,164	2,078	18,251	999	10,467	420	9,233	-	-	58,120	(58,120)	-
Total current liabilities	135,055	14,226	1,816	1,986	1,001	2,426	2,385	26,864	1,420	16,145	453	9,673	242	-	213,692	(63,926)	149,766
Long-term debt, net of current portion	190,726	-	-	-	-	-	-	41	-	-	-	-	1,814	-	192,581	-	192,581
Postretirement benefit obligations	75,521	-	-	-	-	-	-	-	-	-	-	-	-	-	75,521	-	75,521
Amounts due to third-party payors and other liabilities	88,826	31,988	-	-	-	-	541	17,298	-	782	-	5,737	-	-	145,172	(26,390)	118,782
Due to affiliates, net of current portion	5,181	-	-	-	-	190	-	1,524	791	1	124	10	-	-	7,820	(7,820)	-
Total liabilities	495,309	46,214	1,816	1,986	1,001	2,616	2,926	45,727	2,210	16,928	577	15,420	2,056	-	634,786	(98,136)	536,650
Net assets																	
Unrestricted	417,513	1,356	23,214	6,546	650	1,785	287	(3,772)	856	(7,804)	(577)	(13,914)	(360)	-	425,780	(6,546)	419,234
Temporarily restricted	24,098	-	8,393	2,659	9,292	186	-	75	-	-	-	-	-	-	44,703	(20,286)	24,417
Permanently restricted	4,500	-	448	814	436	-	-	-	-	-	-	-	-	-	6,198	(814)	5,384
Total net assets	446,111	1,356	32,055	10,019	10,378	1,971	287	(3,697)	856	(7,804)	(577)	(13,914)	(360)	-	476,681	(27,646)	449,035
Total liabilities and net assets	$ 941,420	$ 47,570	$ 33,871	$ 12,005	$ 11,379	$ 4,587	$ 3,213	$ 42,030	$ 3,066	$ 9,124	$ -	$ 1,506	$ 1,696	$ -	$ 1,111,467	$ (125,782)	$ 985,685

Health Quest Systems, Inc. and Subsidiaries
Consolidating Balance Sheet – Obligated Group
December 31, 2015

(in thousands)

	VBMC	PHC	NDH	Health Quest	Total	Eliminations	HQ Obligated Group
Assets							
Current assets							
Cash and cash equivalents	$ 42,207	$ 17,232	$ 29,538	$ 1,959	$ 90,936	$ -	$ 90,936
Restricted cash	-	633	-	-	633	-	633
Investments	131,744	26,037	5,245	-	163,026	-	163,026
Assets whose use is limited and required for current liabilities							
Externally restricted	800	494	719	-	2,013	-	2,013
Patient accounts receivable, net	58,474	15,214	7,825	-	81,513	-	81,513
Supplies and prepaid expenses	11,681	3,959	2,415	5,669	23,724	-	23,724
Other current assets	186	398	189	99	872	-	872
Amounts due from third party payors	5,180	2,052	1,432	-	8,664	-	8,664
Interest in Foundation, current	1,001	251	882	-	2,134	-	2,134
Due from affiliates, current portion	7,414	22,656	6,493	32,699	69,262	(29,730)	39,532
Total current assets	258,687	88,926	54,738	40,426	442,777	(29,730)	413,047
Interest in Foundation	7,356	9,768	8,388	-	25,512		25,512
Assets whose use is limited							
Externally restricted	8,382	6,544	6,669	-	21,595		21,595
Long-term investments	8,447	-	-	-	8,447		8,447
Property, plant and equipment, net	245,541	67,450	69,132	14,256	396,379		396,379
Goodwill	25,916	123	-	-	26,039		26,039
Other assets	3,578	902	842	10,867	16,189		16,189
Due from affiliates, net of current	22,813	7,209	5,908	30,642	66,572	(32,360)	34,212
Total assets	$ 580,720	$ 180,922	$ 145,677	$ 96,191	$ 1,003,510	$ (62,090)	$ 941,420
Liabilities and net assets							
Current liabilities							
Current portion of long-term debt	$ 14,852	$ 786	$ 1,139	$ 651	$ 17,428	$ -	$ 17,428
Accounts payable and accrued expenses	44,121	14,507	8,838	31,900	99,366		99,366
Amounts due to third-party payors	5,530	1,394	493	-	7,417		7,417
Due to affiliates, current portion	20,450	983	3,200	15,941	40,574	(29,730)	10,844
Total current liabilities	84,953	17,670	13,670	48,492	164,785	(29,730)	135,055
Long-term debt, net of current portion	112,754	30,791	47,181	-	190,726		190,726
Postretirement benefit obligations	52,865	22,656	-	-	75,521		75,521
Amounts due to third-party payors and other liabilities	48,245	12,626	9,897	18,058	88,826		88,826
Due to affiliates, net of current portion	2,211	948	411	33,971	37,541	(32,360)	5,181
Total liabilities	301,028	84,691	71,159	100,521	557,399	(62,090)	495,309
Net assets							
Unrestricted	266,550	91,803	63,490	(4,330)	417,513		417,513
Temporarily restricted	10,951	3,614	9,533	-	24,098		24,098
Permanently restricted	2,191	814	1,495	-	4,500		4,500
Total net assets	279,692	96,231	74,518	(4,330)	446,111	-	446,111
Total liabilities and net assets	$ 580,720	$ 180,922	$ 145,677	$ 96,191	$ 1,003,510	$ (62,090)	$ 941,420

Health Quest Systems, Inc. and Subsidiaries
Consolidating Balance Sheet
December 31, 2014

(in thousands)

	HQ Obligated Group	VBH Insurance	Foundation for VBMC	PHC Foundation	NDH Foundation	NDRHCF	RDSI	HQ Med Practice	HQUMCP	HV Cardio Practice	Alamo	HQ Homecare	Wells Manor	RMSI	Total	Total Eliminations	Consolidated
Assets																	
Current assets																	
Cash and cash equivalents	$ 54,339	$ 395	$ 6,155	$ 3,957	$ 2,546	$ 4,196	$ 476	$ 1,973	$ 98	$ 895	$ -	$ 405	$ 23	$ -	$ 75,458	$ -	$ 75,458
Restricted cash	633	-	-	-	27	26	-	-	-	-	-	-	22	-	708	-	708
Investments	164,984	-	25,801	6,608	3,167	-	-	-	-	-	-	-	-	-	200,560	-	200,560
Assets whose use is limited and required for current liabilities																	
Externally restricted	2,014	-	-	-	-	-	-	-	-	-	-	-	-	-	2,014	-	2,014
Patient accounts receivable, net	75,055	-	-	-	-	918	388	4,791	586	2,655	-	611	-	-	85,004	-	85,004
Supplies and prepaid expenses	22,210	113	4	19	18	64	10	2,359	23	487	-	17	-	-	25,524	-	25,524
Other current assets	2,324	10,571	1,069	334	675	54	1	407	11	1,434	-	-	11	-	16,891	(6,873)	10,018
Amounts due from third party payors	9,749	-	-	-	-	-	-	-	-	-	-	-	-	-	9,749	-	9,749
Interest in Foundation, current	2,078	-	-	-	-	-	-	-	-	-	-	-	-	-	2,078	(2,078)	-
Due from affiliates, current portion	37,066	-	265	2	-	66	1,953	362	342	3,700	-	-	-	-	43,776	(43,776)	-
Total current assets	370,452	11,079	33,314	10,920	6,433	5,324	2,828	10,092	1,060	9,171	-	1,033	56	-	461,762	(52,727)	409,035
Interest in Foundation	23,292	-	-	-	-	-	-	-	-	-	-	-	-	-	23,292	(23,292)	-
Assets whose use is limited																	
Externally restricted	54,756	-	-	-	-	-	-	-	-	-	-	-	-	-	54,756	-	54,756
Investments held by captive	-	28,059	-	-	-	-	-	-	-	-	-	-	-	-	28,059	-	28,059
Long-term investments	8,618	-	-	-	414	-	-	-	-	-	-	-	-	-	9,032	-	9,032
Property, plant and equipment, net	348,839	-	64	10	23	2,011	9	7,390	1,855	734	-	84	1,143	-	362,182	-	362,182
Goodwill	123	-	-	-	-	-	-	1,501	-	3,342	-	298	-	-	5,264	-	5,264
Other assets	20,441	-	2,802	776	2,264	213	2,840	14,158	-	74	-	-	486	-	44,057	-	44,057
Due from affiliates, net of current	35,899	-	-	-	-	49	-	-	-	-	-	-	-	-	35,748	(35,748)	-
Total assets	$ 862,220	$ 39,138	$ 36,180	$ 11,709	$ 9,134	$ 7,597	$ 5,677	$ 33,141	$ 2,915	$ 13,341	$ -	$ 1,415	$ 1,685	$ -	$ 1,024,152	$ (111,767)	$ 912,385
Liabilities and net assets																	
Current liabilities																	
Current portion of long-term debt	$ 13,460	$ -	$ -	$ -	$ -	$ -	$ -	$ 98	$ -	$ -	$ -	$ -	$ 111	$ -	13,669	$ -	$ 13,669
Accounts payable and accrued expenses	91,052	423	66	32	7	1,011	292	5,610	567	3,498	34	393	116	-	103,111	(31)	103,080
Amounts due to third-party payors	5,510	-	-	-	-	255	-	134	-	-	-	-	-	-	5,899	-	5,899
Captive insurance loss reserve payable	-	7,626	-	-	-	-	-	-	-	-	-	-	-	-	7,626	-	7,626
Due to affiliates, current portion	4,365	-	2,978	699	1,743	3,387	1,241	12,787	756	17,562	371	4,779	-	-	50,668	(50,668)	-
Total current liabilities	114,397	8,049	3,044	731	1,750	4,653	1,533	18,629	1,323	21,060	405	5,172	227	-	180,973	(50,699)	130,274
Long-term debt, net of current portion	186,090	-	-	-	-	-	-	139	-	-	-	-	1,937	-	188,166	-	188,166
Postretirement benefit obligations	75,124	-	-	-	-	-	-	-	-	-	-	-	-	-	75,124	-	75,124
Amounts due to third-party payors and other liabilities	80,927	28,518	-	-	-	212	2,833	14,533	-	80	-	9,228	-	-	136,331	(24,418)	111,913
Due to affiliates, net of current portion	8,668	-	-	-	-	232	-	1,510	753	-	107	10	-	2,932	14,212	(14,212)	-
Total liabilities	465,206	36,567	3,044	731	1,750	5,097	4,366	34,811	2,076	21,140	512	14,410	2,164	2,932	594,806	(89,329)	505,477
Net assets																	
Unrestricted	370,616	2,571	24,021	6,706	1,167	2,314	1,311	(1,680)	839	(7,799)	(512)	(12,995)	(479)	(2,932)	383,148	(3,774)	379,374
Temporarily restricted	21,893	-	8,667	3,453	5,781	186	-	10	-	-	-	-	-	-	39,990	(17,845)	22,145
Permanently restricted	4,505	-	448	819	436	-	-	-	-	-	-	-	-	-	6,208	(819)	5,389
Total net assets	397,014	2,571	33,136	10,978	7,384	2,500	1,311	(1,670)	839	(7,799)	(512)	(12,995)	(479)	(2,932)	429,346	(22,438)	406,908
Total liabilities and net assets	$ 862,220	$ 39,138	$ 36,180	$ 11,709	$ 9,134	$ 7,597	$ 5,677	$ 33,141	$ 2,915	$ 13,341	$ -	$ 1,415	$ 1,685	$ -	$ 1,024,152	$ (111,767)	$ 912,385

Health Quest Systems, Inc. and Subsidiaries
Consolidating Balance Sheet – Obligated Group
December 31, 2014

(in thousands)

	VBMC	PHC	NDH	Health Quest	Total	Eliminations	HQ Obligated Group
Assets							
Current assets							
Cash and cash equivalents	$ 24,245	$ 13,431	$ 10,582	$ 6,081	$ 54,339	$ -	$ 54,339
Restricted cash	-	633	-	-	633	-	633
Investments	133,487	26,363	5,134	-	164,984	-	164,984
Assets whose use is limited and required for current liabilities							
Externally restricted	802	494	718	-	2,014	-	2,014
Patient accounts receivable, net	49,686	17,041	8,328	-	75,055	-	75,055
Supplies and prepaid expenses	11,161	3,617	2,408	5,024	22,210	-	22,210
Other current assets	818	222	162	1,122	2,324	-	2,324
Amounts due from third party payors	6,474	2,091	1,184	-	9,749	-	9,749
Interest in Foundation, current	1,069	334	675	-	2,078	-	2,078
Due from affiliates, current portion	10,148	15,621	5,721	20,610	52,100	(15,034)	37,066
Total current assets	237,890	79,847	34,912	32,837	385,486	(15,034)	370,452
Interest in Foundation	7,565	10,643	5,084	-	23,292	-	23,292
Assets whose use is limited							
Externally restricted	8,300	6,844	39,612	-	54,756	-	54,756
Long-term investments	8,618	-	-	-	8,618	-	8,618
Property, plant and equipment, net	221,989	70,446	40,508	15,896	348,839	-	348,839
Goodwill	-	123	-	-	123	-	123
Other assets	4,572	1,034	920	13,915	20,441	-	20,441
Due from affiliates, net of current	23,046	7,347	5,633	30,256	66,282	(30,583)	35,699
Total assets	$ 511,980	$ 176,284	$ 126,669	$ 92,904	$ 907,837	$ (45,617)	$ 862,220
Liabilities and net assets							
Current liabilities							
Current portion of long-term debt	$ 9,521	$ 1,500	$ 1,165	$ 1,274	$ 13,460	$ -	$ 13,460
Accounts payable and accrued expenses	39,119	14,285	6,526	31,132	91,062	-	91,062
Amounts due to third-party payors	4,297	671	542	-	5,510	-	5,510
Due to affiliates, current portion	6,910	2,095	150	10,244	19,399	(15,034)	4,365
Total current liabilities	59,847	18,551	8,383	42,650	129,431	(15,034)	114,397
Long-term debt, net of current portion	104,139	32,979	48,321	651	186,090	-	186,090
Postretirement benefit obligations	51,669	23,455	-	-	75,124	-	75,124
Amounts due to third-party payors and other liabilities	44,000	10,806	8,313	17,808	80,927	-	80,927
Due to affiliates, net of current portion	2,107	842	319	35,983	39,251	(30,583)	8,668
Total liabilities	261,762	86,633	65,336	97,092	510,823	(45,617)	465,206
Net assets							
Unrestricted	236,701	84,380	53,723	(4,188)	370,616	-	370,616
Temporarily restricted	11,326	4,452	6,115	-	21,893	-	21,893
Permanently restricted	2,191	819	1,495	-	4,505	-	4,505
Total net assets	250,218	89,651	61,333	(4,188)	397,014	-	397,014
Total liabilities and net assets	$ 511,980	$ 176,284	$ 126,669	$ 92,904	$ 907,837	$ (45,617)	$ 862,220

Health Quest Systems, Inc. and Subsidiaries
Consolidating Statement of Operations
Year Ended December 31, 2015

(in thousands)

	HQ Obligated Group	VBH Insurance	Foundation for VBMC	PHC Foundation	NDH Foundation	NDRHCF	RDSI	HQ Med Practice	HQUMCP	HV Cardio Practice	Alamo	HQ Homecare	Wells Manor	RMSI	Total	Eliminations	Consolidated
Operating revenue																	
Net patient service revenue	$ 771,276	$ -	$ -	$ -	$ -	$ 9,998	$ 2,835	$ 54,695	$ 4,493	$ 21,210	$ -	$ 4,386	$ -	$ -	$ 868,893	$ -	$ 868,893
Provision for bad debts	(20,822)	-	-	-	-	(1)	(283)	(3,378)	(188)	(886)	-	(33)	-	-	(25,591)	-	(25,591)
Net patient service revenue less provisions for bad debts	750,454	-	-	-	-	9,997	2,552	51,317	4,305	20,324	-	4,353	-	-	843,302	-	843,302
Other revenue	36,498	8,553	1,529	665	263	29	938	28,608	8	(94)	-	8	934	2,932	80,871	(53,378)	27,493
Net assets released from restriction for operations	54	-	-	-	-	-	-	-	-	-	-	-	-	-	54	-	54
Total operating revenue	787,006	8,553	1,529	665	263	10,026	3,490	79,925	4,313	20,230	-	4,361	934	2,932	924,227	(53,378)	870,849
Operating expenses																	
Salaries and fees	292,693	-	522	209	132	5,651	2,383	62,665	2,950	24,906	-	3,211	-	-	395,322	-	395,322
Employee benefits	95,641	-	106	53	38	1,798	311	10,010	559	3,206	48	790	-	-	112,560	-	112,560
Supplies	126,624	-	1	1	1	1,063	1	2,574	174	1,050	-	84	-	-	131,573	-	131,573
Other expenses	141,080	9,786	543	264	440	2,609	785	22,684	2,060	5,134	17	1,153	541	-	187,096	(50,446)	136,650
Interest	9,205	-	-	-	-	-	-	-	-	-	-	-	185	-	9,391	-	9,391
Depreciation and amortization	45,013	-	9	4	7	202	3	2,118	155	292	-	42	89	-	47,934	-	47,934
Total operating expenses	710,257	9,786	1,181	531	618	11,323	3,483	100,051	5,898	34,588	65	5,280	815	-	883,876	(50,446)	833,430
Operating income (loss)	76,749	(1,233)	348	134	(355)	(1,297)	7	(20,126)	(1,585)	(14,358)	(65)	(919)	119	2,932	40,351	(2,932)	37,419
Investment (loss) income	(3,307)	18	(1,155)	(294)	(162)	-	-	-	-	-	-	-	-	-	(4,900)	-	(4,900)
Gain on sale of property, plant and equipment	252	-	-	-	-	-	-	-	-	-	-	-	-	-	252	-	252
Excess (deficiency) of revenue over expenses	73,694	(1,215)	(807)	(160)	(517)	(1,297)	7	(20,126)	(1,585)	(14,358)	(65)	(919)	119	2,932	35,703	(2,932)	32,771
Pension related changes other than net periodic pension costs	4,271	-	-	-	-	-	-	-	-	-	-	-	-	-	4,271	-	4,271
Net assets released from restrictions for capital expenditures	2,615	-	-	-	-	-	-	-	-	-	-	-	-	-	2,615	-	2,615
Grant revenue for capital expenditures	203	-	-	-	-	-	-	-	-	-	-	-	-	-	203	-	203
Change in interest in foundation	(160)	-	-	-	-	-	-	-	-	-	-	-	-	-	(160)	160	-
Transfers of equity	(33,726)	-	-	-	-	768	(1,031)	18,034	1,602	14,353	-	-	-	-	-	-	-
Increase (decrease) in unrestricted net assets	$ 46,897	$ (1,215)	$ (807)	$ (160)	$ (517)	$ (529)	$ (1,024)	$ (2,092)	$ 17	$ (5)	$ (65)	$ (919)	$ 119	$ 2,932	$ 42,632	$ (2,772)	$ 39,860

Health Quest Systems, Inc. and Subsidiaries
Consolidating Statement of Operations – Obligated Group
Year Ended December 31, 2015

(in thousands)

	VBMC	PHC	NDH	Health Quest	Eliminations	HQ Obligated Group
Operating revenue						
Net patient service revenue	$ 520,204	$ 158,716	$ 92,356	$ -	$ -	$ 771,276
Provision for bad debts	(15,147)	(3,941)	(1,734)	-	-	(20,822)
Net patient service revenue less provisions for bad debts	505,057	154,775	90,622	-	-	750,454
Other revenue	10,184	4,120	1,982	156,354	(136,142)	36,498
Net assets released from restriction for operations	-	-	54	-	-	54
Total operating revenue	515,241	158,895	92,658	156,354	(136,142)	787,006
Operating expenses						
Salaries and fees	138,281	50,054	27,652	76,706	-	292,693
Employee benefits	49,781	19,293	7,984	18,583	-	95,641
Supplies	78,379	25,699	14,561	7,985	-	126,624
Other expenses	158,142	45,886	24,282	48,912	(136,142)	141,080
Interest	5,495	1,952	1,425	334	-	9,206
Depreciation and amortization	27,488	9,209	4,338	3,978	-	45,013
Total operating expenses	457,566	152,093	80,242	156,498	(136,142)	710,257
Operating income (loss)	57,675	6,802	12,416	(144)	-	76,749
Investment loss	(2,679)	(543)	(85)			(3,307)
Gain on sale of property, plant and equipment	246	1	3	2		252
Excess (deficiency) of revenue over expenses	55,242	6,260	12,334	(142)	-	73,694
Pension related changes other than net periodic pension costs	2,751	1,520	-	-	-	4,271
Net assets released from restrictions for capital expenditures	1,541	760	314	-	-	2,615
Grant revenue for capital expenditures	-	6	197	-	-	203
Change in interest in foundation	-	(160)	-	-	-	(160)
Transfers of equity	(29,685)	(963)	(3,078)	-	-	(33,726)
Increase (decrease) in unrestricted net assets	$ 29,849	$ 7,423	$ 9,767	$ (142)	$ -	$ 46,897

Health Quest Systems, Inc. and Subsidiaries
Consolidating Statement of Operations
Year Ended December 31, 2014

(in thousands)

	HQ Obligated Group	VBH Insurance	Foundation for VBMC	PHC Foundation	NDH Foundation	NDRHCF	RDSI	HQ Med Practice	HQUMCP	HV Cardio Practice	Alamo	HQ Homecare	Wells Manor	RMSI	Total	Eliminations	Consolidated
Operating revenue																	
Net patient service revenue	$ 709,174	$ -	$ -	$ -	$ -	$ 10,059	$ 2,421	$ 45,576	$ 4,088	$ 26,751	$ -	$ (4,580)	$ -	$ -	$ 793,489	$ -	$ 793,489
Provision for bad debts	(25,554)	-	-	-	-	(75)	(319)	(3,014)	(217)	(1,138)	-	(35)	-	-	(30,352)		(30,352)
Net patient service revenue less provisions for bad debts	683,620	-	-	-	-	9,984	2,102	42,562	3,871	25,613	-	(4,615)	-	-	763,137	-	763,137
Other revenue	37,903	6,611	2,065	847	698	84	1,349	25,839	97	1,389		21	928		77,831	(44,331)	33,500
Net assets released from restriction for operations	83	-	-	-	-	-	-	-	-	-	-	-	-	-	83	-	83
Total operating revenue	721,606	6,611	2,065	847	698	10,068	3,451	68,401	3,968	27,002	-	(4,594)	928	-	841,051	(44,331)	796,720
Operating expenses																	
Salaries and fees	271,326	-	192	-	44	5,575	2,266	50,520	2,914	25,989		3,522	-	-	362,348	-	362,348
Employee benefits	90,272	-	45	-	12	2,373	275	9,163	561	4,249	(1)	865	-	-	107,814	-	107,814
Supplies	115,661	-	2	-	1	1,148	-	1,209	134	1,166		68	-	-	119,389	-	119,389
Other expenses	132,460	9,310	869	606	546	2,631	919	20,796	2,275	6,286	16	974	605	-	178,293	(44,331)	133,962
Interest	8,266	-	-	-	-	-	-	-	-	-	-	-	194	-	8,460	-	8,460
Depreciation and amortization	43,155	-	6	5	8	233	3	1,604	154	782	1	122	86	-	46,161	-	46,161
Total operating expenses	661,140	9,310	1,114	611	611	11,960	3,463	83,292	6,038	38,472	16	5,551	887	-	822,465	(44,331)	778,134
Operating income (loss)	60,466	(2,699)	951	236	87	(1,892)	(12)	(14,891)	(2,070)	(11,470)	(16)	(10,145)	41	-	18,586	-	18,586
Investment income	10,212	1,468	354	12	13	-	-	-	-	-	-	-	-	-	12,061	-	12,061
Loss on sale/disposal of property, plant and equipment	(16)	-	-	-	-	-	-	(6)	-	-	-	-	-	-	(22)	-	(22)
Excess (deficiency) of revenue over expenses	70,662	(1,231)	1,305	248	100	(1,890)	(12)	(14,897)	(2,070)	(11,470)	(16)	(10,145)	41	-	30,625	-	30,625
Pension related changes other than net periodic pension costs	(28,016)	-	-	-	-	-	-	-	-	-	-	-	-	-	(28,016)	-	(28,016)
Net assets released from restrictions for capital expenditures	2,254	-	-	-	-	-	-	-	-	-	-	-	-	-	2,254	-	2,254
Grant revenue for capital expenditures	197	-	-	-	-	-	-	-	-	-	-	-	-	-	197	-	197
Change in interest in foundation	248	-	-	-	-	-	-	-	-	-	-	-	-	-	248	(248)	-
Transfers of equity	(23,645)	-	-	-	-	1,824	-	15,972	2,178	3,671	-	-	-	-	-	-	-
Increase (decrease) in unrestricted net assets	$ 21,700	$ (1,231)	$ 1,305	$ 248	$ 100	$ (66)	$ (12)	$ 1,075	$ 108	$ (7,799)	$ (16)	$ (10,145)	$ 41	$ -	$ 5,308	$ (248)	$ 5,060

Health Quest Systems, Inc. and Subsidiaries
Consolidating Statement of Operations – Obligated Group
Year Ended December 31, 2014

(in thousands)

	VBMC	PHC	NDH	Health Quest	Eliminations	HQ Obligated Group
Operating revenue						
Net patient service revenue	$ 465,664	$ 158,256	$ 85,254	$ -	$ -	$ 709,174
Provision for bad debts	(18,591)	(4,994)	(1,969)	-	-	(25,554)
Net patient service revenue less provisions for bad debts	447,073	153,262	83,285	-	-	683,620
Other revenue	12,726	5,323	2,632	151,246	(134,024)	37,903
Net assets released from restriction for operations	41	1	41	-	-	83
Total operating revenue	459,840	158,586	85,958	151,246	(134,024)	721,606
Operating expenses						
Salaries and fees	124,896	48,161	24,960	73,309	-	271,326
Employee benefits	46,058	17,445	8,339	18,430	-	90,272
Supplies	70,087	24,733	13,191	7,650	-	115,661
Other expenses	145,576	46,256	22,857	51,795	(134,024)	132,460
Interest	5,264	1,833	764	405	-	8,266
Depreciation and amortization	26,520	8,775	4,052	3,808	-	43,155
Total operating expenses	418,401	147,203	74,163	155,397	(134,024)	661,140
Operating income/(loss)	41,439	11,383	11,795	(4,151)	-	60,466
Investment income	8,602	1,304	306	-	-	10,212
Gain/(Loss) on sale of property, plant and equipment	-	-	20	(36)	-	(16)
Excess of revenue over expenses	50,041	12,687	12,121	(4,187)	-	70,662
Pension related changes other than net periodic pension costs	(11,810)	(16,206)	-	-	-	(28,016)
Net assets released from restrictions for capital expenditures	1,661	271	322	-	-	2,254
Grant revenue for capital expenditures	-	-	197	-	-	197
Change in interest in foundation	-	248	-	-	-	248
Transfers of equity	(18,926)	(728)	(3,991)	-	-	(23,645)
Increase (decrease) in unrestricted net assets	$ 20,966	$ (3,728)	$ 8,649	$ (4,187)	$ -	$ 21,700

(in thousands)

1. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidating balance sheets and consolidating statements of operations by business unit as of December 31, 2015 and 2014 are provided for purposes of additional analysis and is not required as part of the basic consolidated financial statements. The information is presented on the accrual basis of accounting and is prepared net of related eliminations. This schedule is not intended to be a presentation in accordance with accounting principles generally accepted in the United States of America as a result of the exclusion of the changes in temporarily restricted and permanently restricted net assets.

The accompanying obligated group information has been prepared to satisfy debt covenant requirements and is not required as part of the basic consolidated financial statements. The Obligated Group consists of VBMC, PHC, NDH, and Health Quest. The information is prepared on the accrual basis of accounting and is prepared net of related eliminations. These schedules are not intended to be a presentation in accordance with accounting principles generally accepted in the United States of America as a result of the exclusion of entities that would otherwise be required to be consolidated under GAAP.

EXHIBIT L

FOR-PROFIT

Applicant Name: Sharon Hospital
Financial Worksheet (B)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2015 Actual	(1a) FY 2016 Actual (est)	(2) FY 2017 Projected	(3) FY 2017 Projected	(4) FY 2017 Projected	(5) FY 2018 Projected	(6) FY 2018 Projected	(7) FY 2018 Projected	(8) FY 2019 Projected	(9) FY 2019 Projected	(10) FY 2019 Projected	(11) FY 2020 Projected	(12) FY 2020 Projected	(13) FY 2020 Projected
	Description	Results	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$143,606,025	$143,045,832	$145,191,519	$12,601,211	$157,792,731	$147,369,392	$39,143,763	$186,513,155	$149,579,933	$43,096,890	$192,678,823	$151,823,632	$44,410,471	$196,234,103
2	Less: Allowances	$90,594,363	$89,942,355	$91,291,490	$7,617,521	$98,909,012	$92,660,863	$23,319,935	$115,980,798	$94,050,776	$25,864,445	$119,915,221	$95,461,537	$26,689,364	$122,150,901
3	Less: Charity Care	$741,722	$536,593	$541,959	$47,037	$588,996	$547,379	$145,393	$692,771	$552,852	$159,295	$712,147	$558,381	$163,334	$721,715
4	Less: Other Deductions	$853,781	$832,193	$840,515	$72,949	$913,463	$848,920	$225,487	$1,074,407	$857,409	$247,048	$1,104,457	$865,983	$253,312	$1,119,295
	Net Patient Service Revenue	**$51,416,139**	**$51,734,691**	**$52,517,555**	**$4,863,704**	**$57,381,260**	**$53,312,231**	**$15,452,947**	**$68,765,178**	**$54,118,896**	**$16,828,102**	**$70,946,998**	**$54,937,731**	**$17,304,461**	**$72,242,191**
5	Medicare	$22,417,977	$22,674,886	$23,018,009	$2,131,721	$25,149,730	$23,366,309	$6,772,899	$30,139,208	$23,719,864	$7,375,618	$31,095,481	$24,078,752	$7,584,402	$31,663,154
6	Medicaid (CT & NY)	$4,630,448	$4,497,479	$4,565,537	$422,819	$4,988,356	$4,634,620	$1,343,379	$5,978,000	$4,704,747	$1,462,926	$6,167,673	$4,775,931	$1,504,338	$6,280,269
7	CHAMPUS & TriCare	$85,803	$86,335	$87,641	$8,117	$95,758	$88,967	$25,788	$114,755	$90,313	$28,083	$118,396	$91,680	$28,878	$120,557
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$27,134,228**	**$27,258,700**	**$27,671,187**	**$2,562,657**	**$30,233,843**	**$28,089,897**	**$8,142,066**	**$36,231,962**	**$28,514,924**	**$8,866,627**	**$37,381,550**	**$28,946,363**	**$9,117,617**	**$38,063,980**
9	Commercial Insurance	$20,061,924	$19,533,993	$19,829,587	$1,836,438	$21,666,025	$20,129,641	$5,834,726	$25,964,367	$20,434,221	$6,353,958	$26,788,179	$20,743,397	$6,533,821	$27,277,218
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$2,279,632	$2,989,621	$3,034,861	$281,062	$3,315,922	$3,080,783	$892,988	$3,973,771	$3,127,398	$972,455	$4,099,853	$3,174,717	$999,982	$4,174,699
12	Workers Compensation	$925,487	$931,221	$945,312	$87,546	$1,032,859	$959,617	$278,152	$1,237,769	$974,136	$302,905	$1,277,041	$988,875	$311,479	$1,300,355
13	Other	$1,014,868	$1,021,156	$1,036,609	$96,001	$1,132,610	$1,052,294	$305,015	$1,357,309	$1,068,216	$332,159	$1,400,375	$1,084,379	$341,561	$1,425,940
	Total Non-Government	**$24,281,911**	**$24,475,991**	**$24,846,369**	**$2,301,048**	**$27,147,416**	**$25,222,334**	**$7,310,882**	**$32,533,216**	**$25,603,972**	**$7,961,476**	**$33,565,448**	**$25,991,368**	**$8,186,844**	**$34,178,212**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$51,416,139**	**$51,734,691**	**$52,517,555**	**$4,863,704**	**$57,381,259**	**$53,312,231**	**$15,452,947**	**$68,765,178**	**$54,118,896**	**$16,828,102**	**$70,946,998**	**$54,937,731**	**$17,304,461**	**$72,242,192**
14	Less: Provision for Bad Debts	$1,930,565	$2,583,831	$2,325,448	$215,362	$2,540,810	$2,348,702	$680,789	$3,029,491	$2,372,189	$737,625	$3,109,814	$2,385,911	$754,672	$3,150,583
	Net Patient Service Revenue less Provision for bad debts	**$49,485,574**	**$49,150,860**	**$50,192,107**	**$4,648,342**	**$54,840,450**	**$50,963,529**	**$14,772,159**	**$65,735,687**	**$51,746,707**	**$16,090,477**	**$67,837,184**	**$52,541,819**	**$16,549,789**	**$69,091,608**
15	Other Operating Revenue	$851,556	$577,554	$577,554	$0	$577,554	$583,330	$0	$583,330	$589,163	$0	$589,163	$595,054	$0	$595,054
17	Net Assets Released from Restrictions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	**$50,337,130**	**$49,728,414**	**$50,769,661**	**$4,648,342**	**$55,418,004**	**$51,546,858**	**$14,772,159**	**$66,319,017**	**$52,335,869**	**$16,090,477**	**$68,426,347**	**$53,136,874**	**$16,549,789**	**$69,686,663**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$17,318,636	$17,915,561	$18,273,893	$0	$18,273,893	$18,639,370	$898,560	$19,537,930	$19,012,158	$1,149,811	$20,161,969	$19,392,401	$1,172,807	$20,565,208
2	Fringe Benefits	$4,138,300	$3,654,422	$3,758,110	$0	$3,758,110	$3,833,273	$184,793	$4,018,066	$3,909,938	$236,464	$4,146,402	$3,988,137	$241,193	$4,229,330
3	Physicians Fees	$1,806,481	$2,499,784	$2,499,784	$97,274	$2,597,058	$2,499,784	$309,059	$2,808,843	$2,499,784	$336,562	$2,836,346	$2,499,784	$346,089	$2,845,873
4	Supplies and Drugs	$5,436,800	$5,555,783	$5,844,072	$541,225	$6,385,298	$5,136,276	$1,778,645	$7,914,921	$6,443,090	$2,003,459	$8,446,548	$6,785,244	$2,130,938	$8,896,182
5	Depreciation and Amortization	$2,548,585	$1,299,760	$1,338,753	$44,900	$1,383,652	$1,378,915	$24,818	$1,403,734	$1,420,283	$718,411	$2,138,693	$1,462,891	$1,411,382	$2,874,274
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$18,377	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676
8	Malpractice Insurance Cost	$1,286,699	$896,570	$896,570	$0	$896,570	$896,570	$259,877	$1,156,447	$896,570	$278,786	$1,175,356	$896,570	$282,404	$1,178,974
9	Lease Expense	$246,778	$388,838	$200,244	$0	$200,244	$71,021	$0	$71,021	$71,021	$0	$71,021	$71,021	$0	$71,021
10	Other Operating Expenses	$15,598,586	$17,265,810	$17,438,468	$486,370	$17,924,839	$17,612,853	$1,545,295	$19,158,148	$17,788,981	$1,682,810	$19,471,792	$17,968,871	$1,730,446	$19,697,317
	TOTAL OPERATING EXPENSES	**$48,393,242**	**$49,546,224**	**$50,279,570**	**$1,169,770**	**$51,449,340**	**$51,097,738**	**$5,001,048**	**$56,098,786**	**$52,071,501**	**$6,406,302**	**$58,477,803**	**$53,072,595**	**$7,315,261**	**$60,387,856**
	INCOME/(LOSS) FROM OPERATIONS	**$1,943,889**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
	NON-OPERATING INCOME	**($15,331,206)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Income before provision for income taxes	**($13,387,318)**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
	Provision for income taxes[c]	**$1,683,460**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	NET INCOME	**($15,070,778)**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
C.	**Retained Earnings, beginning of year**		**$21,513,301**	**$21,695,491**	**$0**	**$21,695,491**	**$3,478,573**	**$0**	**$3,478,573**	**$13,698,804**	**$0**	**$13,698,804**	**$23,647,347**	**$0**	**$23,647,347**
	Retained Earnings, end of year	**$21,513,301**	**$21,695,491**	**$22,185,582**	**($18,707,010)**	**$3,478,573**	**$3,927,693**	**$9,771,111**	**$13,698,804**	**$13,963,172**	**$9,684,175**	**$23,647,347**	**$23,711,626**	**$9,234,528**	**$32,946,154**
	Principal Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
D.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**5.6%**	**0.4%**	**1.0%**	**74.8%**	**7.2%**	**0.9%**	**66.1%**	**15.4%**	**0.5%**	**60.2%**	**14.5%**	**0.1%**	**55.8%**	**13.3%**
2	Hospital Non Operating Margin	**-43.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-43.1%**	**0.4%**	**1.0%**	**74.8%**	**7.2%**	**0.9%**	**66.1%**	**15.4%**	**0.5%**	**60.2%**	**14.5%**	**0.1%**	**55.8%**	**13.3%**
E.	FTEs	**254**	**257**	**257**	**0**	**257**	**257**	**12**	**269**	**257**	**18**	**275**	**257**	**18**	**275**
F.	**VOLUME STATISTICS[d]**														
1	Inpatient Discharges	2,466	2,411	2,435	363	**2,798**	2,459	1,227	**3,686**	2,484	1,297	**3,781**	2,509	1,326	**3,835**
2	Outpatient Visits	90,592	90,590	91,496	3,813	**95,309**	92,411	10,131	**102,542**	93,335	11,980	**105,315**	94,268	12,626	**106,894**
	TOTAL VOLUME	**93,058**	**93,001**	**93,931**	**4,176**	**98,107**	**94,870**	**11,358**	**106,228**	**95,819**	**13,278**	**109,097**	**96,777**	**13,953**	**110,729**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Applicant: Health Quest Systems, Inc.
Financial Worksheet (A)

NON-PROFIT

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY16	FY17	FY17 (3 mo.)	FY17	FY18	FY18	FY18	FY19	FY19	FY19	FY20	FY20	FY20
	Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$2,543,236,000	$2,655,559,000	$44,336,760	$2,699,895,760	$2,740,023,000	$210,994,558	$2,951,017,558	$2,899,092,000	$220,009,851	$3,119,101,851	$2,944,688,000	$225,153,201	$3,169,841,201
2	Less: Allowances	$1,519,221,000	$1,564,843,260	$27,597,330	$1,592,440,590	$1,583,734,393	$130,070,368	$1,713,804,761	$1,650,457,357	$135,512,819	$1,785,970,176	$1,643,449,110	$138,587,680	$1,782,036,790
3	Less: Charity Care	$41,274,000	$41,686,740	$150,959	$41,837,699	$42,103,607	$754,826	$42,858,433	$42,524,643	$800,617	$43,325,260	$42,949,890	$823,960	$43,773,850
4	Less: Other Deductions			$228,366	$228,366		$1,074,407	$1,074,407		$1,104,457	$1,104,457		$1,119,295	$1,119,295
	Net Patient Service Revenue	**$982,741,000**	**$1,049,029,000**	**$16,360,125**	**$1,065,389,125**	**$1,114,185,000**	**$79,094,957**	**$1,193,279,956**	**$1,206,110,000**	**$82,591,958**	**$1,288,701,958**	**$1,258,289,000**	**$84,622,266**	**$1,342,911,266**
5	Medicare	$461,888,270	$493,043,630	$6,742,407	$499,786,037	$523,666,950	$32,416,786	$556,083,736	$566,871,700	$33,637,809	$600,509,509	$591,395,830	$34,353,066	$625,748,896
6	Medicaid	$186,720,790	$199,315,510	$1,610,398	$200,925,908	$211,695,150	$7,840,489	$219,535,639	$229,160,900	$8,267,567	$237,428,467	$239,074,910	$8,513,233	$247,588,143
7	CHAMPUS & TriCare	$0	$0	$31,040	$31,040	$0	$150,493	$150,493	$0	$158,415	$158,415	$0	$163,003	$163,003
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$648,609,060**	**$692,359,140**	**$8,383,844**	**$700,742,984**	**$735,362,100**	**$40,407,769**	**$775,769,868**	**$796,032,600**	**$42,063,791**	**$838,096,391**	**$830,470,740**	**$43,029,302**	**$873,500,042**
9	Commercial Insurers	$9,827,410	$10,490,290	$6,562,686	$17,052,976	$11,141,850	$31,884,839	$43,026,689	$12,061,100	$33,482,697	$45,543,797	$12,582,890	$34,404,743	$46,987,633
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pa	$19,654,820	$20,980,580	$861,872	$21,842,452	$22,283,700	$4,152,440	$26,436,140	$24,122,200	$4,305,555	$28,427,755	$25,165,780	$4,395,245	$29,561,025
12	Workers Compensation	$9,827,410	$10,490,290	$268,572	$10,758,862	$11,141,850	$1,292,601	$12,434,451	$12,061,100	$1,339,541	$13,400,641	$12,582,890	$1,367,037	$13,949,927
13	Other	$294,822,300	$314,708,700	$283,152	$314,991,852	$334,255,500	$1,357,309	$335,612,809	$361,833,000	$1,400,375	$363,233,375	$377,486,700	$1,425,940	$378,912,640
	Total Non-Government	**$334,131,940**	**$356,669,860**	**$7,976,281**	**$364,646,141**	**$378,822,900**	**$38,687,189**	**$417,510,089**	**$410,077,400**	**$40,528,168**	**$450,605,568**	**$427,818,260**	**$41,592,965**	**$469,411,225**
	Net Patient Service Revenuea (Government+Non-Government)	**$982,741,000**	**$1,049,029,000**	**$16,360,125**	**$1,065,389,125**	**$1,114,185,000**	**$79,094,958**	**$1,193,279,957**	**$1,206,110,000**	**$82,591,959**	**$1,288,701,958**	**$1,258,289,000**	**$84,622,267**	**$1,342,911,267**
14	Less: Provision for Bad Debts	$29,727,000	$32,544,000	$699,451	$33,243,451	$34,432,000	$3,359,654	$37,791,654	$36,059,000	$3,481,972	$39,540,972	$37,403,000	$3,545,798	$40,948,798
	Net Patient Service Revenue less provision for bad debts	**$953,014,000**	**$1,016,485,000**	**$15,660,674**	**$1,032,145,674**	**$1,079,753,000**	**$75,735,303**	**$1,155,488,303**	**$1,170,051,000**	**$79,109,987**	**$1,249,160,986**	**$1,220,886,000**	**$81,076,468**	**$1,301,962,468**
15	Other Operating Revenue	$26,732,000	$29,243,000	$420,781	**$29,663,781**	$31,326,000	$1,521,655	**$32,847,655**	$33,485,000	$1,530,272	**$35,015,272**	$33,749,000	$1,538,975	**$35,287,975**
17	Net Assets Released from Restrictions				**$0**		$0	**$0**		$0	**$0**		$0	**$0**
	TOTAL OPERATING REVENUE	**$979,746,000**	**$1,045,728,000**	**$16,081,455**	**$1,061,809,455**	**$1,111,079,000**	**$77,256,958**	**$1,188,335,958**	**$1,203,536,000**	**$80,640,258**	**$1,284,176,258**	**$1,254,635,000**	**$82,615,443**	**$1,337,250,443**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$420,595,000	$441,418,000	$6,099,585	$447,517,585	$462,515,000	$27,824,657	$490,339,657	$484,167,000	$28,681,967	$512,848,967	$506,211,000	$29,592,582	$535,803,582
2	Fringe Benefits	$121,017,000	$127,910,000	$1,192,905	$129,102,905	$133,845,000	$5,409,397	$139,254,397	$140,383,000	$5,577,278	$145,960,278	$146,960,000	$5,747,000	$152,707,000
3	Physicians Fees	$31,033,000	$60,668,000	$923,607	$61,591,607	$60,735,000	$3,906,213	$64,641,213	$60,806,000	$3,933,716	$64,739,716	$60,818,000	$3,943,243	$64,761,243
4	Supplies and Drugs	$148,115,000	$163,223,000	$1,746,217	$164,969,217	$177,599,000	$8,684,276	$186,283,276	$196,440,000	$9,306,211	$205,746,211	$204,992,000	$9,818,687	$214,810,687
5	Depreciation and Amortization	$54,515,000	$61,446,000	$345,913	$61,791,913	$69,031,000	$1,403,734	$70,434,734	$88,874,000	$2,138,693	$91,012,693	$95,504,000	$2,874,274	$98,378,274
6	Provision for Bad Debts-Otherb			$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$8,604,000	$9,004,000	$7,419	$9,011,419	$12,604,000	$29,676	$12,633,676	$23,597,000	$29,676	$23,626,676	$22,994,000	$29,676	$23,023,676
8	Malpractice Insurance Cost			$307,509	$307,509		$1,617,386	$1,617,386		$1,647,171	$1,647,171		$1,667,709	$1,667,709
9	Lease Expense			$164,885	$164,885		$656,864	$656,864		$672,920	$672,920		$687,848	$687,848
10	Other Operating Expenses	$135,456,000	$111,820,000	$5,388,720	$117,208,720	$116,016,000	$23,292,954	$139,308,954	$122,984,000	$23,844,549	$146,828,549	$124,726,000	$24,212,853	$148,938,853
	TOTAL OPERATING EXPENSES	**$919,335,000**	**$975,489,000**	**$16,176,760**	**$991,665,760**	**$1,032,345,000**	**$72,825,156**	**$1,105,170,156**	**$1,117,251,000**	**$75,832,182**	**$1,193,083,182**	**$1,162,205,000**	**$78,573,873**	**$1,240,778,873**
	INCOME/(LOSS) FROM OPERATIONS	**$60,411,000**	**$70,239,000**	**($95,305)**	**$70,143,695**	**$78,734,000**	**$4,431,802**	**$83,165,802**	**$86,285,000**	**$4,808,077**	**$91,093,076**	**$92,430,000**	**$4,041,570**	**$96,471,570**
	NON-OPERATING REVENUE	**$12,720,000**	**$12,720,000**	**$0**	**$12,720,000**	**$12,720,000**	**$0**	**$12,720,000**	**$12,720,000**	$0	**$12,720,000**	**$12,720,000**		**$12,720,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$73,131,000**	**$82,959,000**	**($95,305)**	**$82,863,695**	**$91,454,000**	**$4,431,802**	**$95,885,802**	**$99,005,000**	**$4,808,077**	**$103,813,076**	**$105,150,000**	**$4,041,570**	**$109,191,570**
	Principal Payments				**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	**6.1%**	**6.6%**	**-0.6%**	**6.5%**	**7.0%**	**5.7%**	**6.9%**	**7.1%**	**6.0%**	**7.0%**	**7.3%**	**4.9%**	**7.1%**
2	Hospital Non Operating Margin	**1.3%**	**1.2%**	**0.0%**	**1.2%**	**1.1%**	**0.0%**	**1.1%**	**1.0%**	**0.0%**	**1.0%**	**1.0%**	**0.0%**	**0.9%**
3	Hospital Total Margin	**7.4%**	**7.8%**	**-0.6%**	**7.7%**	**8.1%**	**5.7%**	**8.0%**	**8.1%**	**6.0%**	**8.0%**	**8.3%**	**4.9%**	**8.1%**
D.	FTEs	**4,739**	4,832	74	**4,906**	4,878	322	**5,200**	4,918	329	**5,247**	4,930	331	**5,261**
E.	**VOLUME STATISTICSc**													
1	Inpatient Discharges	34,888	35,603	700	**36,303**	36,060	3,686	**39,746**	38,677	3,781	**42,458**	39,085	3,835	**42,920**
2	Outpatient Visits	2,232,267	2,781,929	35,552	**2,817,481**	3,070,814	163,344	**3,234,158**	3,333,985	172,428	**3,506,413**	3,384,166	177,493	**3,561,659**
	TOTAL VOLUME	**2,267,155**	**2,817,532**	**36,252**	**2,853,784**	**3,106,874**	**167,030**	**3,273,904**	**3,372,662**	**176,209**	**3,548,871**	**3,423,251**	**181,328**	**3,604,579**

a Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
b Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
c Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

ATTACHMENT V

Supplemental CON Application Form

Transfer of Ownership/Sale of Hospital

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

Applicants: Essent Healthcare of Connecticut, Inc. & Vassar Health Connecticut, Inc.

Project Name: Transfer of Ownership of Sharon Hospital

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

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

RESPONSE:

As previously mentioned, Health Quest began providing management services to Sharon after the Asset Purchase Agreement was signed. As part of these services, Health Quest is evaluating how Hospital operations will be transitioned to Vassar Connecticut and how Sharon will be integrated into the Health Quest system. The result of this evaluation will be a detailed transition plan. The plan is being spearheaded by Claudine Fasse, Health Quest's AVP for Operations, who is working closely with Peter Cordeau, the President of Sharon, and his staff. Teams involved with transition planning include Finance and Accounting, HR, Lab, Facilities, Clinical Contracts, Non-Clinical Contracts, Medical Staff Office, and IT. Retaining the existing management team at Sharon is critical to the successful transition of the Hospital, and this has been accomplished. Moreover, having Vassar Connecticut provide management services to Sharon while the CON is pending will allow an orderly transfer of the Hospital and ensure continuity of care for the people in the Sharon service area. In addition, Vassar Connecticut has agreed to hire all eligible employees of Sharon. These employees know the market. They know the patients. They know the facility. They are part of the community and are committed to the community. They are familiar faces for the patients. Health Quest has also agreed to retain all services at Sharon. Patients will not have to seek care that they are used to getting at Sharon elsewhere. All of these factors will also help to ensure a smooth transition and continuity of care.

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

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

RESPONSE:

Attached as Exhibit M are corporate organizational charts for Sharon Hospital and the Health Quest system before and after the proposed transaction. Essent Connecticut is a Connecticut stock corporation governed by a Board of Directors. Vassar Connecticut is a Connecticut non-stock corporation, which will also be governed by a Board of Directors. As mentioned in the CON Application Main Form the Vassar Connecticut Board of Directors will be comprised of 15 members, including 12 appointed by FCH.

2. Historical and Projected Volume

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

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Service*[1]	Actual Volume (Last 3 Completed FYs)			
	FY 2013**	FY 2014**	FY 2015**	FY 2016***[2]
Med/Surg	2,024	1,737	1,619	1,531
Psych (Senior)	311	343	317	325
Maternity	294	281	270	279
Newborn	249	255	260	276
Total	**2,878**	**2,616**	**2,466**	**2,411**

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

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY 2013**	FY 2014**	FY 2015**	FY 2016***[3]
Medical/Surgical	7,646	6,517	6,107	4,774
Psych (Senior)	3,371	3,895	3,646	3,628
Maternity	733	699	681	738
Newborn	588	579	595	648
Total	**12,338**	**11,690**	**11,029**	**9,788**

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

[1] Sharon Hospital does not offer inpatient rehabilitation services, so this category has been eliminated from historic and projected discharges and patient days by service. In addition, the hospital sees very few pediatric inpatients other than the newborns accounted for above. Non-newborn pediatric admissions are counted under the medical/surgical service.
[2] Data includes a complete fiscal year from October 1, 2015 through September 30, 2016.
[3] Data includes a complete fiscal year from October 1, 2015 through September 30, 2016.

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

TABLE C
PROJECTED DISCHARGES BY SERVICE

Service*	Projected Volume			
	FY 2017**	FY 2018**	FY 2019**	FY 2020**[4]
Medical/Surgical	1,855	2,561	2,517	2,546
Psych (Senior)	348	428	471	480
Maternity	299	350	398	406
Newborn	296	347	395	403
Total	**2,798**	**3,686**	**3,781**	**3,835**

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

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

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Service*	Projected Volume			
	FY 2017**	FY 2018**	FY 2019**	FY 2020**[5]
Medical/Surgical	5,436	7,098	6,610	6,297
Psych (Senior)	3,885	4,778	5,258	5,363
Maternity	789	924	1,051	1,072
Newborn	696	815	928	947
Total	**10,806**	**13,615**	**13,847**	**13,679**

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

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

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

RESPONSE:

The Hospital experienced a 24% decline in medical/surgical discharges and a 38% decline in medical/surgical patient days between FY 2013 and FY 2016 (a 16% decline in inpatient discharges overall). Discharges for this service went from 2,024 in FY 2013 to 1,619 in FY 2016. This was largely due to a decrease in ED visits

[4] Fiscal year is October 1 through September 30.
[5] Fiscal year is October 1 through September 30.

(including those resulting in admission) driven by increasing consumerism and insurance design. The closure of the Smilow's oncology service at Sharon in FY 2015 also played a significant role in service utilization declines. Patient day declines are primarily due to reduced discharges as well as year-over-year length of stay improvements.

The slight decline in senior behavioral health volume in FY 2015 was the result of reduced admissions for a one-month period in order to accommodate renovations to the unit. The Sharon inpatient psychiatric service is one of only a handful in the State of Connecticut focused on geriatric patients. It has an excellent reputation and sees a steady volume of patients each year, as is evidenced by the discharges in Table A above.

As discussed throughout this CON Application, Health Quest will bring an infusion of capital, technology enhancements, service line upgrades, and additional physicians to the Sharon area. Through the integration of Sharon into a regional health network, the expectation is that the Hospital will see material utilization increases across most of its service lines drastically increasing inpatient discharges and outpatient visits. Aggregate patient days will also increase due to an increase in admissions, even though lengths of stay are getting shorter.

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

RESPONSE:

Health Quest will begin to shift some admissions from VBMC and NDH, both of which are at or near capacity. These will be medically appropriate patients for the Hospital to accept and will be patients that live east of the Taconic and have shorter travel distances to Sharon than they have to either VBMC or NDH. Direct participation with New York insurance payers will also contribute to and support the shift. Health Quest anticipates that this shift will occur in FY 2017 and FY 2018 and be the equivalent of an average daily census ("ADC") of six (6) patients. This will also include geropsychiatric patients, for which Health Quest does not have a service currently. In addition, through the recruitment of cardiology, orthopedics, general surgery, OB/GYN, oncology and primary care physicians, which Health Quest will do in FY 2017 and FY 2018, an additional four (4) patients per day can be kept in the community by the end of FY 2017, increasing the ADC by ten (10) patients. Beyond that time, Health Quest projects demand growing with the aging of the population and as the impact of the newly recruited physicians takes hold in the community. Health Quest has projected demand to increase by approximately 2% per annum between FY 2018 and FY 2020. This also accounts for the continued shift to ambulatory patients, which will depress the growth of the inpatient demand.

Clear Public Need

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

RESPONSE:

Not applicable. The proposed transaction does not require anti-trust review.

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

RESPONSE:

While the proposal is not being submitted due to provisions of PPACA, it will achieve certain objectives of the law including enhancements to quality and the operating efficiencies that come with regionalized healthcare. In addition, Health Quest has contracts with most of the providers on the New York exchange. The company anticipates developing contracts with the providers on the Connecticut exchange as well.

3. Supplemental Questions

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

RESPONSE:

As previously mentioned, RCCH conducted an ongoing review of a wide range a strategic options to address the financial and recruitment issues that have threatened the viability of the Hospital. These included discussions with larger health systems, both not-for-profit and investor-owned. They included in-state systems, as well as out-of-state companies pursing expansion opportunities in-state. At the end of the day, RCCH determined that Health Quest was the best option for Sharon in terms of proximity, resources and overall fit.

All of the alternatives considered would have brought continued and, in many instances, enhanced access to care for Sharon area residents. None of the alternatives would have adversely impacted provider diversity or consumer choice. Sharon is the only hospital within a 30-mile radius. Therefore, regardless of who owns Sharon it will be the only hospital option for many in the community.

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

RESPONSE:

Vassar Connecticut is not planning on any consolidation, reduction or elimination of services at Sharon in its first three (3) years of ownership. To the contrary, Vassar Connecticut intends to leverage its membership in the Health Quest system to bring physicians to the Sharon community and add services that might not otherwise be available. These physicians include members of HQMP specializing in internal medicine/family practice, OB/GYN, general surgeons, cardiologists, and medical oncologists. Vassar Connecticut also intends to recruit orthopedic surgeons and others to practice with the Connecticut Medical Foundation. In addition, Vassar Connecticut is evaluating the potential of adding a daVinci robotics surgery system at Sharon. This will allow more urology and gynecological surgeries to be performed at the Hospital, keeping more surgical patients local.

Health Quest is in the process of developing a strategic plan for Sharon Hospital, a process which is expected to take 4 to 6 months and which will be completed in time to influence the operating and capital budgets for the Hospital for FY 2018 through FY 2022. The strategic planning process at Health Quest is very participative and involves both qualitative and quantitative data. The company interviews community members, physicians, board members, and staff and has a steering committee for the process that includes members of the aforementioned groups. Health Quest will review data, analyze the market, examine the services offered by its providers and others, and develop an environmental assessment and a SWOT analysis. Health Quest then uses this information to help determine how it should provide services in the future, what services it should provide, and where those services should be located. The draft strategic plan is reviewed with the steering committee and is presented to the Health Quest and local governing boards.

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

RESPONSE:

Vassar Connecticut proposes to hire all existing employees of the Hospital provided that they meet Health Quest eligibility criteria, such as criminal background checks and drug screenings. Vassar Connecticut has agreed to provide wages and benefits that are the same or better than the wages and benefits that the Sharon employees are currently receiving.

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

RESPONSE:

As a for-profit entity, Essent Connecticut was not required to conduct a CHNA for the Sharon service area. As a 501c(3) organization, Vassar Connecticut is required to develop a CHNA and a plan for how to address the needs identified therein. Health Quest has just completed its CHNA for 2016 through 2019 for its other system hospitals. The company anticipates that it will complete a CHNA for Sharon in 2017 following the acquisition, and then place Sharon on the same schedule for updates as the other Health Quest hospitals.

By way of process, each Health Quest hospital has a community health needs committee, which is chaired by a board member and has representation from the hospital board, the community and hospital staff. The company partners with the Department of Health in Dutchess and Putnam Counties, as well as the Dutchess County council on Aging and other community groups in the development and implementation of it plan. Health Quest expects to use a similar process for Sharon.

In addition, Health Quest has reviewed the CHNA developed by FCH in 2014. It provides a wealth of information about the health status of the Sharon service area. This will be a good starting point for Health Quest as it develops its plan for Sharon.

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

RESPONSE:

See Response to Question 12 (Public Need & Access to Care) in the CON Application Main Form and Exhibit J.

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

RESPONSE:

Health Quest has a close association with Hudson River HealthCare, an FQHC with an office in Amenia, NY ("HRCH"). Health Quest provides a community benefits grant to HRHC to help support obstetrics, dental and family medicine clinics in Dutchess County. HRHC initiatives and programs may be of benefit to patients residing in the Hospital's New York service area. In addition HQMP, which is also a tax-exempt organization that sees patients regardless of their ability to pay, will be caring for patients at Sharon.

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

RESPONSE:

Among the first capital projects undertaken by Vassar Connecticut will be the replacement of Sharon's existing EHR with Cerner, the system used throughout Health Quest. As previously discussed, bringing Sharon onto Health Quest's EHR system will make care coordination easier. It will also enhance quality of care at Sharon by allowing providers to easily compare data with other Health Quest facilities and utilize best practice information to improve quality of care at the Hospital. In addition, Vassar Connecticut intends to renovate the operating rooms at Sharon and potentially add a daVinci robotics service in the operating suite. This is a priority because it will allow physicians to perform certain procedures at Sharon that were not otherwise possible given equipment limitations. Note also that as part of its management services, and during the integration period, Vassar Connecticut may identify additional capital expenditures that become top priorities.

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

RESPONSE:

The top priority for service improvements at Sharon is to stabilize the Medical Staff. Key physicians have left the service area, which has led to decreased access to care and reductions in patient volume at the Hospital. As previously stated, Health Quest intends to recruit several new physicians to the area. This includes the expansion of HQMP physician practices, as well as the addition of physicians to the new Medical Foundation. These measures will increase access to care and will allow more patients to be treated locally and to receive their hospital services at Sharon. It is difficult to prioritize among the physicians specialties that are needed in Sharon, but cardiology,

internal medicine/family practice, OB/GYN, general surgery, oncology, and orthopedics are targeted to add physicians within the first year. Note also that as part of its management services and during the integration period, Vassar Connecticut may identify other service improvements that become top priorities.

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

RESPONSE:

There are no anticipated changes to existing payer contracts as a result of this proposal. Vassar Connecticut intends to assume Essent Connecticut's contracts. These agreements will be renegotiated in the normal course of business prior to expiration.

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

RESPONSE:

Existing debt and pension obligations will be satisfied by Essent Connecticut and its affiliates. Going forward, Sharon employees will be eligible to participate in the Health Quest 403(b) retirement plan.

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

RESPONSE:

See Response to Question 9(a) (Public Need & Access to Care) in the CON Application Main Form.

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

RESPONSE:

See Exhibit N.

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

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

RESPONSE:

See Response to Question 4(e) above and Exhibit J.

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

RESPONSE:

Sharon does not have a written policy regarding review of its pricing structure. The chargemaster is reviewed periodically and any revisions are filed with OHCA in accordance with Conn. Gen. Stat. §19a-681.

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

RESPONSE:

Not applicable.

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

Monthly Financial Measurement/Indicators

A.	**Operating Performance:**
	Operating Margin
	Non-Operating Margin
	Total Margin
B.	**Liquidity:**
	Current Ratio
	Days Cash on Hand
	Days in Net Accounts Receivables
	Average Payment Period
C.	**Leverage and Capital Structure:**
	Long-term Debt to Equity
	Long-term Debt to Capitalization
	Unrestricted Cash to Debt
	Times Interest Earned Ratio
	Debt Service Coverage Ratio
	Equity Financing Ratio
D.	**Additional Statistics**
	Income from Operations
	Revenue Over/(Under) Expense
	EBITDA
	Patient Cash Collected
	Cash and Cash Equivalents
	Bad Debt as % of Gross Revenue
	Net Working Capital
	Unrestricted Assets
	Credit Ratings (S&P, Fitch, Moody's)

RESPONSE:

See Exhibit O.

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

RESPONSE:

Essent Connecticut is a for-profit entity. It does not complete the IRS Form 990, which is applicable to tax-exempt organizations. Vassar Connecticut, however, will be a tax-exempt entity. As such, it will complete the IRS Form 990 going forward and submit it to OHCA as part of the Hospital's Twelve Months Actual Filing. Vassar Connecticut expects to provide more than $750,000 in financial assistance to the Sharon community by FY 2020. Health Quest will also prepare a CHNA for Sharon that will drive its provision of financial assistance and community benefits going forward.

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

RESPONSE:

Vassar Connecticut anticipates that it will achieve 1% to 2% vendor savings compared with what Sharon currently pays based on Health Quest's regional purchasing power. The transaction will likely not impact the Hospital's negotiating position with payers as Health Quest does not presently do business in Connecticut.

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

RESPONSE:

With respect to vendor contracts, Vassar Connecticut anticipates a 1% to 2% savings. It is impossible to quantify tangible savings to healthcare consumers from these activities. They do, however, improve the bottom line of the Hospital and the overall strength and stability of the healthcare delivery system in the Sharon region.

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

RESPONSE:

There are fourteen (14) standards that have been developed by the United States Department of Health and Human Services to advance health equity. Health Quest's staff are trained to provide, and do in fact provide, effective, understandable and respectful care. Health Quest follows equal employment opportunity guidelines and seeks to recruit a culturally diverse staff. The company has language assistance services and written notices and can provide verbal notices regarding care as needed. Health Quest assures the competency of the staff providing language assistance services and does not rely on family or friends of the patients to facilitate communication. Health Quest brochures are available in English and Spanish, which is the most frequently spoken non-English language in the Sharon area. The company collects data on admissions regarding, among other things, the ethnicity of its patients. Health Quest hospitals conduct community needs assessments every three (3) years and as a result of those assessments, collaborate with a variety of community agencies to provide care that meets the health needs of the community. This information is made available to the communities served by Health Quest in a variety of ways, including on the company's website. These measures will be in place under Health Quest ownership of Sharon.

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

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

RESPONSE:

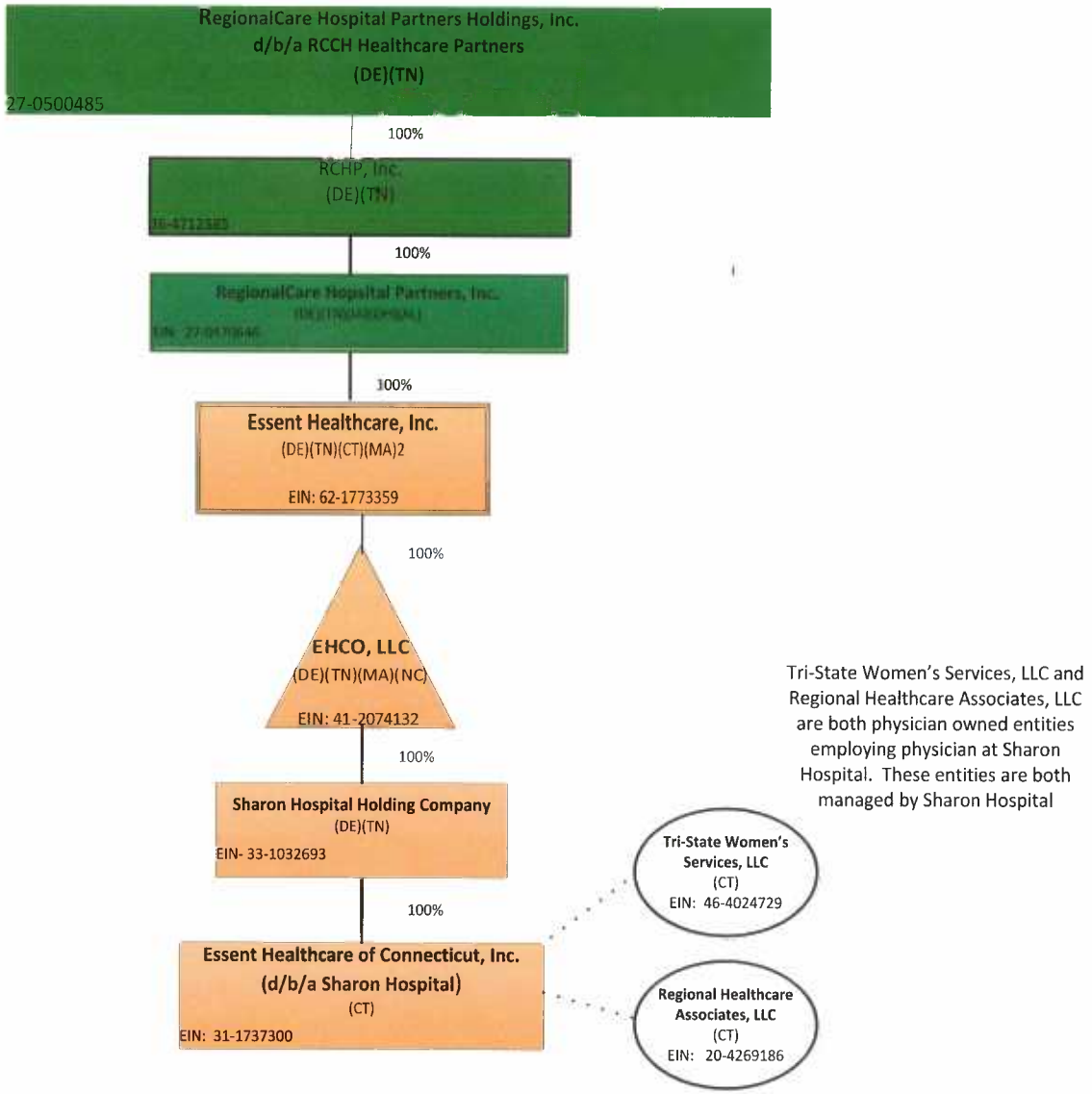
Not applicable.

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

RESPONSE:

Not applicable.

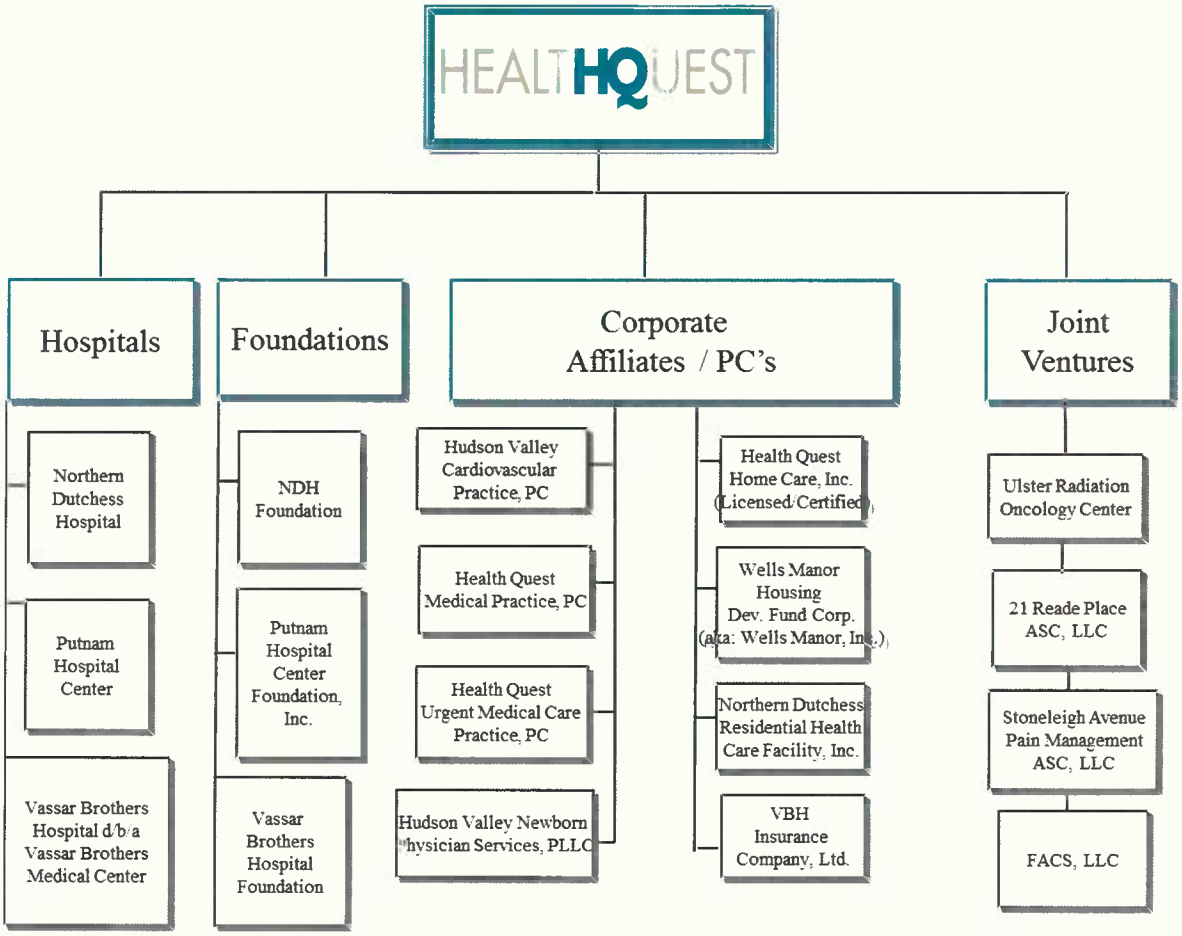
EXHIBIT M



Tri-State Women's Services, LLC and Regional Healthcare Associates, LLC are both physician owned entities employing physician at Sharon Hospital. These entities are both managed by Sharon Hospital

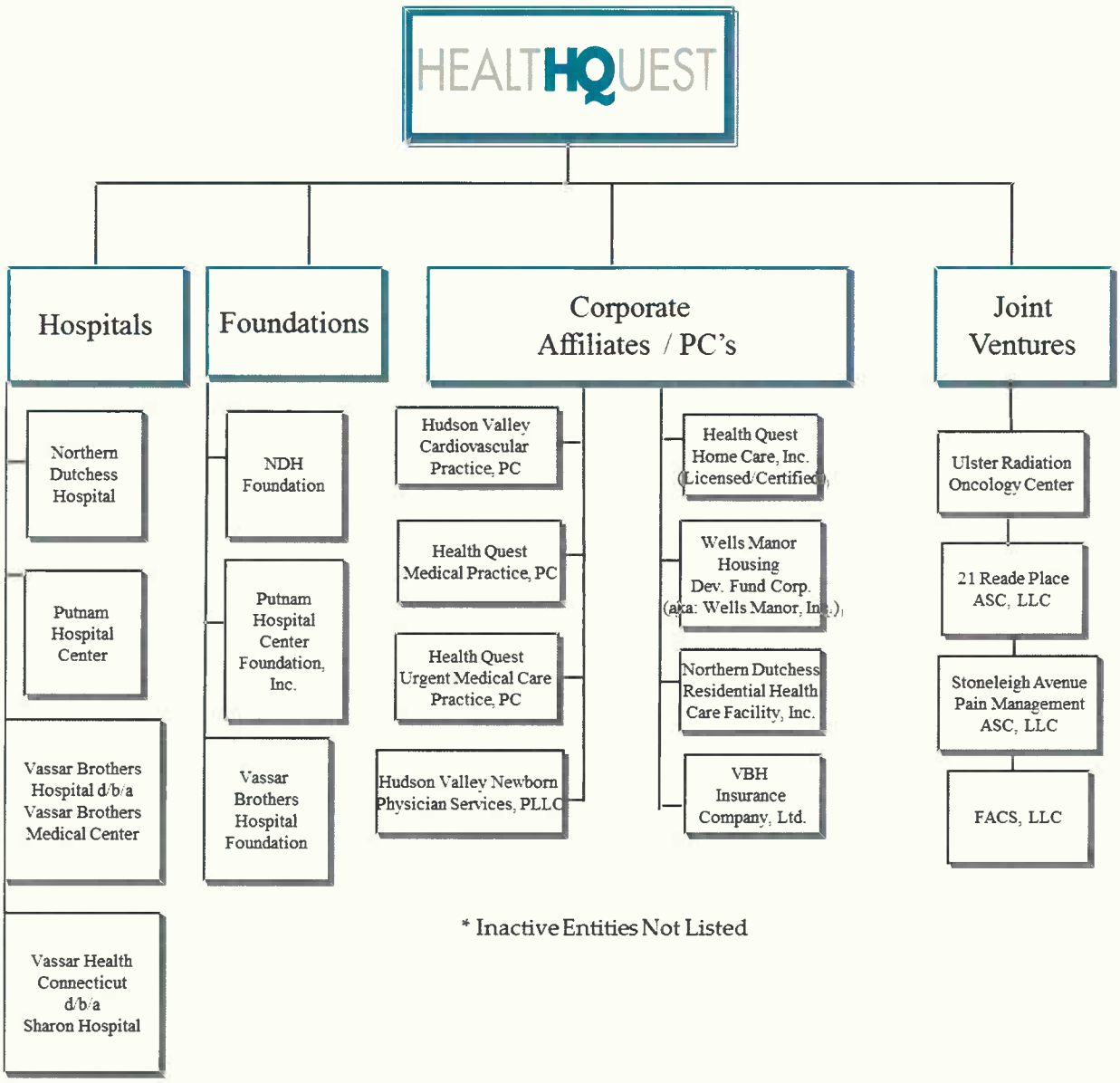
SH000549

11/03/2016



* Inactive Entities Not Listed

Existing Structure



* Inactive Entities Not Listed

EXHIBIT N

CMS
Centers for Medicare & Medicaid Services
Office of the Regional Administrator

Boston Region I
JFK Federal Building, Room 2325
Boston, MA 02203-0003
FAX #: 443-380-8871

Confidential Facsimile Transmittal

To: **Mr. Peter Cordeau, Interim CEO**
Company:
Fax: 8603644011
Phone

From: **Kathy Mackin**
Fax: 443-380-5597
Phone: (617) 565-1211
E-mail: kathy.mackin@cms.hhs.gov

Date and time: Wednesday, March 23, 2016 8:35:54 AM

Number of pages: 42

cc:

NOTES: Advanced copy of Notice of Findings

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

March 23, 2016

Mr. Peter Cordeau, Interim CEO
Sharon Hospital
50 Hospital Hill Road
Sharon, CT 06069

Re: **CMS Certification Number: 070004**
Survey ID: P6UJ11, 03/04/2016
Initial Notice of Termination

Dear Mr. Cordeau:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act, State Survey Agencies may conduct at CMS's direction, surveys of deemed status providers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the State of Connecticut Department of Public Health (State Survey Agency) at Sharon Hospital on March 4, 2016 found that the facility was not in substantial compliance with the following CoPs for hospitals:

42 C.F.R. §482.12 – Governing Body
42 C.F.R. §482.21 – Quality Assessment and Performance Improvement Program (QAPI)
42 C.F.R. §482.25 – Pharmaceutical Services
42 C.F.R. §482.41 – Physical Environment
42 C.F.R. §482.42 – Infection Control

As a result, effective March 4, 2016, your deemed status has been removed and survey jurisdiction has been transferred to the State Survey Agency.

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction).

When a hospital, regardless of whether it has deemed status, is found to be out of compliance with the CoPs, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of Sharon Hospital and accordingly, the Medicare agreement between Sharon Hospital and CMS is being terminated. The date on which the Medicare agreement terminates is June 21, 2016.

The Medicare program will not make payment for services furnished to patients who are admitted on or after June 21, 2016. For inpatients admitted prior to June 21, 2016, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after June 21, 2016. You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your facility on June 21, 2016 to Kathy Mackin, DHHS/CMS, JFK Federal Building, Room 2325, Boston, MA, 02203 to facilitate payment for services to these individuals.

We will publish a public notice in the *Hartford Courant* at least fifteen days prior to the termination date.

Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the State Survey Agency. The Form CMS-2567 with your PoC, dated and signed by your facility's authorized representative, **must be submitted to the State Survey Agency no later than April 2, 2016.** Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", keying your responses to the deficiencies on the left. Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiencies cited remain corrected and in compliance with regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. § 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

If an acceptable POC is timely submitted, your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the State Survey Agency and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If your Medicare agreement is terminated and you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 C.F.R. Part 498. An appeal/request for hearing must be filed no later than sixty (60) calendar days from the date of receipt of the initial notice of termination.

You must file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov, unless you have received approval from the Civil Remedies Division (CRD) to file in hardcopy. It is important that you also send a copy of your request for hearing to this office to the attention of: Survey Branch, Northeast Consortium Division of Survey & Certification, Centers for Medicare and Medicaid Services (CMS), JFK Federal Building, Room 2275, Government Center, Boston, MA 02203. A request for a hearing should identify the specific issues, the findings of fact and the conclusions of law, if applicable, with which you disagree. You may be represented by counsel at a hearing at your own expense.

If you have any questions, please contact Kathy Mackin at (617) 565-1211.

Sincerely,

J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification

Enclosure: Form CMS-2567

cc: State Survey Agency
The Joint Commission (TJC)

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 HOSPITAL HILL ROAD, PO BOX 789 SHARON, CT 06069

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A 000	INITIAL COMMENTS The following reflects the findings of the Connecticut Department of Public Health during an authorized substantial allegation survey concluded on 3/4/16 in response to complaint # 19553 at: Sharon Hospital 50 Hospital Hill Road Sharon, CT 06069 The following Conditions of Participation were reviewed as they pertained to the complaint and determined to be out of compliance: Governing Body 482.12 QAPI 482.21 Pharmaceutical Services 482.25 Physical Environment 482.41 Infection Control 482.42 Condition Level noncompliance was identified under: Governing Body 482.12 QAPI 482.21 Pharmaceutical Services 482.25 Physical Environment 482.41 Infection Control 482.42 Acronyms and Abbreviations that may be used throughout this document include: MD Medical Director CNO Chief Nursing Officer RN Registered Nurse Pt Patient Tx Treatment	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 QAPI Quality Assurance Program Improvement P&P Policy and Procedure EM Environmental Monitoring Definitions: USP-797: United States Pharmacopeia, Chapter 797, Pharmaceutical Compounding. Requirements for licensed entities that compound sterile products. PPE: Personal Protective Equipment: gowns, hair covering, masks, gloves and booties that are worn by personnel within the area of sterile compounding as directed by USP 797 standards. CFU: Colony Forming Units: a measurement of how large a mold area has grown. Certification of the rooms involve airborne non-viable particle counting (determining of ISO classification), airflow testing and smoke pattern test, room pressurization, HEPA filter leak test, general temperature and humidity. Environmental Monitoring: is a combination of both the non-viable and viable testing done every 6 months. Non-viable is to determine the ISO classification. Viable testing includes surface and air sampling of the compounding areas including the hoods or PEC's (primary engineering controls). USP 797 Environmental sampling: The ES program should provide information to staff and leadership to demonstrate that the PEC is maintaining an environment within the compounding area that consistently ensures acceptably low viable and nonviable particle	A 000		

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A 000	Continued From page 2 levels. Environmental Sampling data shall be collected and reviewed on a periodic basis as a means of evaluating the overall control of the compounding environment.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, it was determined that the hospital failed to meet the Condition of Participation for Governing Body as evidenced by: 1. The Governing Body did not ensure that services offered and provided met the Medicare Conditions of Participation. Areas of noncompliance identified include: Quality Assessment and Performance Improvement (QAPI), Pharmaceutical Services, Physical Environment, and Infection Control. Please refer to A-263, A-283, A-490, A-492, A-501, A-700, A-701, A-724, A-747, and A-749. 2. The Governing body failed to function effectively to ensure quality services were	A 043		

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A 043	Continued From page 3 provided by two contractors, Company #1 and Company #2. Please refer to A-83 Based on observations, review of facility documentation, contractor reports, and interviews, the following was ascertained: a. During tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was in a staff break room that as observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide and Ranitidine. b. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM	A 043		

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A 043	Continued From page 4 stated although he was aware that the room needed to be monitored he had only been in the facility for one month and did not have the opportunity to review all systems in place. c. The Interim Director of Pharmacy failed to identify that pressures within the isolator were monitored to ensure the required ISO classification was maintained in accordance with manufacturer guidelines and/or USP 797 Interview with the Interim Director of Pharmacy on 2/9/16 at 10:35 AM stated although he was aware the isolator needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. d. The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10: 40 AM stated although he was aware that humidity levels needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. e. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of the contract reports (Company #1) during the period of July of 2014 through February of 2015 failed to identify that the reports were comprehensive to include; an airflow	A 043		

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A 043	Continued From page 5 smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic conditions in the antechamber in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not reviewed any of these reports. Review of the aforementioned reports and interview with the Chief Nursing Officer (CNO identified that the prior pharmacy director handled the testing and/or reports as part of the directors responsibility. f. Governing Body Committee Minutes dated July of 2014 through February of 2015 failed to identify concerns with contracted services, specifically, Company #1 and Company #2. Interview with the CNO on 3/2/16 stated she attended the Governing Body Committee meetings and the prior pharmacy director did not report concerns regarding certification/environmental testing. g. Although the hospital had policies related to sterile compounding dated January 2014, entitled Sterile Preparation:Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Staff, the hospital failed to ensure the policies were followed. Interview with the CEO on 3/3/16 identified he did not have knowledge of the USP 797 law that was enforceable in July of 2014. The CEO indicated the pharmacy was a contracted service and he	A 043		

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A 043	Continued From page 6 expected to be informed of USP 797 regulations through the employees of the contract so that he could ensure compliance. Additionally the CEO indicated that although he was aware that environmental cultures were conducted through the quality council and governing body meetings, he did not have an understanding of its meaning. Further interview with the CEO identified he was responsible to oversee the pharmaceutical contract to ensure the services provided were in compliance with state laws. On 2/11/16 the facility submitted an immediate action plan to the Department of Public Health that identified the following components in part, one (1) hour beyond use date, a thorough cleaning of the room where the isolator was located and to initiate a line of demarcation. A certification company was consulted to perform viable air sampling immediately and media fill testing and fingertip sampling would also be conducted. A thermometer and humidity monitor were installed and a daily log was initiated to record temperature, humidity and isolator pressures. Daily cleaning of the segregated compounding room would also be conducted. Pharmacy personnel would be trained and complete all competencies.	A 043		
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of	A 083		

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A 083	Continued From page 7 participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the Governing body failed to ensure that quality services were rendered by Company #1 who conducted certification of the isolator/s and/or by Company #2 who provided pharmaceutical services for the hospital. The findings include the following: On 2/9/16 during a tour of the pharmacy it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16. Pharmacist #1 indicated that the chemotherapy isolator had not been operational since 4/14/14 as chemotherapy services were provided at a community infusion center. a. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the antechamber in accordance with USP 797. b. Further review of the reports indicated that certification testing of the non-chemo isolator failed to be completed in July of 2015 and had not been conducted since February of 2015.	A 083		

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A 083	Continued From page 8 The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. c. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne viable particles based on a risk assessment of activities performed. Locations would include those prone to contamination during compounding activities such as staging, labeling, gowning and cleaning. d. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units	A 083		

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A 083	Continued From page 9 (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning. The hospital policy entitled Sterile Preparations: Competency for Pharmacy personnel dated January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level. e. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not reviewed any of these reports.	A 083		

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A 083	Continued From page 10 Interview with the CEO on 3/3/16 identified he was responsible to oversee the contract for Company #1 that conducted mechanical testing of the isolators and for Company #2 who provided the hospital with pharmaceutical services. The CEO indicated he did not review the certification reports, environmental testing or collaborate with Company #2 to ensure the services rendered were comprehensive or complete.	A 083		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on a review of hospital documentation, contractor reports, interviews, and policies, it was determined that the hospital failed to meet the Condition of Participation for Quality Assessment and Performance Improvement as evidenced by: 1. The hospital failed to develop specific QAPI	A 263		

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A 263	Continued From page 11 indicators to monitor the performance of contracted services (Company #1 and #2) and/or ensure the Infection control program effectively monitored high risk area's including but not limited to Pharmacy services. Refer to A-283	A 263		
A 283	Cross reference A-83, A-490, A-492, and A-747. 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - ....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

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A 283	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the hospital failed to develop quality performance improvement activities regarding high risk area's in the hospital that included contracted services (Pharmacy). The findings include the following: Cross reference A-83 During tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was in a staff break room that as observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the antechamber in accordance with USP 797. Further review of the reports indicated that certification testing of the non-chemo isolator failed to be completed in July of 2015 and had not been conducted since February of 2015.	A 283		

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A 283	Continued From page 13 The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne viable particles based on a risk assessment of activities performed. Locations would include those prone to contamination during compounding activities such as staging, labeling, gowning and cleaning. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units (CFU) to	A 283		

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A 283	Continued From page 14	A 283		

ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning.

The hospital policy entitled Sterile Preparations. Competency for Pharmacy personnel dated January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control.

The hospital policy entitled Sterile Preparations. Environmental Monitoring Viable dated January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level.

Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not reviewed any of these reports.

a. Review of the P&T minutes (chaired by the

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A 283	Continued From page 15 Director of Pharmacy) dated July of 2014 through February of 2016 and interview with the CNO on 3/3/16 at 1:00 PM noted "growth or no growth", however, failed to identify that comprehensive testing was conducted by Company #1. b. Review of the Infection control minutes dated July 2014 through February 2016 and interview with the CNO on 3/3/16 at 1:30 PM failed to identify that a comprehensive mechanism was in place to identify and monitor potential infections in the compounding area of the pharmacy. Further review of the infection control meeting minutes failed to reflect that the facility analyzed the environmental testing that was conducted to determine implementation of appropriate interventions to prevent and control communicable disease. The minutes failed to reflect that surveillance rounds were conducted in the compounding area of the hospital and/or that other departments and specialty areas collaborated regarding adherence to the USP 797 guidelines and compliance with Pharmacy policies. Interview with the Infection Control Nurse and the Infectious Disease physician on 3/3/15 indicated he/she had heard of patient safety issues with compounding however were not aware of USP 797 guidelines and all of the criteria and/or elements required to ensure compliance with the law. Further interview with the CNO indicated the meeting minutes from P&T and Infection control are then brought for review to the Quality Assurance Committee. c. Review of the Quality Assurance Committee Minutes dated July 2014 through February 2016 and interview with the CNO on 3/3/16 at 2:00 PM	A 283		

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A 283	Continued From page 16 failed to identify that concerns regarding contracted services was discussed. The CNO indicated the meeting minutes from the Quality Assurance Committee and are then brought for review to the Medical Executive Committee d. Review of the Medical Executive Committee Minutes and interview with the CNO on 3/3/16 at 2:20 PM lacked documentation to support a review of concerns identified in the compounding area of the pharmacy that were discussed for disposition. e. Review of the Governing Body Minutes and interview with the CEO on 3/3/16 at 3:00 PM identified that all of the aforementioned subcommittee minutes are complied into a binder prior to the governing body meeting that is held every other month for all members to review. The CEO indicated he did not have knowledge of the USP 797 law that was enforceable in July of 2014 therefore he did not inquire or recognize elements of USP 797 that were not conducted. The CEO identified the pharmacy was a contracted service and he expected to be informed of USP 797 regulations through the employees of the contract so that he could ensure compliance.	A 283		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.	A 490		

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A 490	Continued From page 17 This CONDITION is not met as evidenced by: Based on observation, a review of hospital documentation, contractor reports, interviews, and policies, it was determined that the hospital failed to meet the Condition of Participation for Pharmaceutical Services as evidenced by: 1. The hospital failed to ensure that the Pharmacy Director (Contractor #2) effectively supervised the day to day operations of the Pharmacy Department as evidenced by failure to follow policy/procedures, failure to ensure environmental sampling and certification of the isolators were comprehensive, failure to compound medications in a sanitary environment and/or maintain compliance with federal and state laws (USP-797). Please refer to A-492 and A-501	A 490		
A 492	482.25(a)(1) PHARMACIST RESPONSIBILITIES A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contractor reports, interviews, and policy review, the hospital failed to provide the necessary supervision of Pharmacy services to ensure that the isolators where intravenous compounding was performed was tested/certified and/or that environmental testing was conducted in accordance with Federal and/or state laws.	A 492		

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A 492	Continued From page 18 United States Pharmacopeia, Chapter 797, Pharmaceutical Compounding (USP-797). The findings include: Cross reference A-501 a. During tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was relocated in a staff break room that was observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide and Ranitidine. The hospital policy entitled Sterile Preparations dated January 2014: Segregated Compounding Area directed in part that the pharmacy would compound sterile preparations in a segregated compounding area which meets the requirements of USP 797. The hospital policy entitled Sterile Preparations: Cleaning and Disinfecting the Sterile	A 492		

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A 492	Continued From page 19 Compounding Areas dated January 2014 directed in part that sterile preparation areas and segregated compounding areas would be cleaned monthly to include the floors, walls, shelving and ceilings. b. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the antechamber in accordance with USP 797. c. Further review of the reports indicated that certification testing of the non-chemo isolator failed to be completed in July of 2015 and had not been conducted since February of 2015. The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. d. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was	A 492		

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A 492	Continued From page 20 conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparations Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne viable particles based on a risk assessment of activities performed. Locations would include those prone to contamination during compounding activities such as staging, labeling, gowning and cleaning. e. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning. The hospital policy entitled Sterile Preparations: Competency for Pharmacy personnel dated	A 492		

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A 492	Continued From page 21 January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level. f. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not reviewed any of these reports. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed in part that semiannual certification of nonviable and viable environmental monitoring of all ISO 5 and segregated compounding areas would be conducted. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not	A 492		

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A 492	Continued From page 22 reviewed any of these reports. The Interim Director of Pharmacy further identified he was aware of USP 797 guidelines however did not inquire about the hospital's compliance and was not aware of the mechanical or environment testing that was conducted or any other elements that were necessary to be compliant with USP 797. Review with the aforementioned reports with the CNO on 3/3/16 at 11:15 AM identified that the prior pharmacy director handled the testing and/or reports as part of the directors responsibility. g. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM stated although he was aware that the room needed to be monitored he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed that quality control practices in part would include daily documentation of temperature in areas where sterile products or sterile preparations are stored or compounded. h. The Interim Director of Pharmacy failed to	A 492		

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A 492	Continued From page 23 identify that pressures within the isolator were monitored to ensure the required ISO classification was maintained in accordance with manufacturer guidelines and/or USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:35 AM stated although he was aware the isolator needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed that quality control practices in part would include daily documentation of pressure or velocity to monitor pressure differential or airflow between the buffer and ante-area and the general environment outside the compounding area. i. The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:40 AM stated although he was aware that humidity levels needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: General directed in part that the Director of the Pharmacy shall ensure the sterility and integrity of sterile preparations compounded by the pharmacy department, and oversee the policies and procedures for compounded sterile preparations throughout the hospital.	A 492		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 HOSPITAL HILL ROAD, PO BOX 789 SHARON, CT 06069

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A 492	Continued From page 24 The job description for the Director of Pharmacy, in part, included to plan, organize and direct all functions of the hospital pharmacy services. To ensure compliance with all state, local and federal regulations. Establish standards/training for sterile product preparation. To participate in the P&T committee assuring all pertinent information was communicated. To train and develop staff and ensure competency of designated staff on proper use of equipment and skills.	A 492		
A 501	482.25(b)(1) PHARMACIST SUPERVISION OF SERVICES All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, interviews, and policy review, the hospital, who compounds sterile pharmaceuticals, failed to maintain a sanitary environment and/or that staff competencies were conducted in accordance with hospital policies. The findings include: 1. During tour of the Pharmacy on 2/9/16 at 10:00 AM with the Interim Pharmacy Director and CNO, the following concerns were identified: a. A non-chemo isolator was observed in a room cluttered with kitchen and office supplies including the counter tops where intravenous	A 501		

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A 501	Continued From page 25 bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview and review of the cleaning logs on 2/9/16 with Pharmacist #1 indicated although daily cleaning of the isolator was completed, terminal cleaning was not conducted in the break room since the isolator was re-located on 1/6/16 in accordance with USP 797. Further interview with Pharmacist #1 identified staff were not trained to conduct terminal cleaning. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide and Ranitidine. The hospital policy entitled Sterile Preparations: Cleaning and Disinfecting the Sterile Compounding Areas dated January 2014 directed in part that sterile preparation areas and segregated compounding areas would be cleaned monthly to include the floors, walls, shelving and ceilings. The pharmacies policies failed to identify that a line of demarcation was necessary to differentiate dirty from clean. b. On 2/9/16 at 1:00 PM, Pharmacy Technician #2 was observed with long fingernails, and was wearing nail polish and jewelry. The Technician washed her hands then proceeded to compound an IV medication. The Technician failed to clean beneath her nails and/or remove jewelry and/or	A 501		

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A 501	Continued From page 26 remove nail polish prior to compounding in accordance with facility policy and/or USP 797 guidelines. The hospital policy entitled Sterile Preparation: General dated November 2014 directed in part that personnel working in the sterile compounding area shall keep their nails neat and trimmed, however, failed to include all components to ensure safe compounding. c. Further observation of Pharmacy Technician #2 on 2/9/16 at 1:00 PM identified she placed the intravenous solutions and medications in the antechamber of the isolator and immediately opened the isolator and placed the compounding items into the main chamber. Interview with Pharmacy Technician #2 indicated she was not aware that a waiting time was necessary to return conditions to ISO 5 prior to the initiation of compounding. Subsequent to the observation the Interim Director of Pharmacy identified per manufacturers guidelines a five (5) minute waiting time was needed to return to an ISO 5 condition and placed a clock in the room to ensure compliance. The hospital policy entitled Sterile Preparations: Sterile Compounding Area dated January 2014 in part directed that the isolator shall maintain ISO class 5 conditions, including transferring ingredients, components, and devices into and out of the isolator and during preparation of medications that are compounded. d. Interview with the Interim Pharmacy Director on 2/9/16 at 1:15 PM identified although written competencies were conducted yearly for the staff that compounded medications, observations where not conducted to ensure aseptic techniques and practices in accordance with USP	A 501		

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A 501	Continued From page 27 797 and should have been. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed in part that initial and annual competence documentation of personnel would include hand hygiene and garbing. e. Interview and review of the finger-tip testing with Pharmacist #1 on 2/9/16 identified testing was not conducted in 2015 and should have been completed yearly. Subsequent to the surveyors inquiry finger-tip testing of the pharmacy staff was initiated. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed in part the initial and annual competence documentation of personnel would include glove fingertip sampling.	A 501		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: The facility failed to ensure that the condition of the physical plant and overall hospital environment was developed and maintained in a manner that provides an acceptable level of safety and well-being of patients, staff, and visitors based upon a tour of the Main Pharmacy on 02/10/16. Please refer to A-701 and A-724	A 700		

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on tour of the Pharmacy, interviews and policy review, the Hospital failed to maintain the overall hospital environment in such a manner that the safety and well-being of patients are assured. The findings include the following: On 02/10/16, the surveyor, accompanied by the Supervisor of Engineering and Property, observed the following: a. The facility installed into service a temporary medication compounding room within the Main Pharmacy employee "breakroom" without first submitting a stamped set of architectural drawings for review and obtaining approvals from the Connecticut Department of Public Health detailing building construction equipment installed in the space. b. The facility installed a fume hood designed to be utilized for the mixing of pharmaceutical medications in an employee "breakroom" that also contained a coffee maker, food products, personal belongings, a microwave oven, filing cabinets, and unsecured electrical power distribution panels.	A 701		

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A 701	Continued From page 29 c. The facility failed to provide pharmaceutical staff that mixes and handles medications with an area within the "breakroom" in proximity to the fume hood to safely process, handle, and store medications. d. The facility constructed a new medication compounding room within the Main Pharmacy that contained a new medication compounding hood with associated HVAC ductwork, room pressurization monitoring equipment, and electrical equipment without first submitting a stamped set of architectural drawings detailing building construction, equipment installed in the space without obtaining an approval from the Connecticut Department of Public Health. e. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy (contractor #2) on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM stated although he was aware that the room needed to be monitored he had only been in the facility for one month and did not have the opportunity to review all systems in place. f. The Interim Director of Pharmacy failed to identify that pressures within the isolator were monitored to ensure the required ISO classification was maintained in accordance with manufacturer guidelines and/or USP 797. Interview with the Interim Director of Pharmacy	A 701		

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A 701	Continued From page 30 on 2/9/16 at 10:35 AM stated although he was aware the isolator needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed that quality control practices in part would include daily documentation of pressure or velocity to monitor pressure differential or airflow between the buffer and ante-area and the general environment outside the compounding area. g. The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:40 AM stated although he was aware that humidity levels needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place.	A 701		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: The hospital failed to ensure that adequate provisions to ensure the availability and reliability of equipment needed for its operations and services was provided based upon observations conducted within the Main Pharmacy on 02/10/16. These observations include:	A 724		

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A 724	Continued From page 31 a. The facility constructed a new medication compounding room within the Main Pharmacy that contained a new medication compounding hood with associated HVAC ductwork, room pressurization monitoring equipment, and electrical equipment without first submitting a stamped set of architectural drawings detailing building construction, equipment installed in the space without obtaining an approval from the Connecticut Department of Public Health.	A 724		
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, it was determined that the hospital failed to meet the Condition of Participation for Infection Control as evidenced by: 1. The hospital failed to ensure that the Infection Control program was comprehensive to include high risk areas including surveillance of the hospital's pharmacy. Please refer to A-749	A 747		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM	A 749		

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A 749	Continued From page 32 The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: 1. Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the hospital failed to ensure the Infection Control program evaluated and monitored the presence of "growth" identified during environmental testing at the hospital pharmacy to establish a plan of surveillance to maintain a safe environment. The findings include the following: Cross reference A-492. a. During tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was relocated in a staff break room that was observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide and Ranitidine.	A 749		

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A 749	Continued From page 33 Interview with the Infection Control Nurse on 3/3/16 at 11:15 AM indicated she assumed the role of Infection Control Nurse in July of 2015. The Infection Control Nurse stated she was not included in the decision to move the isolator prior to the initiation of construction and does not conduct surveillance rounds of the pharmacy. b. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning.	A 749		

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A 749	Continued From page 34 Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Review of the Infection Control Meeting minutes dated 8/27/15 and interview with the Infection control nurse on 3/3/16 at 11:15 AM stated environmental cultures identified "no growth". The meeting minutes dated 10/29/15 indicated the environmental cultures identified "growth" and cleaning was conducted. Further review of the minutes and interview with the infection control nurse and the CNO identified they were in attendance of the infection control meetings however were not involved in the results or analysis of the information as they felt it was the responsibility of the pharmacist. Interview with the Infectious Disease Physician on 3/3/16 indicated he was aware of patient safety issues with intravenous compounding however was unaware of USP 797 guidelines and all of the criteria and/or elements required to ensure compliance with the law. Further interview with the Infectious Disease Physician indicated it would be important to obtain comprehensive environment sampling within the isolator to identify specific microorganisms and that he should be consulted for analysis and interpretation of the testing to determine appropriate interventions for remediation. 2. Based on a tour of the facility, review of facility policies, observations and interviews the facility failed to ensure that facility infection control practices were followed. The findings include the following:	A 749		

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A 749	Continued From page 35 a. During a tour of the OR with the OR Director on 2/9/16 at 10:56 AM, a surgical case was being performed in OR #3. Further observation at this time identified that the male scrub nurse had donned a mask and facial hair was exposed under the chin and at the sides of the face. Interview with the OR Director on 2/9/16 at 10:56 AM noted that the facility followed the Association of periOperative Registered Nurses (AORN) regarding OR attire. The facility policy for surgical attire identified that complete hair coverage is necessary in restricted areas (OR). b. Patient #27 was admitted to the ED on 3/4/16 with a diagnosis of overdose. Observation on 3/3/16 at 2:10 PM identified the RN obtained blood from a finger on the patient's left hand, placed the strip with the patient's blood in the glucometer, and sanitized the glucometer with a 70% alcohol pad after use. The facility policy for maintenance of the glucometer (Precision Exceed Pro Glucometer) identified to clean the meter with alcohol or ammonia solution for decontamination. According to the Association for Professionals in Infection Control and Epidemiology (APIC) 2014 Infection Prevention; alcohol is never an acceptable disinfectant in shared- use situations c. During a tour of the emergency department (ED) on 3/2/16 at 1:55 PM, RN #4 was observed to draw up medication into a syringe from two (2) new medication containers/vials without the benefit of sanitizing the rubber diaphragm with an alcohol pad. Interview with RN #4 on 3/2/16 at 1:55 PM noted that he/she believed that the rubber diaphragm was sterile when the vial was first opened. The facility policy for sterile	A 749		

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A 749	Continued From page 36 preparations directed to prepare the vial by removing protective caps and cleaning the port diaphragm with an alcohol pad.	A 749		

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A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.. This condition is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, it was determined that the hospital failed to meet the Condition of Participation for the Governing Body as evidenced by: 1. The Governing Body did not ensure that services offered and provided met the Medicare Condition of Participation. Areas of non-compliance identified include: Quality Assessment and Performance Improvement (QAPI), Pharmaceutical Services, Physical Environment, and Infection Control. Please refer to A-263, A-283, A-490, A-492, A-501, A-700, A701, A-724, A-747, and A-749. 2. The Governing Body failed to function effectively to ensure quality services were provided by two contractors, company #1 and company #2. Please refer to A-83. Based on observations, review of facility documentation, contractor reports, and interviews, the following was ascertained: a. During tour of the pharmacy on 2/9/16 at 10:00 am with the Interim Director of Pharmacy, the CNO, and pharmacist #1 it was	A 043	1. & 2.)The Governing Body (GB) meeting was held with CEO and CNO in attendance. The GB responsibility to review & approve meeting minutes from Infection Control (IC), Pharmacy and Therapeutics Committee (P&T), Safety and Quality Committee, and to recognize and address deficiencies including contracted services was discussed. Historically, the GB reviews minutes brought to the GB. Moving forward, an emphasis will be placed on review & approval of all minutes and specifically the meeting minutes of the Plan of Correction Committee (POCC), IC, P&T, Quality, and Safety Committees. The GB was advised by CNO of all condition level deficiencies regarding GB, QAPI, Pharmaceutical Services, Physical Environment, and IC. USP797 processes including air and surface sampling, hood certification, staff competencies, media fill, gloved fingertip sampling, environmental monitoring of temperature, humidity, pressure, cleaning of the room and isolator and the pharmacy construction project were discussed. The reporting procedure for USP797 and its related processes was presented by the CNO including reporting structure up to the GB; the GB verbalized an understanding of the process, their responsibility & resolved steps outlined in POC shall be taken to ensure compliance with CoP During the survey, CQO developed a spreadsheet to monitor the reporting structure compliance of IC, P&T, Quality, & MEC meeting minutes up to the GB. A reporting template to monitor monthly elements of comprehensive CETA certification was developed, to be presented to POCC, IC, P&T, Quality, and Safety Committees. Reports of each will be added to the agenda of the GB, for a minimum of one year or until the deficiencies identified by the CT DPH have been corrected, in order to ensure communication between the hospital committees and the Governing Board regarding QAPI, pharmaceutical services, physical environment and infection control. The CNO and CEO committed to ensuring communication with the board, individually and specifically through the Plan of Correction Committee, pertaining to any matters.	3/22/16 3/22/16 3/2/16 4/18/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peter R. Cimbolo	President & CEO	4/1/16

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**
This document contains a listing of deficiencies cited by the surveying State Agency (SA) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. **FORM COMPLETION**
Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

11/03/2016 SH000596

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 Hospital Hill, PO Box 789, Sharon, CT 06069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	continued from page 1 identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was in a staff break room hat as observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins Iron Oxide, and Ranitidine. b. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM stated although he was aware that the room needed to be monitored he had only been in the facility for one month and did not have the opportunity to review all systems in place. c. The Interim Director of Pharmacy failed to identify that pressures within the isolator were monitored to ensure the required ISO classification was maintained in accordance with manufacturer guidelines and/or USP 797. Interview with the The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with		1 &2. (cont) Responsibility: CEO The hospital has created a Plan of Correction Committee (POCC) to oversee the development and implementation of this Plan of Correction and particularly for the purpose of facilitating the flow of information described in this Plan. The POCC comprised of the CEO, CNO, CQO, Quality Coordinator, IC Nurse, Educator, Surgical Services, Lab, Pharmacy, Emergency, Med/Surg and ICU Directors, Facilities &EVS Supervisors. The CNO will be the committee chair. The POCC begins meeting on April 4, 2016, and will continue meeting at least monthly, and more often ad hoc, for a minimum of 1 year or until the deficiencies identified have been corrected. The POCC will ensure that the IC, P&T, Quality, and Safety Committees are regularly collecting and reviewing information related to deficiencies, & POCC will assist them in obtaining this information as necessary. All info. to be collected and reviewed by hospital committees as delineated in this plan will also be reported to and reviewed by the POCC. Completion of competency training as described herein will also be reported to the POCC. The chair or his/her designee will report to the GB regarding the POCC's activities at each of the GB's regular meetings, and ad hoc when issues arise that need immediate attention. The agenda items for all GB meetings will include receiving POCC, IC, P&T, Quality, and Safety Committee minutes for review/approval, for a minimum of one year or until the deficiencies identified by the CT DPH have been corrected. A standing agenda developed by POCC will be inclusive of all deficiencies noted, to ensure all elements for the POC are implemented Responsibility: CEO After exit conference, steps were immediately taken to mitigate risks where medication preparation is conducted. The room was cleaned, demarcation lines were placed. Pharmacy personnel received competency training related to cleaning and maintenance of the compounding room and isolator. A policy will be developed including the steps taken to ensure the room is cleaned per USP 797 guidelines.	4/18/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	4/1/16

SH000597

11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 043	continued from page 2 Interim Director of Pharmacy on 2/9/16 at 10:35 AM stated although he was aware that humidity levels needed to be monitored, e had only been in the facility for one month and did not have the opportunity to review all systems in place. d. The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:40 AM stated although he was aware that humidity levels needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. e. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of the contract reports (Company #1) during the period of July of 2014 through February 2015 failed to identify that the reports were comprehensive to include, an airflow smoke pattern test was conducted an/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic conditions n the antechamber in accordance with USP 797. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:45 AM stated he had only been in this role for (1) month therefore had not reviewed any of these reports. Review of the aforementioned reports and interview with the Chief Nursing Officer (CNO identified that the prior pharmacy director handled the testing and/or reports as part of the directors responsibility.		b. A temperature monitor was initially installed 2/12/16 followed by installation of an electronic temperature monitor 2/23/16. A policy will be developed and a monitoring log was developed to monitor daily temperature documentation compliance. Log implemented: 2/12/16. Pharmacy personnel began training 02/12/16. c. A new policy will be developed related to the isolator and updated to reflect manufacturer's instructions for use. All appropriate staff were re-trained related to the appropriate operation, including appropriate pressurization, documentation of parameters, and trouble shooting. This policy will be added to the departmental orientation and annual competency training. d. A humidity monitor was initially installed 2/12/16 followed by installation of an electronic humidity monitor 2/23/16. A policy will be developed and a monitoring log was developed to monitor daily humidity documentation compliance. Log implemented: 2/12/16. Pharmacy personnel began training 02/12/16. e. A comprehensive CETA certification evaluation was initiated on 02/16/16. Appropriate maintenance and trouble shooting by the hospital and contractor were conducted. Initial work completed 02/27/16. The policy titled, "Sterile Preparations Environmental Monitoring" will be reviewed, revised, and implemented, to ensure all CETA certification requirements are met as required by manufacturer and state and federal regulations. Competencies and training are completed at time of hire and annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility: CEO	4/18/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 043	continued from page 3 f. Governing Body Committee Minutes dated July of 2014 through February of 2015 failed to identify concerns with contracted services, specifically, Company #1 and Company #2. Interview with CNO on 3/2/16 stated she attended the Governing Body Committee meetings and the prior pharmacy director did not report concerns regarding certification/environmental testing. g. Although the hospital had policies related to sterile compounding dated January 2014, entitled Sterile Preparation: Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Staff, the hospital failed to ensure the policies were followed. Interview with the CEO on 3/3/16 identified he did not have knowledge of the USP 797 law that was enforceable in July 2014. The CEO indicated the pharmacy was a contracted service and he expected to be informed of USP 797 regulations through the employees of the contract so that he could ensure compliance. Additionally the CEO indicated that although he was aware that environmental cultures were conducted through the quality council and governing body meetings he did not have an understanding of the meaning. Further interview with the CEO identified he was responsible to oversee the pharmaceutical contract to ensure the services provided were in compliance state laws. On 2/11/16 the facility submitted an immediate action plan to the Department of Public Health that identified the following components in part, one (1) hour beyond use date, a thorough		f. GB responsibility of contractor oversight was reviewed at GB meeting 03/22/16. USP 797 processes and condition level deficiencies were discussed. The CNO and CEO committed to ensuring communication with the GB pertaining to clinical contract matters as they arise. A standing agenda developed by POCC will be inclusive of all deficiencies noted, to ensure all elements for the POC are implemented and reported to GB. Reports of each of the POCC, IC, P&T, Quality, and Safety Committees will be added to the agenda items for each meeting of the GB, for a minimum of one year or until the deficiencies identified by the Department of Public Health have been corrected, in order to ensure communication between the hospital committees and the Governing Board regarding contracted services. g. All pharmacy policies and procedures will be reviewed and revised, if applicable. Pharmacy personnel started reviewing policies and procedures. Select policies and procedures related to Sterile preparation, Cleaning and Disinfection in the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency will be a focus of increased review and education. All compounding competencies were completed with pharmacy personnel according to USP797 regulations. Staff were trained on the line of demarcation, signage, and processes related to the line of demarcation. Hospital nursing staff that perform compounding completed Sterile Product Preparation compounding education prior to compounding IV medications with the implementation of the 1 Hour BUD Competencies and training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and reported to POCC chair. Responsibility: CEO	3/22/16 4/18/16 3/24/16 4/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 043	continued from page 4 cleaning of the room where the isolator was located and to initiate a line of demarcation. A certification company was consulted to perform viable air sampling immediately and media fill testing and fingertip sampling would also be conducted. A thermometer and humidity monitor were installed and a daily log was initiated to record temperature, humidity, and isolator pressures. Daily cleaning of the segregated compounding room would also be conducted. Pharmacy personnel would be trained and complete all competencies.	A 043	Governing Body responsibility related to contractor oversight as stipulated in the Conditions of Participation were reviewed at the GB meeting 3/22/16. The GB was apprised of the current status of the corrective actions as they relate to compounding, pharmacy construction, and compliance with regulatory requirements. The GB has tasked administration with forming a subcommittee that will oversee the plan of correction (PoC). POCC will routinely review, analyze and report all of the findings to the GB. First meeting of the POCC is scheduled for 4/4/16. The POCC will meet minimally at one month intervals for a minimum of a year. Minutes will be presented to the IC, P&T, Quality Committee, and GB meetings. The CNO will report any deficiencies reported at the POCC to the GB at least bi-monthly.	3/22/16 4/4/16
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the Governing body failed to ensure that quality services were rendered by Company #1 who conducted certification for the isolator/s and/or by Company #2 who provided pharmaceutical services for the hospital. The findings included the following: On 2/9/16 during a tour of the pharmacy it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16. Pharmacist #1 indicated that the chemotherapy isolator had not been operational since 4/14/14 as chemotherapy services were	A 083	A standing agenda item will be added to the GB agenda to ensure contracted services are reviewed. Provision of Patient Care and Services Plan will be reviewed, revised, and approved by Quality and GB. The plan includes contractor oversight, responsibilities and reporting requirements. All appropriate personnel will be educated on the policy. As part of new manager orientation this policy will be reviewed. Pharmacy service indicators were reviewed and approved as part of the Quality Improvement Plan. Plan will be presented to the Quality Committee and GB for review and approval. Pharmacy policies and procedures will be reviewed, approved, and implemented. Competencies and training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility: CEO	4/18/16

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	President & CEO	4/1/16

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A 083	Continued from page 5 provided at a community infusion center. a. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the antechamber in accordance with USP 797. b. Further review of the reports indicated that certification testing of the non-chemo isolator failed to be completed in July of 2015 and had not been conducted since February of 2015. The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. c. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne	A 083	a. & b.) A complete CETA evaluation was initiated on 2/16/16 and completed 2/27/16. Appropriate maintenance and trouble shooting by the hospital and contractor were conducted. All work was completed 2/27/16. All appropriate air flow ingress egress testing were completed and found to be in compliance with USP 797 standards. Policy "Sterile Preparations- Environmental Monitoring" will be reviewed, revised, and implemented to ensure all CETA requirements are met as required by manufacturer and regulation. The policy related to the Sterile Compounding area was reviewed with staff to ensure compliance with all requirements. The policy will be added to new hire and annual training. Monitoring of these processes will be added to the PoC reporting template This reporting template will be reviewed for approval at the first POCC meeting scheduled for 4/4/16 and will continue until the POCC feels the process has been adequately implemented c. & e.) A complete CETA evaluation was initiated on 2/16/16 and completed 2/27/16. Appropriate maintenance and trouble shooting by the hospital and contractor were conducted according to manufacturer's instructions and regulations. Initial work was completed 2/27/16. All appropriate air sampling and surface sampling was completed and found to be in compliance with USP 797 standards. The policy "Sterile Preparations- Environmental Monitoring" will be reviewed, revised, and implemented to ensure all CETA requirements are met as required by manufacturer and regulation. Culture results, including speciation if growth is present, will be sent to the Pharmacist, ICP, ID Physician, CQO, CNO, & CEO for review. ICP will collaborate with ID physician collectively with Pharmacist to determine action plan for positive growth. CT Drug Control will be notified and appropriate action taken or actionable positive cultures. Reports will be provided to the POCC, IC, P&T, Quality and GB Committees for review Responsibility: CEO	2/27/16 4/18/16 4/18/16 2/27/16 4/18/16 4/18/16

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	President & CEO	4/1/16

SH000601

11/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 083	Continued from page 6 airborne viable particles based on a risk assessment of activities performed. Locations would included those prone to contamination during compounding activities such as staging, labeling, gowning, and cleaning d. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming unit (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning. The hospital policy entitled Sterile Preparations: Competency for pharmacy personnel dated January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable date January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures, and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level.	A 083	Subsequent to the survey findings, steps were immediately taken to clean the isolator and the environment. The room was appropriately cleaned and isolator was terminally cleaned. All pharmacy personnel were retrained to the concepts of cleaning. The policy related to daily cleaning of the environment and the isolator were reviewed and revised. All appropriate pharmacy personnel will be educated and complete competency training. A cleaning log was developed to monitor cleaning for compliance of maintaining a sanitary environment; re-education face to face with appropriate personnel as needed. Data will be provided to IC, Quality, P&T, POCC and GB. Job responsibilities will be reviewed with appropriate pharmacy and EVS personnel responsible. Competencies related to cleaning began developed and completed. The competencies will be added to new hire and annual training. Surveillance of the room, isolator and log is conducted on a daily basis by Pharmacist, ICP and EVS manager. Results reviewed face to face with appropriate personnel and leadership and in committee. CNO will report any deficiencies to IC, P&T, POCC, Quality, and GB at minimum monthly. IC Nurse rounds minimally three times per week for observation of compliance for environmental observation. Staff will be provided continued face to face education as needed. Findings will be reported to POCC and at IC Meeting monthly. Procedures for culture growth "Sterile Compounding Area-Environmental Monitoring and Sterile Compounding Area-Surface Testing" were developed, procedure will go to P&T for approval and provided to POCC and up to the GB.	2/9/16 4/18/16 2/12/16 4/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 083	continued from page 7 e. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in this role for one (1) month therefore had not reviewed any of these reports. Interview with the CEO on 3/3/16 identified he was responsible to oversee the contract for Company #1 that conducted mechanical testing of the isolators and for company #2 who provided the hospital with pharmaceutical services. The CEO indicated he did not review the certification reports, environmental testing or collaborate with Company #2 to ensure the services rendered were comprehensive or complete.	A 083	Provision of Patient Care and Services Plan will be reviewed, revised, and approved by Quality and GB. The plan includes contractor oversight, responsibilities and reporting requirements. All appropriate personnel will be educated on the policy. As part of new manager orientation this policy will be reviewed. A list of all contractors has been reviewed according to the conditions of participation. Annually an evaluation review of all contracted services is provided to the GB for approval. A standing agenda item has been added to the GB agenda to ensure contracted services are reviewed and remain in compliance. Competencies and training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. The CNO will report any deficiencies at least monthly to the GB Responsibility: CNO	4/18/16 4/18/16 4/18/16
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. The CONDITION is not met as evidenced by: Based on a review of hospital documentation, contractor reports, interviews, and	A 263	The hospital has a Quality Committee which completes an annual Quality Improvement Plan and Evaluation. Both are presented annually to the Quality Committee and GB for review and approval. The hospital Quality Improvement Plan for QAPI is equivalent to the QAPI nomenclature used by CMS. The Quality Improvement Plan will be re-reviewed and revised to include indicators for contracted services. The indicators will be reported and reviewed through the QAPI committee and POCC with recommendations for improvement up to GB. Responsibility: CQO	Quality: 12/23/15 GB: 3/22/16 4/18/16

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A 263	Continued from page 8 policies, it was determined that the hospital failed to meet the Condition for Participation for Quality Assessment and Performance Improvement as evidenced by: 1. The hospital failed to develop specific QAPI indicators to monitor the performance of contracted services (Company #1 and #2) and/or ensure the Infection control program effectively monitored high risk area's including but not limited to the Pharmacy services. Refer to A-283 Cross reference A-83, A-490, A-492, and A-747.	A 263	1. The hospital has a Quality Committee and completes an annual Quality Improvement Plan and Evaluation. Both are presented to the Quality Committee and GB for review and approval annually. The Quality Committee's plan for QAPI is the patient safety and performance improvement plan; it is equivalent to the QAPI nomenclature used by CMS. Increased environmental surveillance and formalized indicators for areas cited will be added to the 2016 Quality Improvement Plan and presented to the Quality Committee and GB for analysis, recommendations, and approval. USP 797 will be added as a standing agenda item to be reported monthly at IC, P&T, Quality Committee Meetings and to the GB for final review and approval.	3/22/15 4/18/16
A 283	482.21(b)(2)(ii), (c)(1), (c)(3)QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to.....] (ii) Identify opportunities for improvement and changes that will lead to improvement (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that: (i) Focus on high risk, high volume, or problem prone areas, (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that	A 283	The annual IP Plan will be revised to include environmental and high risk area surveillance and formalized indicators for areas cited. The revised plan will be presented to the IC Committee for analysis, recommendations, and approval. The CQO will be responsible for oversight of revisions of the Quality Improvement Plan and IC Nurse will be responsible for oversight of revisions of the IC Plan and reporting at each meeting and up to the GB on a bi-monthly basis minimally Provision of Patient Care and Services Plan will be reviewed, revised, and approved by Quality and GB. The plan includes contractor oversight, responsibilities and reporting requirements. All appropriate personnel will review the policy. Appropriate contracted services attend general hospital orientation. Event reporting is part of general hospital orientation and will be ongoing. Responsibility: CQO	

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A 283	Continued from page 9 improvements are sustained. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the hospital failed to develop quality performance improvement activities regarding high risk area's in the hospital that included contracted services (Pharmacy). The findings include the following: Cross reference A-83 During tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identified that the compounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was in a staff break room that as observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the antechamber in accordance with USP 797. Further review of the reports indicated that certification testing of	A 283	Following survey several steps were taken to ensure the pharmacy was operating according to nationally recognized standards of practice. As part of development of quality monitors the quality leadership and pharmacy will review the appropriate USP 797 standards. The pharmacist and hospital leadership will review appropriate Association of Health System pharmacy (ASHP) standards to ensure the policies and processes met nationally recognized standards of practice. Appropriate pharmacy policies will be updated if necessary and all will be reviewed by the appropriate staff. QAPI Indicators for pharmacy will be developed and added to the QAPI plan. Cleaning and environment of care check lists were developed and/or modified. POCC will review all monitoring and surveillance related to the specific corrective actions. QAPI will be updated each meeting on this information Appropriate contract staff will be re-educated related to QAPI plan, processes, and event reporting policies. The POCC information will be added as a standing agenda item on IC, P&T, Quality and GB agendas. Competencies/training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted by assigned supervisor and reported to POCC chair. Responsibility: CQO	2/9/16 04/18/16 3/29/16

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A 283	Continued from page 10 the non-chemo isolator failed to be completed in July of 2015 and had not been conducted since February of 2015. The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparation: Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne viable particles based on a risk assessment of activities performed. Locations would include those prone to contamination during compounding activities such as staging, labeling, gowning and cleaning. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units (CFU) to ascertain a microorganism has exceeded a threshold in accordance with	A 283	The QAPI plan will be reviewed and revised to include appropriate monitoring for the pharmacy. The Infection control plan will be reviewed and revised to include appropriate monitoring of the pharmacy. All appropriate personnel will be educated related to the revisions. All appropriate personnel will be re-educated as to the standards for operations and environment of the pharmacy. This information will be added to new hire and annual training. The pharmacy staff will be re-educated on adverse event reporting, appropriate notification policies, and all monitoring required to be in compliance with the CoP. This information will be added to the departmental orientation as well as the annual training. A reporting template with all required monitors has been developed and will be approved by POCC at first meeting on 4/4/16. Monitoring will continue throughout the year. Changes to the monitoring will be approved through QAPI and POCC. A list of required monitors for CETA, USP 797, and condition level requirements will be reviewed and approved through committees. The Director of Pharmacy will be reeducated as to the requirements. Appropriate surveillance oversight is conducted by the CNO/IC All results, updates and issues related to compliance will be reported in IC, P&T, Quality, POCC, and up to the GB. Responsible party: CQO	4/18 /16

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A 283	Continued from page 11 USP 797. Although terminal clean was listed as the action plan, interviews with Pharmacist #1 and Pharmacy technician #1 indicated that only the daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning. The hospital policy entitled Sterile Preparation: Competency for Pharmacy personnel dated January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control. The hospital policy entitled Sterile Preparations: Environmental Monitoring Viable dated January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in his role for one (1) month therefore had not reviewed any of these reports. a. Review of the P&T minutes (chaired by the Director of Pharmacy) dated July of 2014 through February 2016 and interview with the CNO on 3/3/16 at 1:00 PM noted "growth or no growth", however failed to identify that comprehensive testing was conducted by Company #1.	A 283	All pharmacy employees were retrained on policies and procedures including Sterile Preparation: Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Staff. Staff training will start on March 29, 2016. Cleaning requirements and logs were developed to meet USP 797 guidelines Pharmacy personnel competency training for cleaning was completed by Director of Pharmacy. Cleaning competency training will be added to the new hire and annual competency checklist for pharmacy personnel. A cleaning log was developed to monitor compliance and is maintained daily by pharmacy staff with direct oversight by the Pharmacy Director. a. The P&T committee met and reviewed the findings of the survey. Approval of actions taken and recommendations for further action were made. The P&T committee was provided education related to the requirements of USP 797. All policies and procedure revisions will be approved through P&T after revisions have been completed. All monitors and logs will be reviewed and approved. Findings related to pharmacy environment and operations will be reviewed in P&T with analysis and recommendations necessary to meet compliance with standards and regulations. Review of POC reports will be added to the P&T committee agenda. QAPI information and newly revised indicators will be reviewed with the committee as well. The Director of Pharmacy is responsible to ensure the P&T committee is apprised of all POC information. P&T meeting minutes and implementation of the plan will be reviewed in POCC Responsibility: Director of Pharmacy	4/18/16 2/15/16

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A 283	Continued from page 12 b. Review of the Infection control minutes dated July 2014 through February 2016 and interview with the CNO on 3/3/16 at 1:30 PM failed to identify that a comprehensive mechanism was in place to identify and monitor potential infections in the compounding area of the pharmacy. Further review of the infection control meeting minutes failed to reflect that the facility analyzed the environmental testing that was conducted to determine implementation of appropriate interventions to prevent and control communicable disease. The minutes failed to reflect that surveillance rounds were conducted in the compounding area of the hospital and/or that other departments and specialty areas collaborated regarding adherence to the USP 797 guidelines and compliance with Pharmacy policies. Interview with the Infection Control Nurse and the Infectious Disease physician on 3/3/15 indicated he/she had heard of patient safety issues with compounding however were not aware of USP 797 guidelines and all of the criteria and/or elements required to ensure compliance with the law. Further interview with the CNO indicated the meeting minutes from P&T and Infection control are then brought for review to the Quality Assurance Committee. c. Review of the Quality Assurance Committee Minutes dated July 2014 through February 2016 and Interview with the CNO on 3/3/16 at 2:00 PM failed to identify that concerns regarding contracted services was discussed. The CNO indicated the meeting minutes from the Quality Assurance Committee are then brought to the Medical Executive Committee. d. Review of the Medical Executive Committee Minutes and	A 283	b. The infection control committee was apprised of survey findings. Environmental sampling required to meet CETA, USP 797 guidelines was reviewed. The annual IC Plan will be reviewed, revised and approved through the IC committee and GB Pharmacy policies related to USP 797 have been reviewed. Any developed or revised policies will be reviewed and approved at P&T. A list of updated surveillance activities will be reviewed and approved. All of the activities, plans, policies will be reviewed and approved by the committee then sent to GB for same at the next GB meeting. Responsibilities of the IC Nurse will be updated to include increased surveillance in the pharmacy. Standing agenda items will be added to the Infection Control Meeting pertaining to USP 797. Appropriate staff will be trained on the revised policies, surveillance activities, reporting requirements. Infection Control EOC audits will be reported through QAPI. Responsibility: CQO c. Notification of any concerns regarding services provided by contracted services will be reported to QAPI and then to the GB by the CEO, CQO, or CNO; concerns are reflected in the annual evaluation of contracted services. Responsibility: CEO	2/25/16 04/18/16

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A283	Continued from page 13 interview with the CNO on 3/316 at 2:20 PM lacked documentation to support a review of concerns identified in the compounding area of the pharmacy that were discussed for disposition. e. Review of the Governing Body Minutes and interview with the CEO on 3/3/16 at 3:00 PM identified that all of the aforementioned subcommittee minutes are compiled into a binder prior to the governing body meeting that is held every other month for all members to review. The CEO indicated he did not have knowledge of the USP 797 law that was enforceable in July of 2014 therefore he did not inquire or recognize elements of USP 797 that were not conducted. The CEO identified the pharmacy was a contracted service and he expected to be informed of USP 797 regulations through the employees of the contract so that he could ensure compliance.	A 283	A POCC will be formed at the recommendation of the GB for direct oversight of the PoC, particularly for the purpose of facilitating the flow of information described in the PoC. The GB will be updated monthly and ad hoc. POCC will report to the IC, P&T, and Quality Committees monthly and ad hoc as needed. Minutes will be presented to the GB for review and approval. Direct oversight of POCC communication to the GB by CNO, chair. Meetings are held monthly at minimum and ongoing for a minimum of a year The Director of Pharmacy will review the Condition of Participation Pharmaceutical Services. The job description and responsibilities of the Director of Pharmacy and hospital policy "Scope of Pharmacy Services" will be reviewed with the Director. "Provision of Patient Care and Services" Plan will be reviewed and revised; Quality Committee and GB will approve. Hospital management will review to re-educate on responsibilities of contracted services.	4/4/16 4/18/16
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This STANDARD is not met as evidenced by: Based on observation, a review of hospital documentation, contractor reports, interviews, and policies. It was determined that the hospital failed to meet the Condition of Participation for Pharmaceutical Services as evidenced by:	A 490	A standing agenda item will be added to the GB agenda to ensure contracted services are reviewed and remain in compliance and reported on monthly at the IC, P&T, POCC and Quality Committees. Minutes will be presented to the GB for review and approval. Director of Pharmacy continues to review pharmacy policies and make appropriate revisions according to nationally recognized standards of practice. All pharmacy personnel will review policies related to USP797 gguidelines.. Responsibility: CNO	

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A 490	Continued from page 14 1. The hospital failed to ensure that the pharmacy Director (Contractor #2) effectively supervised the day to day operations of the Pharmacy Department as evidenced by failure to follow policy/procedures, failure to ensure environmental sampling and certification of the isolators were comprehensive, failure to compound medications in a sanitary environment and/or maintain compliance with federal and state laws (USP-797). Please refer to A-492 and A-501	A 490	All pharmacy personnel were re-trained related to sterile compounding, the requirements, regulations, and reporting. Competencies related to compounding will be completed by pharmacy personnel at time of hire and annually A list of required education and personnel required to have the education will be developed. Monitoring of these processes will be added to the PoC evaluation sheet. This surveillance will be initiated with the first POCC meeting scheduled for 4/4/16 and will continue until the POCC feels the process has been adequately implemented.	3/24/16 4/18/16
a 492	482.25(a)(1) PHARMACIST RESPONSIBILITIES A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contractor reports, interviews, and policy review, the hospital failed to provide the necessary supervision of Pharmacy services to ensure that the isolators where intravenous compounding was performed was tested/certified and/or tat environmental testing was conducted in accordance with Federal and/or state laws,United States Pharmacopeia, Chapter 797, Pharmaceutical Compounding (USP-797). The findings were: Cross reference A-501 During tour of the pharmacy on 2/9/16 at 10:00 am with the Interim Director of Pharmacy, the CNO, and pharmacist #1 it was identified that the compounding area was under construction and	A 492	The Director of Pharmacy will be re-trained related to sterile compounding, the requirements, regulations, and reporting. Competencies related to compounding will be completed by pharmacy personnel at time of hire and annually. Responsibility: CQO a. The job description and responsibilities of the Director of Pharmacy and hospital policy "Scope of Pharmacy Services" will be reviewed with the Director. The above information will be added to the orientation process of the new director. Under the direction of the Director of Pharmacy, clutter was removed by pharmacy staff. A line of demarcation was placed on floor around isolator as a perimeter identification, differentiating clean vs. dirty area. Pharmacy staff reviewed policy Sterile Preparation for principals and operational use of the line. The policy was added to new hire and annual training. Subsequent to the survey findings, steps were immediately taken to clean the isolator and the environment. The room was appropriately cleaned and isolator was terminally cleaned. All pharmacy personnel completed competency re-training to the concepts of cleaning per USP 797 guidelines.	3/24/16

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	President & CEO	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 Hospital Hill, PO Box 789, Sharon, CT 06069

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	Continued from page 15	A 492	a. (cont) Training consisted of policy review "Sterile Preparations: Segregated Compounding & Cleaning and Disinfecting the Sterile Compounding Areas"and observed technique for validation. Going forward, competency will be completed at time of hire, annually, and anytime there is a threat of break in technique/procedure. Director of Pharmacy will maintain documentation that competency training was completed and will report to POCC.	3/24/16
A 492	the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was in a staff break room hat as observed to be cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins Iron Oxide, and Ranitidine. The hospital policy entitled Sterile Preparations dated January 2014: Segregated Compounding Area directed in part that the pharmacy would compound sterile preparations in a segregated compounding area which meets the requirements of USP 797. he hospital policy entitled Sterile Preparation: Cleaning and Disinfecting the Sterile Compounding Areas dated January 2014 directed in part that sterile preparation areas and segregated compounding areas would be cleaned monthly to include floors, walls, shelving, and ceilings. b. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of reports completed by Company #1 (contracted service who provides certification for the facilities isolator) dated 1/4/16 failed to identify that an airflow smoke pattern test was conducted and/or a preparation ingress and egress test was completed and/or particle testing was conducted under dynamic condition in the		EVS personnel completed competency training related to cleaning per USP 797 guidelines. Training included observation of cleaning technique for validation. Going forward, competency will be completed at time of hire, annually, and anytime there is a threat or break in technique/procedure. EVS Supervisor maintains documentation that competency training was completed and reports competency completion to POCC. A cleaning log was developed to track all cleaning; it will be reviewed by the Pharmacist and ENV manager daily. Any deficiencies noted will be reviewed face to face with appropriate personnel and reported to the POCC chair; the POCC will report findings to IC,P&T, Quality and GB monthly and at ad hoc as the need arises. Director of Pharmacy will have daily oversight of pharmacy for maintenance of sanitary environment. The EVS Manager will monitor for EVS cleaning compliance. The IC Nurse performs random rounding minimally 3 times weekly to monitor for compliance and will report findings at monthly IC meetings. Any deficiencies noted will be reviewed face to face with appropriate personnel. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility CNO	2/15/16 2/15/16 3/2/16

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A 492	Continued from page 16 antechamber in accordance with USP 797. c. Further review of the reports indicated that certification testing of the non-chemo isolator failed to be completed in July 2015 and had not been conducted since February 2015. The hospital policy entitled Sterile Preparation: Sterile Compounding Area directed in part that the sterile compounding facility shall be checked for operational efficiency by a qualified certifier at least once every six months. d. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non-chemo isolators. The chemo isolator identified one (1) area that was sampled and in the non-chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. The hospital policy entitled Sterile Preparation: Environmental Monitoring Viable dated January 2014 directed in part that an environmental sampling plan would be in place to detect airborne viable particles based on a risk assessment of activities performed. Locations would include those prone to contamination during compounding activities such as staging, labeling, gowning, and cleaning. e. Review of the surface environment reports from July 2014	A 492	c. Director of Pharmacy is reviewing pharmacy policies related to USP 797 requirements and revising as needed aligning with state and federal law. Pharmacy personnel is responsible to review policies related to USP 797 requirements. Pharmacy personnel were retrained on practice/procedures included in Sterile Preparation: Sterile Compounding area, Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Training began 3/29/16. Responsibility: Director of Pharmacy d. Surface sampling is performed monthly by the Director of Pharmacy with hospital lab completing testing; if speciation and/or genus level cannot be provided the sample will be sent to an outside agency for speciation. Bi-annual testing will be performed by the contracted service as part of the full CETA certification testing. Testing and compliance monitoring is under the direction of the pharmacy director with oversight by the CNO. The IC RN will collaborate with Infectious Disease physician collectively with Director of Pharmacy to determine action plan for positive growth when applicable. Following an actionable positive culture per USP 797 guidelines, CT Drug Control will be notified and appropriate action taken. All positive and/or negative results, updates and/or issues related to action levels above those listed in USP 797 will be reported to the IC, P&T, POCC and Quality Committees. Minutes will go to the GB for review and approval at least monthly. To ensure a comprehensive sampling of the non-chemo isolator , the pharmacy procedure "Viable Air Sampling" was revised to increase the sampling area to include those areas prone to contamination during compounding activities & will be brought to P&T for review; a full CETA certification sampling was completed 2/27/16 Competencies and training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility: CNO	4/18/16

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	Continued from page 17		e. (cont) Under the direction of the Director of Pharmacy, the isolator will immediately be shut down for microorganisms that exceed a threshold in accordance with USP 797, the isolator and room will be cleaned per policy. The Director of Pharmacy will determine the time the isolator can go back into use per policy. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor	2/15/16
A 492	through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non-chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15. absent speciation and/or colony forming units (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. Although terminal clean was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed and the staff was never trained to conduct terminal cleaning. The hospital policy entitled Sterile Preparation: Competency for Pharmacy personnel dated January 2014 directed in part that surface sampling test that revealed colony forming units above the established threshold would be evaluated by Infection Control. The hospital policy entitled Sterile Preparation: Environmental Monitoring Viable dated January 2014 directed in part that any CFU count that exceeds its respective action level should prompt a re-evaluation of the adequacy of personnel work practices, cleaning procedures, operational procedures and air filtration efficiency within the aseptic compounding location. Any CFU should be identified to at least a genus level. f. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:45 AM stated he had only been in the role for one (1) month therefore had not reviewed any of these reports. The hospital policy entitled Sterile Preparation: Quality Control		The IC RN will collaborate with ID physician collectively with Director of Pharmacy to determine action plan for positive growth when applicable. Following an actionable positive culture, CT Drug Control will be notified and appropriate action taken. All positive and/or negative results, updates and/or issues related to action levels above those listed in USP 797 will be reported at IC, P&T, Quality, POCC and GB. Responsibility: Director of Pharmacy. f. As part of the bi-annual comprehensive CETA certification testing is completed minimally every six months, with subsequent dates pre-scheduled to maintain timely testing compliance. Comprehensive CETA testing completed on 2/27/16 and next testing scheduled for 8/2106. Scheduling and compliance monitoring of pharmacy compounding personnel is under the direction of the pharmacy director The IC Nurse, CQO, and Facilities Supervisor revised surveillance monitoring tools utilized during monthly environment of care rounds. Revisions were based on survey deficiencies. The pharmacy area will be rounded on monthly. A formalized surveillance will review deficiencies cited. A summary of findings are reported at time of rounding face to face with Director of Pharmacy, at bi-monthly Safety Committee meetings, POCC and up the the GB. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair and co-chair. Responsibility: CNO.	2/27/16 2/1/16

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	Continued from page 18		f. (cont) The hospital has a Quality Committee and completes an annual Quality Improvement Plan and Evaluation. Both are presented to the	2016 Plan approved by
A 492	and Quality Assurance dated January 2014 directed in part that semiannual certification of non viable and viable environmental monitoring of all ISO 5 and segregated compounding areas would be conducted.	A 492	Quality Committee and GB for review and approval annually. The Quality Committee's plan for QAPI is the patient safety and performance improvement plan; it is equivalent to the QAPI nomenclature used by CMS.	GB 3/22/16
	Interview with the Interim Director of Pharmacy on 2/9/16 at 10:45 AM stated he had only been in his role for one (1) month therefore had not reviewed any of these reports. The Interim Director of Pharmacy further identified he was aware of USP 797 guidelines however did not inquire about the hospital's compliance and was not aware of the mechanical or environment testing that was conducted or any other elements that were necessary to be compliant with USP 797.		Increased environmental surveillance and formalized indicators for areas cited will be added to the 2016 Quality Improvement Plan then presented to the Quality Committee and GB for analysis, recommendations, and approval.	4/18/16
	Review of the aforementioned reports with the CNO on 3/3/16 at 11:45 AM identified that the prior pharmacy director handled the testing and/or reports as part of the directors responsibility.		USP 797 will be added as a standing agenda item to be reported monthly at IC, P&T, Quality Committee Meetings, POCC and to the GB on at least a bi-monthly basis for final review and approval. The annual Infection Control Risk Assessment surveillance tool will be revised to include surveillance and formalized indicators for areas cited. The revised tool will be presented to the IC Committee for analysis, recommendations, and approval. The CNO is responsible for oversight of revisions of the Quality Improvement Plan and IC Plan and reporting at each meeting and up to the GB.	
	g. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM stated although he was aware that the room needed to be monitored he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed that quality control practices in part would include daily documentation of temperature in areas where sterile products or sterile preparations are stored or compounded.		g. A temporary thermometer was installed to maintain temperature ranges to meet USP 797 requirements. It was replaced with a permanent electronic thermometer . 02/23/16 . A log to monitor daily temperatures was initiated 2/12/16. Pharmacy management completed competency training 2/24/16. Policy will be developed/implemented including system alarm Competencies and training are completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. The CNO will report any deficiencies to the GB at least monthly Responsibility: CNO	2/23/16 4/18/16

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	Continued from page 19		The Director of Pharmacy was oriented to the hospital and pharmacy.	1/12/16
A 492	h. The Interim Director of Pharmacy failed to identify that pressures within the isolator were monitored to ensure the required ISO classification was maintained in accordance with manufacturer guidelines and/or USP 797. Interview with Interim Director of Pharmacy on 2/9/16 at 10:35 AM stated although he was aware the isolator needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: Quality Control and Quality Assurance dated January 2014 directed that quality control practices in part would include daily pressure differential or airflow between the buffer and ante-area and the general environment outside the compounding area. i. The Interim Director of Pharmacy failed to identify that humidity levels were monitored in the room where medications were compounded/stored in accordance with USP 797. Interview with Interim Director of Pharmacy on 2/9/16 at 10:40 AM stated stated although he was aware that humidity levels needed to be monitored, he had only been in the facility for one month and did not have the opportunity to review all systems in place. The hospital policy entitled Sterile Preparations: General directed in part that the Director of Pharmacy shall ensure the sterility and integrity of sterile preparations compounded by the pharmacy department, and oversee the policies and procedures for compounded sterile preparations throughout the hospital. The job description for the Director of Pharmacy, in part, included to plan, organize, and direct all functions of the hospital pharmacy services. To ensure compliance with all state, local, and federal regulations. Establish standards/training for sterile	A 492	All pharmacy policies will be reviewed by the Director of Pharmacy and appropriate revisions made according to nationally recognized standards of practice as needed. The Director of Pharmacy will review the Condition of Participation- Pharmacy and provided education and training to all appropriate pharmacy staff; reviewed the CETA requirements and USP 797 requirements; reviewed all of the required surveillance activity and the reporting structure. The Director of Pharmacy was re-trained related to sterile compounding, the requirements, regulations, and reporting. A competency related to compounding will be added to the Director of pharmacy required orientation. The Director of pharmacy will be required to complete the compounding competency annually. The above information was added to the Director of Pharmacy orientation and departmental training. The above requirements will be reviewed as part of the annual evaluation of the Director of Pharmacy. The Director of Pharmacy will receive education as to the management & oversight of the pharmacy staff and the requirements for training, cleaning, and operation. Director of Pharmacy is reviewing & revising as appropriate all pharmacy policies related to USP 797 requirements to align with state and federal law surrounding USP 797. Pharmacy personnel are responsible to review pharmacy policies related to USP 797 requirements. All appropriate pharmacy staff were retrained on maintenance of sanitary environment, maintenance of compounding areas, and maintenance and operation of isolator. Director of Pharmacy will maintain supporting documentation of policy review. Competencies and training are completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility: CNO	4/18/16

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	Continued from page 20		1. a. Director of Pharmacy is reviewing pharmacy policies and procedures related to survey findings and any revisions will be approved through P&T. Pharmacy personnel will review pharmacy policies and procedures. In addition, policy review will occur at time of hire and annually. Director of Pharmacy will maintain supporting documentation of policy review. EVS and Pharmacy personnel completed competency training related to cleaning consisting of policy review and observed technique for validation. Going forward, competency will be completed at time of hire, annually, and anytime there is a threat of break in technique/procedure. After the exit conference, steps were immediately taken to mitigate risks where medication preparation is conducted. The room was cleaned and appropriate demarcation lines were placed. All appropriate staff were trained related to appropriate cleaning and maintenance of the segregated compounding room and isolator. A policy will be developed including the appropriate steps to be taken to ensure the room is cleaned on a routine schedule. All appropriate staff will be oriented to all updated and reviewed policies and procedures. This information will also be added to departmental orientation as well as annual training. Daily cleaning of segregated compounding room by EVS staff began on 02/15/2016 and continues daily. Daily EVS cleaning log was developed to monitor compliance. Competencies and training are completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and reported to POCC chair. Responsibility: CNO	04/18/16
A 492	product preparation. To participate in the P&T committee assuring all pertinent information was communicated. To train and develop staff and ensure competency of designated staff on proper use of equipment and skills. 482.25(b)(1) PHARMACIST SUPERVISION OF SERVICES	A 492		
A 501	All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, interviews, and policy review, the hospital, who compounds sterile pharmaceuticals, failed to maintain a sanitary environment and/or that staff competencies were conducted in accordance with hospital policies. The findings included: 1. During the tour of the Pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy and CNO, the following concerns were identified: a. A non-chemo isolator was observed in a room cluttered with kitchen and office supplies including the counter tops where intravenous bags were placed after compounding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview and review of the cleaning logs on 2/9/16 with Pharmacist #1 indicated although daily cleaning of the isolator was completed, terminal cleaning was not conducted in the break room since the isolator was re-located on 1/6/16 in accordance with Pharmacist #1 identified staff were not trained to conduct	A 501		

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	Continued from page 21		1. (continued) A review of the ASHP was completed by the hospital leadership. The hospital leadership believes drug control, the	4/18/16
A 501	terminal cleaning. Interview with the Interim Director of Pharmacy (contractor #2) on 2/9/16 at 10:10 AM stated medications compounded in this isolator included but was not limited to Insulin drip, Thiamine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide, and Ranitdine. The hospital policy entitled Sterile Preparations: Cleaning and Disinfecting the Sterile Compounding Areas dated January 2014 directed in part that sterile preparation areas and segregated compounding areas would be cleaned monthly to include the floors, walls, shelving, and ceilings. The pharmacies policies failed to identify that a line of demarcation was necessary to differentiate dirty from clean. b. On 2/9/1 at 1:00 PM, Pharmacy Technician #2 was observed with long fingernails, and was wearing nail polish and jewelry. The technician washed her hands then proceeded to compound an IV medication. The Technician failed to clean beneath her nails and/or remove jewelry and/or remove nail polish prior to compounding in accordance with facility policy and/or USP 797 guidelines. The hospital policy entitled Sterile Preparation: General dated November 2014 directed in part that personnel working in the sterile compounding area shall keep their nails neat and trimmed, however, failed to include all components to ensure safe compounding. c. Further observation of Pharmacy Technician #2 on 2/9/16 at 1:00 PM identified she placed the intravenous solutions and medications n the antechamber of the isolator and immediately opened the isolator and placed the compounding items into the	A 501	procurement, distribution, and control of all drugs used within the hospital is among the pharmacist's most important responsibilities. The job description and responsibilities of the Director of Pharmacy and hospital policy "Scope of Pharmacy Services" will be reviewed with the Director. Staffing patterns were reviewed to ensure the pharmacy has adequate staffing and oversight to carry out the service in a safe and effective manner. Pharmacy scope of services as well as pharmacy policies will be reviewed by appropriate pharmacy personnel. Policy review will be added to new hire and annual competency training. Compounding competencies for all appropriate pharmacy personnel have been conducted in accordance with USP 797, CETA , State and Federal regulation. Competency was added to new hire and annual competency training. Surveillance of compounding is conducted by Director of Pharmacy randomly to ensure compliance of state and federal regulations. Compliance will be reported to IC, P&T, Quality, POCC, and GB. Director of Pharmacy will maintain supporting documentation of policy review. Demarcation signage was posted and staff educated on line of demarcation beginning February 9, 2016. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the Pharmacy Director or assigned supervisor and reported to the POCC chair Responsibility: CNO	2/18/16 04/18/16 2/9/16

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	Continued from page 22			
A 501	main chamber. Interview with Pharmacy Technician #2 indicated she was not aware that a waiting time was necessary to return conditions to ISO 5 prior to the initiation of compounding. Subsequent to the observation the Interim Director of Pharmacy identified per manufacturers guidelines a five (5) minute waiting time was needed to return to an ISO 5 condition and placed a clock in the room to ensure compliance. The hospital policy entitled Sterile Preparations: Sterile Compounding Area dated January 2014 in part directed that the isolator shall maintain ISO class 5 conditions, including transferring ingredients, components, and devices into and out of the isolator and during preparation of mediations that are compounded. d. Interview with the Interim Director of Pharmacy on 2/9/16 at 1:15 PM identified although written competencies were conducted yearly for the staff that compounded medications, observations where not conducted to ensure aseptic techniques and practices in accordance with USP 797 and should have been. The hospital policy entitled Sterile Preparations: Quality control and Quality Assurance dated January 2014 directed in part that initial and annual competency documentation of personnel would include hand hygiene and garbing. e. Interview and review of the finger-tip testing with Pharmacist #1 on 2/9/16 identified testing was not conducted in 2015 and should have been completed yearly. Subsequent to the surveyors inquiry finger-tip testing of the pharmacy staff was initiated. The hospital policy entitled Sterile Preparations: Quality control and Quality Assurance dated January 2014 directed in part that initial and annual competency documentation of personnel would include glove fingertip sampling.	A 501	Increased surveillance and formalized indicators for areas cited will be added to the 2016 Quality Improvement Plan. The information will be presented in the Quality Committee and GB for review and approval annually and ad hoc with revisions. POCC reporting will be added as a standing agenda item to be reported monthly at IC, P&T, Quality Committee Meetings and to the GB for final review and approval. The Infection Control Plan will be revised to include formalized indicators for areas cited. The revised plan will be presented to the IC Committee for analysis, recommendations, and approval. The CQO is responsible for oversight of revisions of the Quality Improvement Plan and Infection Control Plan and reporting at each meeting and up to the GB on least a bi-monthly basis. General orientation is attended by appropriate contracted personnel at time of hire. Subsequent competency education training is performed at intervals specified by the contracted service with direct oversight by the CEO. Competencies and training are completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the Director of Pharmacy or assigned supervisor and POCC chair. Director of Pharmacy will maintain documentation of hospital general orientation attendance. Responsibility: CNO	4/18/16

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	President & CEO	4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 700	Continued from page 23 482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITON was not met as evidenced by: The facility failed to ensure that the condition of the physical plant and overall hospital environment was developed and maintained in a manner that provides an acceptable level of safety and well-being of patients, staff, and visitors based upon a tour of the Main Pharmacy on 2/10/16.	A 700	A policy will be developed to define a formalized process related to hospital construction and room re-purposing. The policy will comply with licensure regulations. The policy will be reviewed by hospital leadership and approved by POCC, Safety Committee and GB. The Safety Management Plan was presented to the Safety Committee 12/21/15 and GB 3/22/16 for review and approval. Any changes made to the plan after re-review pertaining to CoP will be reviewed and approved at Safety Committee and GB. Increased surveillance and formalized indicators for areas cited will be added to the 2016 Safety Management Plan. The indicators will be reviewed through the Safety Committee, the POCC and GB for review and approval. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and reported to the POCC chair.	04/18/16
A 701	Please refer to A-701 and A-724 482.41(a) MAINTENANCE OF PHSYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Based on tour of the Pharmacy, interviews, and policy review, the Hospital failed to maintain the overall hospital environment in such a manner that the safety and well-being of patients are assured. The findings include the following: On 2/10/16, the surveyor, accompanied by the Supervisor of Engineering and Property, observed the following: a. The facility installed into service a temporary medication	A 701	Responsibility: CNO	

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	Continued from page 24		a.,b.,c.,d.	
A 701	compounding room within the Main Pharmacy employee "break room" without first submitting a stamped set of architectural drawings for review and obtaining approvals from the Connecticut Department of Public Health detailing building construction equipment installed in the space. b. The facility installed a fume hood designed to be utilized for the mixing of pharmaceutical medications in an employee "break room" that also contained a coffee maker, food products, personal belonging, a microwave oven, filing cabinets, and unsecured electrical power distribution panels c. The facility failed to provide pharmaceutical staff the mixes and handles medications with an area within the break room in proximity to the fume hood to safely process, handle, and store medications. d. The facility constructed a new medication compounding room within the main Pharmacy that contained a new medication compounding hod with associated HVAC ductwork, room pressurization, monitoring equipment without first submitting a stamped set of architectural drawings detailing building construction, equipment installed in the space without obtaining an approval from the Connecticut Department of Public Health. e. Continued tour of the room where the isolator was located with the Interim Director of Pharmacy (contractor #2) on 2/9/16 failed to identify that the room had a thermostat to ensure the temperature of the room was maintained within an acceptable range to compound medications. Interview with the Interim Director of Pharmacy on 2/9/16 at 10:30 AM stated although he was aware that the room needed to be monitored he had only	A 701	A policy will be developed to define a formalized process related to hospital construction and room re-purposing. The policy will comply with licensure regulations. The policy will be reviewed by hospital leadership and approved by POCC, Safety Committee and GB. e. Policies related to pharmacy operations and environment will be reviewed, revised and implemented. All appropriate staff will be re-educated. The education will be added to new hire and annual competency training. Pharmacy environmental check lists were developed. All appropriate staff were re-educated. Education will be added to new hire and annual competency training. POCC will review all monitoring and surveillance related to the specific corrective actions via the developed reporting template. Reporting template data will be added as a standing agenda item on IC, P&T, Quality and GB agendas. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and reported to the POCC chair. Responsibility: CNO	4/18/16

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	Continued from page 26	A 724	a. A policy will be developed to define a formalized process related to hospital construction and room re-purposing. The policy will comply with licensure regulations. The policy will be reviewed by hospital leadership and approved by POCC, Safety Committee and GB.	04/18/16
A 724	This STANDARD was not met as evidenced by: The hospital failed to ensure that adequate provisions to ensure the availability and reliability of equipment needed for its operations and services was provided based upon observations conducted within the Main Pharmacy on 2/10/16. These observations include: a. The facility constructed a new medication compounding room within the Main Pharmacy that contained a new medication compounding hood with associated HVAC ductwork, room pressurization monitoring equipment, and electrical equipment without first submitting a stamped set of architectural drawings detailing building construction, equipment installed in the space without obtaining an approval from the Connecticut Department of Public Health.	A747	The Infection Control Plan will be revised to include formalized indicators for areas cited. The revised surveillance tool will be presented to the IC Committee for review and approval. IC policies pertaining to pharmacy will be reviewed, revised as necessary, and approved at IC and brought to the GB for review and approval. IC policies will be reviewed by pharmacy personnel. Pharmacy IC policy review will be added to new hire and annual competency training. General hospital orientation includes IC education for newly hired staff and IC education is a part of annual competency training as well. The IC Committee will be apprised of the survey findings. POCC reporting and the Pharmacy reporting template will be a standing item on the IC agenda. The IC Nurse and IC committee will be educated related to USP797 standards. Competencies and training will be completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor. Responsibility: CNO	
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigations of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, it was determined that the hospital failed to meet the Conditions of Participation for Infection Control as evidenced by: 1. The hospital failed to ensure that the Infection Control program was comprehensive to include high risk areas including			

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	Continued from page 27		The Infection Control Nurse and ID physician will review the CETA, USP 797, and the infection control condition of participation.	04/18/16
A 747	surveillance of the hospital's pharmacy. Please refer to A-749	A 747	The IC Committee will be educated on CETA, USP 797, and survey statement of deficiency findings.	
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The Infection Control officer or offices must develop a system for identifying, reporting, investigating, and controlling inflections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, review of facility documentation, contracted service reports, interviews, and policy review, the hospital failed to ensure the Infection Control program evaluated and monitored the presence of "growth" identified during environmental testing at the hospital pharmacy to establish a plan of surveillance to maintain a safe environment. The findings include the following: Cross reference A-492 a. During the tour of the pharmacy on 2/9/16 at 10:00 AM with the Interim Director of Pharmacy, the CNO, and Pharmacist #1 it was identiifed that the ocmpounding area was under construction and the non-chemo isolator was moved into the staff break room on 1/6/16 per interview. The non-chemo isolator was relocated iin a staff break room that was observed to be cluttered with kitchen and office supplies including counter tops where intravenous bags were placed after compunding was completed. Dust was also visible throughout the room. A line of demarcation that differentiated dirty from clean was absent. Interview with the Interim Director of Pharmacy (contractor #2) on2/9/16 at 10:10 AM stated medications compounded in this isolator included but	A 749	The IC Plan will be revised to include formalized indicators for areas cited. The revised plan will be presented to the IC Committee for review and approval. Cleaning policies for the pharmacy will be reviewed, approved and implemented. A policy was developed for cleaning regimen; appropriate staff will review the policy and will be trained according to the revised cleaning regimen; training includes observation for validation. This training and competency will be added to new hire and annual training. The environmental monitoring tool will be reviewed and approved through the IC Committee. All monitoring and findings will be presented to the IC committee, P&T, POCC and GB for a minimum of one year or until the deficiencies identified by the Department of Public Health have been corrected. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and reported to the POCC chair and co-chair. Responsibility: CNO	

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A 749	Continued from page 28 was not limited to Insulin drip, Thaimine, Epinephrine, Diltiazem, Vancomycin, Zosyn, Multivitamins, Iron Oxide, and Ranitidine Interview with the Infection Control Nurse on 3/3/16 at 11:15 AM indicated she assumed the role of Infection Control Nurse in July 2015. The Infection Control nurse stated she was not included in the decision to move the isolator prior to the initiation of construction and does not conduct surveillance rounds of the pharmacy. b. On 7/1/14, USP 797 requirements were enforceable for Connecticut hospitals. Subsequent to that date, a copy of the certification reports for the IV compounding room was requested. Review of the environmental reports completed by the hospital during the period of July 2014 through February 2016 failed to identify that comprehensive surface sampling was conducted within the chemo and non chemo isolators. The chmo isolator identified one (1) area that was sampled and in the non chemo isolator, three (3) areas were sampled. Sampling was absent in the ante chambers of both isolators. The facility was unable to provide a risk assessment to determine what the hospitals comprehensive sampling should entail. Review of the surface environmental reports from July 2014 through February 2016 indicated that the chemo isolator identified growth on 7/31/14. In the non chemo isolator growth was identified on site #3 on 9/29/15 and 11/13/15 absent speciation and/or colony forming units (CFU) to ascertain if a microorganism has exceeded a threshold in accordance with USP 797. although terminal cleaning was listed as the action plan, interviews with Pharmacist #1 and Pharmacy Technician #1 indicated that only daily cleaning of the isolator was completed	A 749	The IC Nurse, CQO, and Facilities Supervisor revised surveillance monitoring tools utilized during monthly environment of care rounds which are conducted throughout the hospital on a rotating basis; revisions were based on survey deficiencies. Pharmacy area will be rounded on monthly for a minimum of one year. A summary of findings will be reported face to face during rounds to the Director of Pharmacy and at bi-monthly Safety Committee, IC, P&T, POCC and Quality Committees. Minutes will be presented to the GB for review and approval. IC Nurse will review IC job responsibilities and requirements of CETA, USP 797,and CoP Infection Control. IC Nurse will review policies entitled Sterile Preparations: Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Staff. IC will add USP 797 as a standing agenda item for discussion monthly. IC monitoring and surveillance of deficiencies will be discussed at the monthly IC meeting and reported up though the GB. IC Policies related to deficiencies cited will be reviewed and revised, and presented to IC Committee for analysis, recommendations, and approval. To maintain current with standards and practice, the IC Nurse attends CT DPH and hospital QIO conferences and webinars, utilizes resources such as NHSN, APIC, JC, CDC for best practices, collaborates with hospital Infectious Disease physician, chairs IC collaborative within (8) hospital system and IC peers within state of CT. Most recently attended CT DPH HAI Regional Training course, 3/30/16. Scheduled to attend APIC Infection Preventionist (7) day course 9/2016. Competencies and training are completed at time of hire and annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor. Responsibility: CNO	4/18/16 4/18/16 On-going

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A 749	Continued from page 29 and the staff was never trained to conduct terminal cleaning. Further review of the environmental testing dated July of 2014 through February 2016 failed to identify that air sampling was conducted within the isolators in accordance with USP 797. Review of the Infection Control meeting minutes dated 8/27/15 and interview with the Infection Control nurse on 3/3/16 at 11:15 AM stated environmental cultures identified as "no growth". The meeting minutes dates 10/29/15 indicated the environmental cultures identified "growth" and cleaning was conducted. Further review of the minutes and interview with the Infection control nurse and CNO identified they were in attendance of the Infection control meetings however were not involved in the results or analysis of the information as they felt is was the responsibility of the pharmacist. Interview with the Infectious Disease Physician on 3/316 indicated he was aware of patient safety issues with intravenous compounding however was unaware of USP 797 guidelines and all of the criteria and/or elements required to ensure compliance with the law. Further interview with the Infectious disease Physician indicated it would be important to obtain comprehensive environment sampling within the isolator to identify specific microorganisms and that he should be consulted for analysis and interpretation of the testing to determine appropriate interventions for remediation. 2. Based on a tour of the facility, review of the facility policies, observations, and interviews, the facility failed to ensure that facility infection control practices were followed. The findings include the following:	A 749	The Infectious Disease (ID) physician works collaboratively with the IC Nurse; chairs the IC monthly meeting. UPS 797 was added to the IC monthly agenda to keep committee up to date with updates, concerns, changes in state and/or federal law for USP 797. Infection Control policies "Cleaning of High Risk Areas", Infection Prevention & Control in Pharmacy", and "Infection Prevention & Control Monitoring and Evaluation Reporting" will be reviewed and revised, approved through IC Committee, chaired by ID Physician. ID physician will review policies entitled Sterile Preparations: Cleaning and Disinfecting the Sterile Compounding Area, Quality Control and Quality Assurance, Environmental Monitoring and Competency for the Pharmacy Staff. Reports from CETA certification contractor will be sent directly to ID physician for review of culture reports. ID physician, IC Nurse and Director of Pharmacy will work collaboratively when positive results are reported. Actionable CFU's as outlined by USP 797 regulations will be reported to CT Drug Control Agent and then ID physician, IC Nurse and Director of Phamacy will collaboratively develop plan until issue is resolved. Progression of actionable items will be reported to IC, P&T, POCC and Quality Committees. Minutes will be presented to the GB for review and approval. Competencies and training are completed at time of hire, annually. Non adherence to the AP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and POCC chair. Responsibility: CNO	4/18/16

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A 749	Continued from page 30 a. during a tour of the OR with the OR Director on 2/9/16 at 10:56 AM a surgical case was being performed in OR #3. further observation at this time identified that the male scrub nurse had donned a mask and facial hair was exposed under the chin and at the sides of the face. Interview with the OR Director on 2/9/16 at 10:56 AM noted that the facility followed the Association of Peri-operative Registered Nurses (AORN) regarding OR attire. The facility policy for surgical attire identified that complete hair coverage is necessary in restricted areas (OR). b. Patient #27 was admitted to the ED on 3/4/16 with a diagnosis of overdose. Observation on 3/3/16 at 2:10 PM identified the RN obtained blood from a finger on the patient's left hand, placed the strip with the patient's blood in the glucometer, and sanitized the glucometer with 70% alcohol pad after use. The facility policy for maintenance of the glucometer (Precison Exceed Pro Glucometer) identified to clean the meter with alcohol or ammonia solution for decontamination. According to the Association for Professionals in Infection control and Epidemiology (EPIC) 2014 Infection Prevention, alcohol is never an acceptable disinfectant in shared use situations. c. during a tour of the emergency department (ED) on 3/2/16 at 1:55 PM, RN #4 was observed to draw up medication into a syringe from two (2) benefit of sanitizing the rubber diaphragm with an alcohol pad. Interview with RN #4 on 3/2/16 at 1:55 PM noted that he/she believe that the rubber diaphragm was sterile when the vial was first opened. The facility policy for sterile preparations directed to prepare the vial by removing the protective caps and cleaning the port diaphragm with an alcohol pad.	A 749	The IC Nurse, CQO, and Facilities Supervisor revised surveillance monitoring tools utilized during monthly environment of care rounds which are conducted throughout the hospital on a rotating basis; revisions were based on survey deficiencies. Surgical service areas and clinical areas are rounded on quarterly. A summary of findings will be reported to the Director of Surgical Services during EOC rounds and at bi-monthly Safety Committee meetings and up to the GB. "Surgical Attire" policy will be revised to address infection control deficiencies cited. All surgical service will be educated on policy revisions. Surgical Services Director utilizes AORN to implement best practices Director of Surgical Services will monitor for compliance and report findings to POCC; POCC minutes will be reported at Quality Committee Meeting and up to the GB. Laboratory Point of Care Testing policy "Precision Xceed Pro Meter Maintenance" will be revised to address infection control deficiency cited in relation to cleaning of glucometer. Laboratory Director will complete re-education with laboratory personnel. Nursing Educator will complete re-education with nursing staff. Glucometer competency training is completed annually with laboratory and nursing staff. Director of Surgical Services will monitor for compliance and report findings to POCC; POCC minutes will be reported at Quality Committee Meeting and up to the GB. "Sterile Preparation" policy will be reviewed with nursing staff to address infection control deficiency cited. IC Nurse and CQO will monitor compliance while completing EOC rounding. Observations will be reported at bi-monthly Safety Committee meetings, and to POCC; POCC minutes are reported at Quality Committee Meeting and up to the GB. Competencies and training are completed at time of hire, annually. Non adherence to the CAP will be addressed immediately, remediation and retraining will be conducted on the spot by the assigned supervisor and reported to POCC chair. Responsibility: CNO	4/18/16

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 5, 2016

Mr. Peter Cordeau,
Sharon Hospital
50 Hospital Hill Road, PO Box 789
Sharon, CT 06069

Dear Mr. Cordeau:

On **March 30, 2016** a substantial allegation survey was concluded at Sharon Hospital. Sharon Hospital was found to be in compliance with the Medicare Conditions of Participation, 42 CFR 482.22 Medical Staff and 482.55 Emergency Services. However, standard level deficiencies were identified in the area of A1103, Integration of Emergency Services and A1112, Qualified Emergency Services Personnel.

Enclosed is the statement of deficiencies noted during the substantial allegation survey concluded on March 30, 2016. Sharon Hospital must submit to the Department of Public Health a signed and dated plan of correction by **April 19, 2016** for all the deficiencies identified in the substantial allegation survey that concluded on **March 30, 2016**. Attachments may not replace the plan of correction.

Each deficiency needs to be addressed with a prospective plan of correction that includes the following components:

- What corrective actions will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice;
- What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and
- How the facility will monitor its corrective actions to ensure the solutions are permanent. The facility must develop and implement a quality assurance tool to ensure that corrections are achieved and sustained; and
- Identify the staff member, by title, who has been designated the responsiblity for monitoring the individual plan of correction for each deficency; and
- Insert a Completion Date in appropriate column (X5).

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Please return your response to me by email at maureen.klett@ct.gov and direct your questions to Maureen H. Klett, R.N.,C., M.S.N., Facility Licensing & Investigations Section at (860) 509-7400.

Sincerely,

Maureen H. Klett, R.N.,C., M.S.N.
Supervising Nurse Consultant
Facility Licensing & Investigations Section

CT 19611

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
070004	A. BUILDING _____ B. WING _____	C 03/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 Hospital Hill Road, PO Box 789, Sharon, CT 06069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An authorized substantial allegation survey was concluded on 3/30/16 in response to complaint # CT 19611 at Sharon Hospital - 070004 50 Hospital Hill Rd. PO Box 789 Sharon, CT 06069 The following Conditions of Participation were reviewed as they pertain to the complaint: 482.22 - Medical Staff 482.55 - Emergency Services	A1103	1. The Emergency Department is integrated with other departments within the hospital. The hospital makes available the full extent of patient care resources to access and render appropriate care. Emergency Department (ED) and Clinical Resource Management (CRM) polices related to the assessment/referral/placement of psychiatric patients, crisis intervention and provision of community resources will be reviewed and revised as needed. Education will be provided to the appropriate Emergency Medical staff, Emergency Nursing Staff, Behavioral Health (SBH) Staff and Clinical Resource Management Staff. The SBH psychiatrist will attend the next ED monthly medical staff meeting to review his role and the consultative process for evaluation of psychiatric patients in the emergency department that meet senior behavioral health admission requirements following assessment by the ED medical provider. The Chief Quality Officer will develop a quick reference memo for the ED medical staff which will provide hospital and community contact resource information for psychiatric patients presenting in the emergency department that require consultations for inpatient or outpatient care, following assessment by the ED medical provider. Responsible Party: Chief Quality Officer The CRM LCSW will provide education to the ED medical staff and appropriate nursing staff on her role and process for evaluation of psychiatric patients in the emergency department that require inpatient or outpatient care, following assessment by the ED medical provider. The CRM LCSW will provide the appropriate medical and nursing staff resources which outline the placement process to follow for NY and CT psychiatric patients with and without insurance who are in need of voluntary or involuntary admission. Responsible party: CRM LCSW	5/13/16
A1103	482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES [If emergency services are provided at the hospital --] (2) The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for 2 of 10 sampled patients (Patient #1 and Patient #3), the facility failed to provide emergency psychiatric services upon dispatch by Emergency Medical Services to be transported to the hospital. The findings include: 1. Patient #1 had complaints of texting suicidal expressions to a significant other. Review of the ambulance run sheet dated 2/7/16 identified that Patient #1 denied the desire to harm self.			

11/03/2016 SHO00029

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		4/18/16

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**
This document contains a listing of deficiencies cited by the surveying State Agency (SA) or Regional Office (RO) as requiring correction. The Summary Statement of Deficiencies is based on the surveyors' professional knowledge and interpretation of Medicare and/or Medicaid or Clinical Laboratory Improvement Amendments requirements.

II. **FORM COMPLETION**
Name and Address of Facility – Indicate the name and address of the facility identified on the official certification record. When surveying multiple sites under one identification number, identify the site where a deficiency exists in the text of the deficiency under the Summary Statement of Deficiencies column.

Prefix Identification Tag – Each cited deficiency and corrective action should be preceded by the prefix identification tag (as shown to the left of the regulation in the State Operations Manual or survey report form). For example, a deficiency in Patient Test Management (493.1107) would be preceded by the appropriate D-Tag in the 3000 series. A deficiency cited in the Life Safety Code provision 2-1 (construction) would be preceded by K8. Place this appropriate identification tag in the column labeled ID Prefix Tag.

III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 070004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 Hospital Hill Road, PO Box 789, Sharon, CT 06069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1103	(Continued from page 1) EMS #1 dispatched Hospital #1 to transport the patient to the emergency department (ED). EMS #1 was diverted to Hospital #2 by MD #2, who requested the patient be sent to another hospital for psychiatric services. Hospital #2 was an additional 45 minutes away. Interview with MD #2 on 3/24/16 identified that he had diverted the patient to Hospital #2 due to the fact it was a Sunday afternoon and the patient would have to wait overnight to be seen by a psychiatrist the next morning. Review of the clinical record from Hospital #2 dated 2/7/16 identified that Patient #1 was evaluated by crisis and was sent home with outpatient services. 2. Patient #3 had complaints of suicidal thoughts. Review of the ambulance run sheet dated 12/27/15 identified that EMS #3 dispatched Hospital #1 for admission since Patient #3 had an Emergency Committal for an evaluation. MD #3 initially accepted the patient, then called back reporting they do not have the appropriate resources available. At that time, MD#2 requested that Patient #3 be transported to Hospital #2 (45 minutes away). Review of clinical record from Hospital #2 dated 12/27/15, identified that Patient #2 was evaluated by crisis and discharged on 12/2/7/15 with a disposition of depression/anxiety. Patient #3 was to follow up with outpatient psychiatric services and VNA services. Review of hospital policies identified that the hospital social worker and/or psychiatrist should be consulted on all patients to assist with a clinical assessment and disposition. Interview with MD #2 on 3/24/16 identified that patients who present to the ED on the weekend would have to wait until Monday to see a psychiatrist and/or social worker if they specific psychiatric needs. Interview with LCSW #1 on 3/24/16 identified that her hours are Monday-Friday. In addition, there is an on-call list for case management on the weekend, however she is the only person qualified to do crisis management. Further interview	A1103	(cont from page 1) The daily on-call schedule will be revised to include "Crisis Intervention". Education of revision will be provided to appropriate staff. 2. Emergency Medical Services (EMS) transporting patients to the hospital emergency department will be medically screened and evaluated by the ED medical staff. An audit will be completed to monitor compliance and reported to the Quality Committee up to the Governing Board monthly for a minimum of one year. The daily ED census will be monitored for patients that may require crisis intervention based on diagnosis. An audit will be completed for compliance with hospital policies utilizing the LCSW to provide crisis intervention and assist patients/families with accessing psychiatric services. Responsible Party: Director of Emergency Services	4/22/16 5/14/16
		A1112	1. The staffing patterns for the ED will be reviewed to ensure consistent staffing of the ED per ENA standards. Medical staff taking part in ED rotations must have privileges in emergency medicine. Competence is established by the review of mechanisms in place by the organized medical staff. The ED medical staff, ED nursing staff, SBH staff, and CRM staff will review the Provision of Patient Care and Services Plan 2016 and Scope and Conduct of Emergency Medical Care policy. Responsible Party: Director of Emergency Services 2. Emergency Department (ED) and Clinical Resource Management (CRM)polices related to the assessment/referral/placement of psychiatric patients, crisis intervention and provision of community resources will be reviewed and revised as needed. Education will be provided to the	3/30/16 5/14/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 4/18/16

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

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II. **FORM COMPLETION**
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III. **Summary Statement of Deficiencies** – Each cited deficiency should be followed by full identifying information, e.g., 493.1107(a). Each Life Safety Code deficiency should be followed by the referenced citation from the Life Safety Code and the provision number shown on the survey report form.

IV. **Plan of Correction** – In the column Plan of Correction, the statements should reflect the facility's plan for corrective action and the anticipated time of correction (an explicit date must be shown). If the action has been completed when the form is returned, the plan should indicate the date completed. The date indicated for completion of the corrective action must be appropriate to the level of the deficiency(ies).

V. **Waivers** – Waivers of other than Life Safety Code deficiencies in hospitals are by regulations specifically restricted to the RN waiver as provided in section 1861(e)(5) of the Social Security Act. The long term care regulations provide for waiver of the regulations for nursing, patient room size and number of beds per room. The regulations provide for variance of the number of beds per room for intermediate care facilities for the mentally retarded. Any other deficiency must be covered by an acceptable plan of correction. The waiver principle cannot be invoked in any other area than specified by regulation.

VI. **Waiver Asterisk(*)** – The footnote pertaining to the marking by asterisk of recommended waivers presumes an understanding that the use of waivers is specifically restricted to the regulatory items. In any event, when the asterisk is used after a deficiency statement, the CMS Regional Office should indicate in the right hand column opposite the deficiency whether or not the recommended waiver has been accepted.

VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070004	A. BUILDING _____ B. WING _____	C 03/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HOSPITAL	50 Hospital Hill Road, PO Box 789, Sharon, CT 06069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1103	(Continued from page 2) with LCSW#1 identified that she has not come in on a Sunday to provide crisis intervention services in over one year. Interview with MD #3 (psychiatrist) on 3/30/16 identified that he/she provides psychiatric services to the Senior Behavioral Health Unit, however, as a favor, he/she and his staff will provide psychiatric evaluations to patients who present to the ED during regular work hours. In addition, MD #3 was not aware that the hospital had a crisis social worker. MD #3 also indicated that on the weekend, he is available either day and/or by phone, otherwise the patient would need to wait until the following morning for a psychiatric evaluation.	A 1112	(cont from page 2) Emergency Medical staff, Emergency Nursing Staff, Behavioral Health (SBH) Staff and Clinical Resource Management Staff. The SBH psychiatrist will attend the next ED monthly medical staff meeting to review his role and the consultative process for evaluation of psychiatric patients in the emergency department that meet senior behavioral health admission requirements following assessment by the ED medical provider. Responsible party: Chief Quality Officer	5/14/16
A1112	482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel, the hospital failed to ensure that crisis intervention services were available when a patient presents to the Emergency Department (ED). The finding includes: Review of provider coverage schedule for psychiatric services dated 3/23/16 identified that ED consultations would be completed by the provider on site for that day, however, the schedule failed to indicate the time frame of provider coverage schedule dated 3/30/16 identified that the provider would provide coverage for ED consultations, while on site from 9:00AM-11:00 AM Saturday and/or Sunday. In addition, review of the Social		The CRM LCSW will provide education to the ED medical staff and appropriate nursing staff on her role and process for evaluation of psychiatric patients in the emergency department that require inpatient or outpatient care, following assessment by the ED medical provider. Education related to crisis intervention will be added to general orientation for all new hires. Responsible party: CRM LCSW The daily on-call schedule will be revised to include "Crisis Intervention". Education of revision will be provided to appropriate staff. Responsible party: Educator	4/22/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		4/18/16

INSTRUCTIONS FOR COMPLETION OF THE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

I. **PURPOSE**
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VII. **Signature** – This form should be signed and dated by the provider or supplier representative or the laboratory director. The original, with the facility's proposed corrective action, must be returned to the appropriate surveying agency (SA or RO) within 10 days of receipt. Please maintain a copy for your records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1112	Continued from page 3 Worker schedule dated 3/30/16 identified that coverage for crisis coverage on weekend was one Saturday a month and a rotation schedule of shifts and Sunday, one week a month. Interview with LCSW #1 on 3/30/16 identified that he/she does not usually come in on a Sunday. Review of hospital policies identified that the hospital social worker and/or psychiatrist should be consulted on all patients to assist with a clinical assessment and disposition. Interview with MD #2 (ED) 3/24/16 identified that patients who present to the ED on the weekend would have to wait until Monday to see a psychiatrist and/or crisis worker for specific psychiatric needs. Interview with LCSW #1 on 3/24/16 identified that her hours are Monday-Friday. In addition, there is an on-call list for case management on the weekend, however she is the only person qualified to do crisis management. Interview with LCSW #1 on 3/30/16 identified that he/she does not usually come in on a Sunday and has not come in on a Sunday to provide crisis intervention services, in over one year. Interview with MD #3 (psychiatrist) on 3/30/16 identified that he/she provides psychiatric services to the senior Behavioral Health Unit, however, as a favor, he/she and his staff will provide psychiatric evaluations to patients who present to the ED during regular work hours. In addition, MD #3 was not aware that the hospital has a crisis social worker. MD #3 also indicated that on the weekend, he is available either day and/or by phone, otherwise the patient would need to wait until the following morning for a psychiatric evaluation.	A1112		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

April 25, 2016

Mr. Peter Cordeau, Interim CEO
Sharon Hospital
50 Hospital Hill Road
Sharon, CT 06069

Re: CMS Certification Number (CCN): 070004
Survey ID: P6UJ12, 04/15/2016

Dear Ms. Lumia:

On April 15, 2016, the State of Connecticut Department of Public Health conducted a survey and determined that your hospital is in compliance with the Medicare Conditions of Participation for Hospitals at 42 C.F.R. Part 482.

Your planned termination from the Medicare program on June 21, 2016 has been rescinded. Based upon this determination, your hospital is returned to "Deemed" status based upon its accreditation by The Joint Commission (TJC). Your hospital is no longer under State Survey Agency jurisdiction.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

Kathy Mackin, Health Insurance Specialist
Survey Branch

cc: State of Connecticut Department of Public Health
TJC

EXHIBIT O

Sharon Hospital (only)
Monthly Financial Measurement/Indicators:

	September		FY	FY
	Current Month	Year to Date	2016 est.	2015
A. Operating Performance:				
Operating Margin	-0.8%	0.1%	0.4%	5.6%
[1]Non-Operating Margin	0.0%	0.0%	0.0%	-43.8%
[1]Total Margin	-0.8%	0.1%	0.4%	-43.1%
B. Liquidity:				
Current Ratio	2.1	2.1	2.1	1.6
[2]Days Cash on Hand	n/a	n/a	n/a	n/a
Days in Net Accounts Receivables	39	39	39	45
Average Payment Period	30.5	30.7	30.6	40.0
C. Leverage and Capital Structure:				
[3]Long-term Debt to Equity	n/a	n/a	n/a	n/a
[3]Long-term Debt to Capitalization	n/a	n/a	n/a	n/a
[2,3]Unrestricted Cash to Debt	n/a	n/a	n/a	n/a
Times Interest Earned Ratio	0.6%	0.6%	1.0%	0.6%
[3]Debt Service Coverage Ratio	n/a	n/a	n/a	n/a
[3]Equity Financing Ratio	n/a	n/a	n/a	n/a
D. Additional Statistics:				
[5]Income from Operations	$ (35,027)	$ 47,429	$ 182,190	$ 1,943,888
[6]Revenue Over/(Under) Expense	$ (35,027)	$ 47,429	$ 182,190	$ 260,428
[7]EBITDA	$ 218,532	$ 2,154,770	$ 3,116,948	$ 6,139,016
Patient Cash Collected	$ 4,120,433	$ 38,017,639	$ 50,648,399	$ 49,485,574
[2]Cash and Cash Equivalents	n/a	n/a	n/a	n/a
Bad Debt as % of Gross Revenue	3.0%	2.1%	1.8%	1.3%
[2]Net Working Capital	n/a	n/a	n/a	n/a
[2, 4]Unrestricted Assets	n/a	n/a	n/a	n/a
[3]Credit Ratings (S&P, Fitch, Moody's)	n/a	n/a	n/a	n/a

Notes:

[1]FY 2015 includes three adjustments: 1) asset impairment charge of ($15.3M), 2) deferred tax asset impairment of ($1.7M) and 3) the removal of "intercompany fees" which represent the loss transfer from physician practices ($3.1M).

[2]RCCH Healthcare Partners uses a centralized cash management system, whereby cash and cash equivalents are held at a corporate level. As such, an accurate representation of this measure is not available.

[3]Essent Healthcare of Connecticut has no long or short term debts.

[4]Essent Healthcare of Connecticut has no restricted assets.

[5]EBITDA adjusted for depreciation, amortization, management fees and corporate interest income.

[6]Income from operations less provision for income taxes

[7]Net patient revenue less operating expenses excluding depreciation, amortization management fees and corporate interest income.

Alice B Yoakum
196 Millerton Road, P. O. Box 271
Lakeville Connecticut 06039

Tel. 860 435 2639 aliceyoakum@gmail.com

November 2, 2016

Ms. Yvonne Addo, Deputy Commissioner
Connecticut Department of Health
Health Care Access Division
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo

The Sharon Hospital and the doctors drawn to it were an important reason why my husband and I and our young children moved to Lakeville 55 years ago. Now, at the age of 85, I am particularly aware of how important the hospital is to all of the residents of the northwest corner of all ages. Recently we have seen a reduction in the number of medical specialists here. For instance, my late husband had to travel to Torrington to see an oncologist, and I have to drive to Rhinebeck or Poughkeepsie to see my ENT doctor.

The proposed purchase of Sharon Hospital by HealthQuest provides assurance that the hospital will continue to be here in the northwest corner and also that once again we will be able to see oncologists, ENTs and other specialists here and not have to travel 30 miles or more for these services. And, when our family members and friends need to be hospitalized, or taken to the emergency room these facilities will be here and not 45 minutes away. With three retirement compounds and/or nursing homes in the area the proximity of medical services is important both for the residents of these facilities and also for providing employment, and for the health and happiness of the whole community.

Health Quest has promised to have a local hospital board and local input toward assessing local needs for services. This and the connection with other hospitals means that specialist physicians will have offices in the community. I hope that the proposed purchase will be approved and will take place.

Sincerely yours,

Alice B. Yoakum

Miriam Tannen
796 Camby Road
Millbrook, NY 12545

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

As a member of the Community, Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family. I think it is important to the Community to have Sharon Hospital return to a not-for-profit hospital. The services that Health Quest brings to a community are sorely needed in our area that serves residents of both NYS and Connecticut.

Sincerely

Miriam Tannen

JON AND SIA ARNASON
86 Charlie Hill Road
Millerton, New York 12546
Tel: (518) 789-3548
jarnason@msn.com sarnason1@aol.com

October 27, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization. Health Quest has demonstrated by their example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local board, as Health Quest has in their other hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely

Sia Arnason

Sia Arnason

FOUNDATION
for
COMMUNITY
HEALTH

Prevention, Access, Collaboration

October 28, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

As the CEO of the Foundation for Community Health, I write this letter in support of Health Quest Systems, Inc.'s acquisition of Sharon Hospital from Regional Care, a for-profit corporation based in Tennessee.

Integrating Sharon Hospital into Health Quest is a perfect option for the residents of Northwestern Connecticut and will have a dramatic effect on enhancing healthcare in the region. Health Quest is a local nonprofit organization and is an active member of the communities it serves. It has a proven track record of running hospitals and other practices in small communities, with successful operations in Rhinebeck and Carmel. Its system hub, Vassar Brothers Medical Center in Poughkeepsie, provides access to the quality of care and patient experience the region's residents deserve. Health Quest reinvests in its communities and is committed to bringing both technological innovation and top physicians into its markets. The same would be true in Sharon. The Health Quest communities take pride in their hospitals and share the same core values. I firmly believe the Sharon community will equally embrace that commitment to these values.

As a local nonprofit organization, Health Quest's only shareholders are the communities it serves. Its "profits" are reinvested in the system, updating facilities, purchasing the latest technology and hiring the best physicians, nurses and staff members, whose commitment to healthcare is second to none.

Foundation for Community Health • 478 Cornwall Bridge Road • Sharon, CT 06069
phone: 800.695.7210 • 860.364.5157 • fax: 860.364.6097 • www.fchealth.org

A supporting organization of Berkshire Taconic Community Foundation, Inc., Community Foundations of the Hudson Valley, Inc., and The Community Foundation of Northwest Connecticut, Inc.
Initially funded with assets from the sale and conversion of Sharon Hospital

About one-third of the residents who go to Sharon Hospital, especially on the New York side, already go to Health Quest for their tertiary care. The system is developing a hub-and-spoke system with Vassar Brothers Medical Center in the center and the other hospitals and affiliates as the healthcare arms that reach into the outlying communities. On the eastern side of this wheel, Sharon Hospital will mesh well as an important addition to the population health model, opening up access for multidisciplinary, specialized care in the eastern Dutchess County, New York, northwestern Connecticut region.

Health Quest has the Foundation's full support and we look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Nancy ~~L. He~~aton, MPH
Chief Executive Officer
Foundation for Community Health

The Foundation for Community Health (FCH) is a private, not-for-profit foundation dedicated to improving the health and wellbeing of the residents of the greater Harlem Valley in New York and the northern Litchfield Hills of Connecticut with an emphasis on serving those most vulnerable. FCH works with health and social service providers, other foundations and with government for change that improves rural health and rural healthcare delivery systems.

1732 1739

TOWN OF SHARON

OFFICE OF SELECTMEN

October 31, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Dear Ms. Addo:

I write this letter with regard to Health Quest Systems, Inc.'s proposed acquisition of Sharon Hospital from Regional Care.

The Health Quest/Sharon Hospital merger has my full support, as I feel that having Sharon Hospital become part of the Health Quest family opens up opportunities and partnerships that will enhance the level of care at the hospital and the quality of life in the Town of Sharon. Health Quest Systems, Inc. is a proven leader in the industry and the perfect fit for our hospital, we're very excited to become a part of their network.

Sharon Hospital's well-being is essential to not only our local economy, but to our community as a whole. It is the only full service hospital in our area, which includes New York and Massachusetts; If we were to lose it, our residents and ambulances would be forced to go to Torrington, Connecticut or Poughkeepsie, New York for critical care. Sharon, Connecticut would be negatively impacted on multiple levels if it were to lose this hospital, this merger is essential to our future, please take that into consideration in making this decision.

Thank you for your time and consideration,

Brent M. Colley
First Selectman,
Sharon, Connecticut

Post Office Box 385, 63 Main Street, Sharon, CT 06069-0385
(860) 364-5789 • FAX (860) 492-7021
www.sharonct.org

Robert G. Kuhbach
173 Indian Lake Road
Millerton, New York 12546

November 1, 2016

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Health
Office of Health Care Access Division
410 Capital Avenue
MS#13HCA
Hartford, CT 06134-0308

Re: Health Quest Application of Certificate of Need – Sharon Hospital, Sharon, Connecticut

Dear Ms. Addo:

I have been a resident of the Town of North East since 1981 and have come to appreciate the tremendous importance Sharon Hospital has had and will continue to have in the greater tri-state New York-Connecticut-Massachusetts area. I am also a member of the Board of the Foundation for Community Health, and have been an active participant in the discussions leading up to Health Quest's willingness to invest in revitalizing Sharon Hospital.

Accordingly, I am writing this letter in support of the Health Quest acquisition of Sharon Hospital from Regional Care. Health Quest is a not-for-profit, locally based organization, which has demonstrated by example at their existing facilities that they will expand services, increase access to care in our community and enhance the services that are already available at Sharon Hospital. They have committed to having a local hospital board of directors, as they have done in their other local New York State hospitals, which will provide local input into quality, physician credentialing and community need for services.

Health Quest has my full support and I look forward to having Sharon Hospital become part of the Health Quest family.

Sincerely,

Robert G. Kuhbach

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ROBERTA B. WILLIS
SIXTY-FOURTH DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 1802
HARTFORD, CT 06106-1591
HOME: (860) 435-0621
CAPITOL: (860) 240-8585
TOLL FREE: (800) 842-8267
FAX: (860) 240-8833
E-MAIL: Roberta.Willis@cga.ct.gov

CHAIRMAN
HIGHER EDUCATION & EMPLOYMENT
ADVANCEMENT COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE

November 7, 2016

Yvonne T. Addo, MBA, Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134-0308

Re: Certificate of Need – Sharon Hospital

Dear Ms. Addo:

I write to you today in enthusiastic support of Sharon Hospital's application for a Certificate of Need that is required for its affiliation with Health Quest. The citizens of Northwest Connecticut are eager to see their small rural hospital to once again become a community not for profit full service acute care health center.

Sharon Hospital's patients will continue to have access to the services they presently receive, and in addition, a greater network of professional providers. There will the added opportunity for expanded services when it joins Health Quest, a family of nonprofit hospitals and healthcare professionals.

Health Quest is a natural fit for Sharon. It is the nearest tertiary care facility to Sharon. With the proposal for Charlotte Hungerford and Hartford Health Care, Sharon becomes one of the few hospitals in Connecticut that does not have an affiliation in the area, which puts a small rural hospital at a tremendous disadvantage and places its future in harm's way. To survive in the present healthcare landscape, the state's smallest hospital requires a sustainable framework.

Thank you for considering the Certificate of Need application being submitted by Sharon Hospital. I think I can say with confidence, the community is hopeful that this application is approved as expeditiously as possible. I have been on the Advisory Board of the hospital since it was acquired by Essent Healthcare, so please do not hesitate to ask any questions you might have on this proposal.

Sincerely,

Roberta Willis
State Representative

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

December 2, 2016

The Honorable Roberta B. Willis
Representative, 64th District
State of Connecticut
House of Representatives
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Dear Representative Willis:

On November 21, 2016, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the transfer of ownership of The Sharon Hospital to Vassar health Connecticut, Inc.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Yvonne T. Addo, MBA
Deputy Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Greer, Leslie

From: Fernandes, David
Sent: Friday, December 02, 2016 3:14 PM
To: dping@health-quest.org
Cc: Greer, Leslie; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Foster, Tillman; Lazarus, Steven
Subject: 16-32132-CON and 16-32133-CON Completeness Letters
Attachments: 16-32132 CON Completeness.docx; 16-32133-CON Final Completeness letter.docx

Good afternoon Mr. Ping,

Please see the attached completeness letters in the matter of the proposed transfer of ownership of Sharon Hospital and Regional Healthcare Associates, LLC to Vassar Health, Inc., a subsidiary of Health Quest Systems, Inc. In responding to the completeness letters, please follow the instructions included in the letters and provide the response document as an attachment only (no hard copies required). Please provide your written responses to OHCA by February 1, 2017.

Email to OHCA@ct.gov and cc:David.Fernandes@ct.gov , Jessica.Schaeffer-Helmecki@ct.gov, Steven.Lazarus@ct.gov, Tillman.Foster@ct.gov and Kaila.Riggott@ct.gov.

If you have any questions regarding the completeness letters, please contact David Fernandes at (860) 418-7032 or Jessica Schaeffer-Helmecki at (860) 418-8075.

Please confirm receipt of this email.

Thank You,

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

December 2, 2016 Via Email Only

Mr. David Ping
Health Quest Systems, Inc.
Senior Vice President of Strategic Planning & Business Development
1351 Route 55, Suite 200
LaGrangeville, NY 12540
dping@health-quest.org

RE: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Certificate of Need Completeness Letter

Dear Mr. Ping:

On November 3, 2016, OHCA received the Certificate of Need application from Essent Healthcare of Connecticut, Inc. ("Essent"), a subsidiary of Health Quest Systems, Inc. ("Health Quest") and Vassar Health Connecticut ("Vassar") (collectively "the Applicants") seeking authorization to transfer ownership interest in The Sharon Hospital (the "Hospital") to Vassar. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to each of the following email addresses: OHCA@ct.gov, jessica.schaeffer-helmecki@ct.gov, steven.lazarus@ct.gov, tillman.foster@ct.gov and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 640** and reference "**Docket Number: 16-32132-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **January 31, 2017**, otherwise your application will be automatically considered withdrawn.

1. What is Vassar Health Connecticut, Inc.'s business or mailing address?

2. Is Sharon Hospital Holding Company, Inc. also part of the transfer of ownership?

3. Regarding the Foundation for Community Health, Inc. ("FCH"):

    a. Elaborate on the nature and purpose of the "conversion" foundation. Is it distinguishable from a traditional foundation and are there any additional restrictions on foundation expenditures?

    b. What is the organizational structure and governing body of the FCH as it currently exists? Do any of the Applicants have influence over the FCH's expenditures or grant approval process?

    c. Please provide a copy of the current bylaws, the incorporating document(s) and the most recent audited financial statements for the FCH.

    d. Will the FCH continue to exist following implementation of the proposal? If so, will it continue with the same mission and structure as it currently has?

    e. Subsequent to the expiration of the terms of the 12 FCH-appointed trustees, how many of the 15 total members will be community-based board members representing the interests of local health care consumers?

    f. Do Health Quest and FCH (or Essent and FCH) have any additional drafted or executed legal agreements with each other that have not been provided as part of the initial CON application?

    g. Confirm that all statutes and regulations related to the operation of charitable foundations such as FCH will allow FCH to provide the anticipated grant to Health Quest for this Asset Purchase.

    h. Will expenditures at the Hospital originating from the FCH be restricted to the foundation's original stated mission of maintaining and improving the physical and mental health of the residents of the area historically serviced by the Hospital?

4. Please clarify the following regarding the Working Capital Grant, which, as stated on page 24 of the application, will be disbursed in annual installments over a period of 3 to 4 years:

    a. Will FCH provide the entire $6M grant to Health Quest at the time of the proposed sale and Health Quest then disburse the annual increment for "strategic investments"? If so, where will this total grant amount be kept over the 3 to 4 year period (on what legal entity's books and in what type of financial instrument)?

    b. Will FCH instead provide the $6M grant to Health Quest in annual increments?

    c. Is there an agreement or contractual document specific to this Working Capital Grant? If so, please provide.

5. Regarding the Purchase Price of $5M as described in Term 2.5 of the Asset Purchase Agreement (subject to closing net working capital), how was the $5M figure determined or calculated as the selling price for the hospital? What factors entered into this determination or calculation? Explain how this price reflects the fair value of the hospital.

6. Provide an explanation of any capital improvements, upgrades or strategic investments the Applicants intend to implement and an approximate timeline for improvement implementation.

7. What tertiary services are currently available in the Hospital's Connecticut-based primary service area?

8. On page 36 and elsewhere in the application, the Applicants state that Vassar Connecticut is not proposing any changes to the clinical services offered by the Hospital. Please confirm or clarify whether this indicates the Applicants are not considering reducing, relocating or eliminating any services currently provided by the Hospital. If this is the case, for how long will the Applicants maintain the current services?

9. The application states on page 36 that Health Quest will "evaluate the licensed beds at Sharon to determine whether the number is appropriate based on historic and project inpatient discharges and average daily census." Is Health Quest considering reducing and/or reallocating the number of licensed beds at the Hospital?

10. The application states that Essent was unable to recruit new physicians, which was a primary cause of the decline in utilization at the Hospital. Explain in detail how Health Quest will be more successful in recruiting physicians?

11. Explain the 143% increase in inpatient discharges or outpatient visits required to cover financial incremental expenses between FY 2018 and FY 2019 as stated on page 44 of the application. How did the Applicants arrive at this increase in incremental inpatient and outpatient utilization? Provide any calculations and assumptions used to arrive at the utilization and contribution margin amounts.

12. The Applicants state that by FY 2018, they anticipate the average daily census would increase by 6 at the Hospital due to referrals from Health Quest's New York-based facilities. What portion of these patients is expected to be geropsychiatric patients? According to Report 400 submitted by Essent to OHCA, the Hospital's adult psychiatric beds were 83% occupied in FY 2015. Will the Hospital's geropsychiatric 12-bed unit be able to accommodate the additional out-of-state patients? Please explain.

13. The Applicants project an average daily census increase of 4 patients per day as a result of the anticipated recruitment of cardiology, orthopedics, general surgery, OBGYN, oncology and primary care physicians. On what do the Applicants base this specific projection, particularly in light of the decline in utilization the Hospital is currently experiencing? Provide the specific calculations that yielded the average of four additional patients per day.

14. Pages 37 and 38 of the application give an overview of Health Quest-initiatives aimed at improving quality at Health Quest's current hospitals. When did Health Quest implement these initiatives and are there any available metrics measuring their effectiveness? If so, please provide them.

15. For the most recent two years, provide CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by Health Quest. Documents may be submitted electronically via e-mail or on a CD accompanying responses.

16. In the Study of Community Health Needs Conducted for the Foundation for Community Health, published in October of 2014 (Exhibit I of the Application), it is noted that areas for health concern in the Hospital's service area include mental health, access to health care, substance abuse, obesity, especially among children and youth, and difficulties encountered by the Hispanic community members accessing health care. Please provide a copy of the Implantation Plan that indicates what the Hospital's strategies have been in addressing these areas of concern.

17. Is a 2017 CHNA study underway? If so, have preliminary needs have been identified? How is Health Quest taking identified community needs into account in its assessment of current and future needs of the Hospital and the community it serves?

18. Complete the table below indicating how many patients from the Hospital's Connecticut primary service area towns (North Canaan, Sharon, Salisbury, New Milford, Torrington, Cornwall, Canaan and Kent) received the following services at each of Health Quest's New York-based hospitals:

	No. of patients originating from the Hospital's CT-based primary service area in FY 2016		
Service	**Vassar Brothers Medical Center**	**Northern Dutchess Hospital**	**Putnam Hospital Center**
Medical/Surgical (adult)			
Maternity			
Psychiatric			
Rehabilitation			
Pediatric			
Newborn			
Total			

19. Regarding the Sharon Hospital Financial Worksheet and related financial assumptions:

    a. The Applicants project incremental gross revenue in FY 2017 of $12.6M, increasing to incremental gross revenue in FY 2018 of $39.1M. Explain in detail how these figures were estimated and how the Applicants specifically took into account the various utilization increases (across the board and/or service specific) in these gross revenue figures. How will prices charged enter into these assumptions?

    b. Regarding the Projected Payer Mix based on Discharges on page 53 and the Projected Net Patient Revenue (Line A. 5) on page 531, how do the projections specific to Medicare reflect a transition of some or many of the system geropsychiatric patients to the Sharon Hospital site. Do the incremental figures provided for Medicare specific assume an increase for these patients? Why do the Applicants project "stable payer mix" in this regard?

    c. The financial projections on page 532 assume "payer contract changes" (page 43). Are the incremental increases in Commercial Insurers Net Patient Service Revenue (Line A. 9) for FY 2017-FY 2018, specifically related to changed payer contracts, overall utilization increases or a combination? Are these factors related to the incremental projections?

    d. Why isn't there any Uninsured Net Patient Service Revenue (with or without the CON) listed on Line A. 10? Per the Hospital's financial filings to OHCA, in FY 2015 Sharon Hospital had 1.7% uninsured based on charges and 0.5% uninsured based on payments. Please reconcile.

e. What does Line A. 13 “Other” represent for the Sharon Hospital projections?

f. Line B. 4, Supplies and Drugs, is projected to continue to increase throughout the fiscal years presented. How much of the incremental amounts reflect the increased volume projections and how much are these amounts offset by being part of the Health Quest purchasing system?

g. Are the increasing incremental operating revenues, as reflected in the financial attachment on page 531 (increasing from approximately $4.6M in FY 2017 to $16.5M in FY 2020) attributable solely to the anticipated average daily census increase of 10 additional patients? Provide a more detailed list of assumptions and explanation.

h. The Financial Attachment includes a projection of 48 additional full time employees through FY 2020. How many of these additional employees are physicians? Will these physicians be new to the Health Quest system and dedicated full time to the Hospital or will they be existing doctors rotating into the Hospital?

20. There is a discrepancy between Sharon Hospital’s total operating expenses on Financial Worksheet (B) of the application in the amount of $48,393,242 and the total operating expense amount of $46,746,699 in the consolidating section of the Sharon Hospital Holding, Inc. FY 2015 audited financial statements. A discrepancy also exists for Net loss amount on Financial Worksheet (B) of ($15,070,778) versus ($18,200,362) on the on the audited financial statements. Correct Worksheet (B) so that the total operating expense amount and net loss amounts for Sharon Hospital agrees with the total operating expense and net loss amounts of the audited financial statements for Sharon Hospital.

21. How did the Applicants arrive at the FY 2016 actual amounts for revenues, expenses and utilization for the Health Quest, Inc. system Financial Worksheet (B) when the system’s fiscal year will not end until December 31, 2016? Resubmit the Financial Worksheet (B) for Health Quest, Inc. which includes FY 2015 actual numbers for revenues, expenses and utilization.

22. Of the incremental revenues, expenses and volume as reported on page 532, please indicate what is specifically attributable to acquiring Sharon Hospital by Health Quest Systems, Inc. What is the projected financial and utilization impact of this acquisition on other system providers? Be specific.

If you have any questions concerning this letter, please feel free to contact me at (860) 509-8075.

Sincerely,

Jessica Schaeffer-Helmecki
Planning Analyst

Greer, Leslie

From: Ping, David <DPing@Health-quest.org>
Sent: Tuesday, December 06, 2016 1:16 PM
To: Fernandes, David; Jennifer Groves Fusco (jfusco@uks.com)
Cc: Greer, Leslie; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Foster, Tillman; Lazarus, Steven
Subject: RE: 16-32132-CON and 16-32133-CON Completeness Letters

Mr. Fernandes –

Thanks so much for sending this information to us. It went into my spam filter today and I pulled it out and added all of the people on this email to my address book so that should not happen again. I am not sure why the delay between Friday and today, but I am glad that we are in receipt of the information. We will begin working through our responses and will be in touch.

Dave

From: Fernandes, David [mailto:David.Fernandes@ct.gov]
Sent: Friday, December 02, 2016 3:14 PM
To: Ping, David
Cc: Greer, Leslie; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Foster, Tillman; Lazarus, Steven
Subject: 16-32132-CON and 16-32133-CON Completeness Letters

Good afternoon Mr. Ping,

Please see the attached completeness letters in the matter of the proposed transfer of ownership of Sharon Hospital and Regional Healthcare Associates, LLC to Vassar Health, Inc., a subsidiary of Health Quest Systems, Inc. In responding to the completeness letters, please follow the instructions included in the letters and provide the response document as an attachment only (no hard copies required). Please provide your written responses to OHCA by February 1, 2017.

Email to OHCA@ct.gov and cc:David.Fernandes@ct.gov , Jessica.Schaeffer-Helmecki@ct.gov, Steven.Lazarus@ct.gov, Tillman.Foster@ct.gov and Kaila.Riggott@ct.gov.

If you have any questions regarding the completeness letters, please contact David Fernandes at (860) 418-7032 or Jessica Schaeffer-Helmecki at (860) 418-8075.

Please confirm receipt of this email.

Thank You,

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

Greer, Leslie

Subject: FW: 16-32132-CON and 16-32133-CON Completeness Letters

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, December 06, 2016 1:27 PM
To: Fernandes, David; Ping, David
Cc: Greer, Leslie; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Foster, Tillman; Lazarus, Steven
Subject: RE: 16-32132-CON and 16-32133-CON Completeness Letters

Thanks, everyone. We look forward to working with you on these matters.

Greer, Leslie

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, January 17, 2017 2:38 PM
To: User, OHCA; Schaeffer-Helmecki, Jessica; Lazarus, Steven; Foster, Tillman; Riggott, Kaila
Subject: Sharon Hospital -- Completeness Question Responses (Docket No. 16-32132-CON)
Attachments: DOCS-#1462075-v1-HEALTH_QUEST_SHARON_HOSPITAL_CQ_UPDATED_FINANCIALS.xlsx; DOCS-#1439933-v3-HEALTH_QUEST_SHARON_HOSPITAL_COMPLETENESS_QUESTION_RESP....docx; Sharon Hospital Completeness Question Responses.pdf

All:

Attached are the completeness question responses in Docket No. 16-32132-CON regarding the transfer of ownership of Sharon Hospital. The PDF file includes narrative responses and all exhibits. I was unable to scan/email the document in color given its size, so I am overnighting a color copy to Jessica's attention. There are only a few color pages. The color copy will not have page numbers (given the difficulty we had scanning it), so if you need select color exhibits numbered please let me know and I will email those to you separately.

I have also included a Word version of the response and an Excel workbook with the updated financials. Note that for this docket the relevant financials are included in the tabs labeled "Sharon Hospital" and "HQ Hospital." The other tabs pertain to Docket No. 16-32133-CON. Completeness questions in that docket are being submitted in a separate email.

Please confirm receipt and let me know if you need any additional information.

Thanks,
Jen

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Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Completeness Question Responses

1. What is Vassar Health Connecticut, Inc.'s business or mailing address?

RESPONSE:

Vassar Health Connecticut, Inc. ("Vassar Connecticut") is a subsidiary of Health Quest Systems, Inc. ("Health Quest") and currently shares the same mailing address– 1351 Route 55, Suite 200, LaGrangeville, NY 12540. Once Vassar Connecticut acquires the assets of Sharon Hospital ("Sharon" or the "Hospital") its business and mailing address will be 50 Hospital Hill Road, Sharon, Connecticut, 06069.

2. Is Sharon Hospital Holding Company, Inc. also part of the transfer of ownership?

RESPONSE:

Sharon Hospital Holding Company ("SHHC"), the direct parent of Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital ("Essent Connecticut"), is a party to the Asset Purchase Agreement ("APA") included in the CON Application at pages 73 through 328. It is typical for a holding company of this type to be included in an APA for reasons including, but not limited to, the need to make certain representations and warranties related to the ownership and operation of the Hospital.

3. Regarding the Foundation for Community Health, Inc. ("FCH"):

    a. Elaborate on the nature and purpose of the "conversion" foundation. Is it distinguishable from a traditional foundation and are there any additional restrictions on foundation expenditures?

RESPONSE:

The Foundation for Community Health ("FCH") is actually not a "foundation" if OHCA is using that phrase to refer to "private foundations" which are 501(c)(3) organizations that, as a general rule, make grants but do not directly conduct charitable activities. FCH is a "public charity" within the meaning of Code 501(c)(3) and 509(a). It is what is known as a supporting organization (Code 509(a)(3)) which derives its tax exempt status from the support (either financial or activities) it provides to its supported organization(s) in conducting charitable activities (Berkshire Taconic, Community Foundations of the Hudson Valley, and The Community Foundation of Northwest Connecticut, Inc.- each of which is a

public charity described in Code 501(c)(3) and 509(a)(1) or (a)(2)). The use of the term "conversion foundation" refers to the fact that FCH, originally formed under the name Sharon Area Community Health Foundation, was the entity approved by the Connecticut Superior Court and Office of Attorney General to receive the charitable assets of the Hospital in connection with its for-profit conversion.

By virtue of being a supporting organization, FCH must exclusively support its three supported organizations. That restriction is mandated by federal law (Code and Treasury regulations issued thereunder) and formalized in FCH's governance documents which outline the purposes that FCH may support (geographic limits and community health). Support does include financial support (i.e., expenditures). FCH has analyzed and confirmed that yes, Treasury regulation 1.509(a)-4(e)(3) permits indirect support, i.e., FCH is deemed to be supporting the interests and charitable purposes of the supported organizations when providing grants to Health Quest (which in and of itself is a tax-exempt entity) for the acquisition of Sharon Hospital assets and ongoing working capital needs because that grant is consistent with the purposes of its supported organizations (which, among other things, is enhancing community health in the Sharon Hospital catchment area). Therefore, while this type of grant is acceptable, FCH could not conduct an activity unrelated to the purposes of the supported organizations even where the activity is undoubtedly charitable (e.g., working to saving marine wildlife).

b. What is the organizational structure and governing body of the FCH as it currently exists? Do any of the Applicants have influence over the FCH's expenditures or grant approval process?

RESPONSE:

Each of the three supported organizations is a member of FCH. At the annual member meeting, the members appoint the directors of FCH (between 11 and 17 individuals; must be odd number) for three year, staggered terms. No more than three directors may be individuals serving on the board(s) of any member. Each director must live in the Sharon Hospital catchment area and have certain experience as a trustee, director or owner of a health care delivery or financing organization. The directors must also come from a pool of candidates vetted and presented by the current FCH Board of Directors. The FCH directors then appoint the officers.

Other than certain enumerated approval rights (these appointment powers, sales/pledge/lease/transfer of substantially all of the assets, any merger or consolidation or dissolution) which have been reserved for the members, the property, affairs and business of FCH is managed by its Board.

None of the Applicants has influence over FCH's expenditures or grant approval process, other than the funds committed by FCH to Health Quest pursuant to the September 13, 2016 Grant Agreement between the parties (the "Grant Agreement") attached as Completeness Exhibit A.

c. Please provide a copy of the current bylaws, the incorporating document(s) and the most recent audited financial statements for the FCH.

RESPONSE:

The following documents pertaining to The Foundation for Community Health, Inc. are attached as Completeness Exhibit B:

- Amended and Restated By-laws;
- Amended and Restated Certificate of Incorporation; and
- FY 2015 Audited Financial Statements and IRS Form 990.

d. Will the FCH continue to exist following implementation of the proposal? If so, will it continue with the same mission and structure as it currently has?

RESPONSE:

Yes, FCH has committed up to $9 million for the Sharon Hospital project, leaving approximately $16 million in other funds which FCH will continue to utilize to carry out its charitable activities. In addition, as a public charity, FCH receives and will continue to receive funds from a variety of sources to use toward its mission. No change to FCH's mission and structure is envisioned other than FCH will have additional activities relating to supporting Health Quest in connection with Sharon Hospital.

e. Subsequent to the expiration of the terms of the 12 FCH-appointed trustees, how many of the 15 total members will be community-based board members representing the interests of local health care consumers?

RESPONSE:

Health Quest has not made any agreement with FCH regarding the role of community-based board members following the final expiration of the last 4 FCH nominated trustees (by the Agreement, 4 Trustees shall serve for at least 4 years; 4 Trustees shall serve for at least 5 years; and 4 Trustees shall serve for at least 6 years, i.e., FCH has a majority of 15 member board for at least 5 years).[1] Notwithstanding the foregoing, it is the intent and expectation of Health Quest and Vassar Connecticut that a majority of the Sharon Hospital Board will continue to be populated by local community members after the expiration of the terms of the initial FCH nominees. Health Quest and Vassar Connecticut expect the non-profit Sharon Board to look much like the Hospital's current Local Governing Board, which is comprised largely of community stakeholders.

[1] FCH has the right to nominate trustees for appointment to the Sharon Hospital Board. The Health Quest Board must then confirm each nominee before he or she becomes a trustee.

f. Do Health Quest and FCH (or Essent and FCH) have any additional drafted or executed legal agreements with each other that have not been provided as part of the initial CON application?

RESPONSE:

Yes, there is a Grant Agreement between FCH, Health Quest and Berkshire Taconic Community Foundation, Inc. A copy is attached as Completeness Exhibit A.

g. Confirm that all statutes and regulations related to the operation of charitable foundations such as FCH will allow FCH to provide the anticipated grant to Health Quest for this Asset Purchase.

RESPONSE:

The grants being provided pursuant to the Grant Agreement are consistent with Code 501(c)(3) purposes and FCH has concluded (with guidance of outside legal counsel) that the Treasury regulation 1.509(a)-4(e)(3) requirements have been met in terms of providing indirect support to its supported organizations.

h. Will expenditures at the Hospital originating from the FCH be restricted to the foundation's original stated mission of maintaining and improving the physical and mental health of the residents of the area historically serviced by the Hospital?

RESPONSE:

Restrictions on the use of grant funds originating from FCH are as follows:

- The first $3 million (subject to adjustments at the time of closing) of grant funds are dedicated to the repurchase of Sharon's assets.

- Subsequent grants are limited to a defined term called "Investments" found in Section 1.3 of the Grant Agreement, which are actual direct cost outlays associated with Health Quest's strategic investments at Sharon Hospital including, without limitation, investments in direct physician and provider costs, investments in strategic equipment, facility upgrades, investments in ambulatory networks, investments in information technology infrastructure, and other strategic programmatic investments. Investments are limited to expenditures that are of direct benefit to Sharon Hospital. They cannot include expenses allocated across the Health Quest system.

- Section 2. 4 of the Grant Agreement includes a provision that prohibits Health Quest from using the funds for anything other than charitable, scientific, educational or other Code-specified purposes.

4. Please clarify the following regarding the Working Capital Grant, which, as stated on page 24 of the application, will be disbursed in annual installments over a period of 3 to 4 years:

    a. Will FCH provide the entire $6M grant to Health Quest at the time of the proposed sale and Health Quest then disburse the annual increment for "strategic investments"? If so, where will this total grant amount be kept over the 3 to 4 year period (on what legal entity's books and in what type of financial instrument)?

RESPONSE:

No, FCH will not provide the entire $6 million grant to Health Quest at the time of the closing. Rather, the Working Capital Grant will be disbursed to Health Quest by FCH in annual increments, for a period of up to four (4) years, based upon expenditures made by Health Quest that meet the definition of Investments in the Grant Agreement (see Completeness Exhibit A, Section 1.3). Any monies disbursed to Health Quest by FCH in accordance with Section 1.3 of the Grant Agreement will appear on Health Quest's books. The undisbursed funds that comprise the balance of the Working Capital Grant will remain with FCH, in the manner described in the Grant Agreement, unless and until they are disbursed.

    b. Will FCH instead provide the $6M grant to Health Quest in annual increments?

RESPONSE:

See Response to Question 4.a. above.

    c. Is there an agreement or contractual document specific to this Working Capital Grant? If so, please provide.

RESPONSE:

Yes, there is an agreement specific to the Working Capital Grant. See Grant Agreement attached as Completeness Exhibit A.

5. Regarding the Purchase Price of $5M as described in Term 2.5 of the Asset Purchase Agreement (subject to closing net working capital), how was the $5M figure determined or calculated as the selling price for the hospital? What factors entered into this determination or calculation? Explain how this price reflects the fair value of the hospital.

RESPONSE:

Cain Brothers, a healthcare-focused investment bank, was engaged by Health Quest to provide transactional advice and market context and to assist the Applicants in negotiating a Purchase Price for the Hospital. Both Health Quest and RCCH HealthCare Partners looked at various measures in valuing Sharon Hospital including multiple of earnings, potential future earnings, and the value of the Hospital's physical assets. Because Sharon has had negative earnings for the last several years, a multiple of earnings methodology resulted in a negative value for the Hospital. Similarly, a methodology based on potential future earnings could not produce a positive valuation. Substantial changes to operations and the recruitment of new physicians to the area to bring patients to the Hospital and stem outmigration would have been needed, and those changes had not been made and were not planned. The physical assets of the Hospital were assessed and their value determined. Based upon the foregoing, the Applicants negotiated at arm's length and mutually agreed upon a $5 million Purchase Price for the assets of Sharon Hospital.

6. Provide an explanation of any capital improvements, upgrades or strategic investments the Applicants intend to implement and an approximate timeline for improvement implementation.

RESPONSE:

While Health Quest is still developing its capital plans for Sharon Hospital, the company anticipates at least the following capital expenditures for FYs 2017 through 2019:

- Information Technology – Health Quest will replace the Sharon Hospital and associated physician practice electronic medical records system with Cerner. This project includes upgrading the wireless service in the Hospital, the new electronic medical record and other information technology upgrades. This project is expected to commence in FY 2017 and should conclude by the first quarter of FY 2018. It is anticipated to cost approximately $3 to $3.5 million.

- Replace Boilers and Oil Tanks; Upgrade HVAC – These are critical infrastructure upgrades. The oil tanks go out of compliance in April 2018 and must be replaced. The total cost for this will be approximately $1.5 million and will be completed by early FY 2018.

- ICU Renovation and Monitor Upgrades – Health Quest will be renovating and installing telemedicine equipment in the Intensive Care Unit. This will allow Sharon to keep more patients in the Hospital by providing direct access to intensivists and

specialists at VBMC. This project should be completed in FY 2018/2019 and will cost around $1.5 million.

- Installing Wireless Telemetry on the Medical/Surgical Unit – Health Quest will make all of the medical/surgical beds on the second floor telemetry capable, so that Sharon will go from having only monitored beds in the ICU to having over 30 monitored beds hospital-wide, which will improve patient care and safety. This project is anticipated to be complete in FY 2018/2019 and will cost over $1 million.

- Converting Five (5) Licensed Beds to Geropsychiatry – Sharon Hospital turns away patients every month that require inpatient geropsychiatry. This project will cost $1.5 million and will commence in FY 2017.

- DaVinci Robot – Health Quest is considering the purchase and installation of a DaVinci robot so that additional general surgery, gynecological surgery and urological surgery can be performed at Sharon. This would cost about $1.5 million and the equipment would potentially be installed and in use in FY 2018/2019.

- Renovation of Space for Medical Oncology/ Infusion and other Clinical Purposes – Health Quest will renovate multi-use clinical space for, among other things, medical oncologists to practice in the community and have a chemotherapy infusion suite. Oncology patients are one of the largest segments of patients leaving the Sharon area for services and this is one of the services that Health Quest is anxious to provide for the community. Health Quest is still examining a location for this service and has not finalized a cost for the renovation at this time. The renovations should be complete in FY 2018/2019.

The foregoing are Health Quest's current anticipated capital investments for the first several years of operation of Sharon Hospital. However, based on its evaluation of Sharon post-closing these priorities, as well as the timing of particular investments and amounts invested in specific projects, may change.

7. What tertiary services are currently available in the Hospital's Connecticut-based primary service area?

RESPONSE:

There are currently no tertiary services available in Sharon Hospital's Connecticut-based primary service area. Residents must leave the area and travel to hospitals as far away as Hartford, Waterbury, Danbury, New Haven, and Poughkeepsie, New York for tertiary care. These tertiary care hospitals are, on average, an hour to an hour-and-a-half drive from Sharon.

8. On page 36 and elsewhere in the application, the Applicants state that Vassar Connecticut is not proposing any changes to the clinical services offered by the Hospital. Please confirm or clarify whether this indicates the Applicants are not considering reducing, relocating or eliminating any services currently provided by the Hospital. If this is the case, for how long will the Applicants maintain the current services?

RESPONSE:

Vassar Connecticut does not intend to relocate or eliminate any services currently provided at Sharon Hospital. Rather, it is Health Quest's express intent to expand service offerings and offer more depth of services as discussed in the CON submission. By way of example Health Quest intends to enhance medical oncology services, including infusions and chemotherapy. Vassar Connecticut expects to maintain current services for a period of three (3) years, subject to patient demand and the availability of physicians and other clinical providers and staff.

9. The application states on page 36 that Health Quest will "evaluate the licensed beds at Sharon to determine whether the number is appropriate based on historic and project inpatient discharges and average daily census." Is Health Quest considering reducing and/or reallocating the number of licensed beds at the Hospital?

RESPONSE:

Vassar Connecticut is considering the potential conversion of a number of Sharon's medical/surgical beds to geropsychiatric beds. The Hospital's medical surgical beds have been underutilized and have an occupancy rate of less than twenty-five percent (25%). The Hospital's geropsychiatric beds typically have an occupancy rate over ninety (90%), suggesting a need to convert additional licensed beds to this service. There are no geropsychiatric beds in Dutchess and Putnam Counties in New York. Health Quest believes that Sharon can be a resource for patients from these areas, as well as patients in need of this level of care residing throughout Connecticut where geropsychiatric services are also extremely limited.

10. The application states that Essent was unable to recruit new physicians, which was a primary cause of the decline in utilization at the Hospital. Explain in detail how Health Quest will be more successful in recruiting physicians?

RESPONSE:

HQMP has been very successful in recruiting physicians of all specialties to practice in the Hudson Valley Region, having recruited 47 physicians (13 primary care and 34 specialists) in FY 2016 alone. HQMP is now the largest medical group in Dutchess and Ulster Counties in New York. Several of HQMP's offices are located in rural areas and medically underserved communities. The practice has had success recruiting practitioners to these areas, which

speaks well of its ability to do the same for Sharon. Examples of this are HQMP's offices in Woodstock and Boiceville, New York. These are federally underserved areas and HQMP has successfully recruited two (2) physicians and two (2) midlevel practitioners to practice at these locations.

Heath Quest has a dedicated team of in-house physician recruiters whose only role is to identify physician recruits and make them part of the Health Quest system. The Connecticut Medical Foundation will be part of the Health Quest system and will utilize Health Quest's recruiting services. HQMP uses a physician-led approach to practice and offers a competitive compensation and benefits package, which is attractive to recruits and a contributing factor in the decision of many physicians to join the practice. In addition, HQMP offers physicians a sense of community and being part of a large, successful organization through its use of quarterly physician meetings, a physician-led committee structure, and the like. HQMP has found that creating a vision breeds success where recruiting is concerned. This vision will extend to practice locations in the Sharon area under the ownership of a Connecticut Medical Foundation. As such, Health Quest expects to be equally successful in recruiting the needed doctors to practice at and around the Hospital.

11. Explain the 143% increase in inpatient discharges or outpatient visits required to cover financial incremental expenses between FY 2018 and FY 2019 as stated on page 44 of the application. How did the Applicants arrive at this increase in incremental inpatient and outpatient utilization? Provide any calculations and assumptions used to arrive at the utilization and contribution margin amounts.

RESPONSE:

Below is a table containing the estimated costs and rates used to determine the minimum units presented on page 44 of the CON Application. Total incremental costs represent the estimated impact of expected investments (e.g. electronic medical records, infrastructure improvements, and service expansion) in the Hospital in order to drive growth and continuity within the Health Quest system. FY 2017 has been prorated assuming a July 1, 2017 closing date. At this point, the cost of integration and future-state investments remain under evaluation.

	2017	2018	2019	2020
*New Depreciation/Amortization	$ 50,000	$ 700,000	$ 1,700,000	$ 2,550,000
*New Other Operating Costs	$ 12,500	$ 175,000	$ 425,000	$ 637,500
***Total Estimated Incremental Costs**	**$ 62,500**	**$ 875,000**	**$ 2,125,000**	**$ 3,187,500**

*Estimated impact related to system conversions, incremental capital investment and other direct operating expenses related to the transition.

**Minimum Inpatient Discharges[1]	6	88	213	319
**Minimum Outpatient Units[2]	208	2,917	7,083	10,625

**Represents the minimum number of units for each service independently in order for the Hospital to cover financial incremental expenses.

Notes:

[1]Assumes average discharge rate of $10,000 / discharge (Sharon's current average)

[2]Assumes average outpatient visit rate of $300 / visit (Sharon's current average)

12. The Applicants state that by FY 2018, they anticipate the average daily census would increase by 6 at the Hospital due to referrals from Health Quest's New York-based facilities. What portion of these patients is expected to be geropsychiatric patients? According to Report 400 submitted by Essent to OHCA, the Hospital's adult psychiatric beds were 83% occupied in FY 2015. Will the Hospital's geropsychiatric 12-bed unit be able to accommodate the additional out-of-state patients? Please explain.

RESPONSE:

Vassar Connecticut anticipates one (1) average daily census increase in geropsychiatric patients by FY 2018, as it relates to referrals sourced from Health Quest for the geropsychiatric unit at Sharon. The FY 2018 incremental projections contemplate a capital investment rendering a five (5) bed expansion of Sharon's geropsychiatric unit and reallocation of medical/surgical beds to accommodate the increased patient days projected in the CON Application (see Response to Q. 9. above). Today, on average, Sharon is unable to admit approximately thirty (30) patients per month due to capacity (i.e. beds) limitations. Based on the Hospital's experience, there is significant need for additional geropsychiatric service capacity in Sharon's service area today and it believes the expansion will be primarily met by existing demand.

13. The Applicants project an average daily census increase of 4 patients per day as a result of the anticipated recruitment of cardiology, orthopedics, general surgery, OBGYN, oncology and primary care physicians. On what do the Applicants base this specific projection, particularly in light of the decline in utilization the Hospital is currently experiencing? Provide the specific calculations that yielded the average of four additional patients per day.

RESPONSE:

The historical decline in the Hospital's utilization is the result of many factors and variables; however, the two largest drivers are: (1) reduced and limited physician services (e.g. oncology) and (2) the continuum and continuity of care for higher acuity needs. Based on current payer data, for certain services (e.g. oncology, cardiology, and orthopedics) Sharon knows that approximately fifty percent (50%) or more of patients seek care outside of Sharon Hospital. As such, one of the fundamental tenets of the growth plan is augmenting and expanding physician access and services in and around Sharon. Health Quest's plans for physician recruitment and service expansion are detailed in the CON Application, in Response to Question 10 above, and in Docket No. 16-32133-CON concerning the transfer of ownership of the related physician practices.

Below is the estimated impact range on ADC based on physician service line. These estimates were derived using Sharon's existing physician service line data as a proxy for the future ADC impact by service line.

	ADC Impact	Need Being Addressed
Cardiology	.25 to .50	Capacity
General Surgery	.75 to 1.0	Capacity & Expanded Service
Oncology	.10 to .25	New Service
Orthopedics	.50 to .75	Capacity
OB/GYN	.75 to 1.0	Expanding Choice

14. Pages 37 and 38 of the application give an overview of Health Quest-initiatives aimed at improving quality at Health Quest's current hospitals. When did Health Quest implement these initiatives and are there any available metrics measuring their effectiveness? If so, please provide them.

RESPONSE:

As a system, Health Quest has undertaken many initiatives to drive change in the quality of services it provides. As discussed in greater detail below, these quality initiatives include, but are not limited to, those addressing length of stay, sepsis mortality and catheter-associated UTIs.

Length of Stay

- Begin discharge planning on day 1 of admission;
- Standardized daily huddles on units to discuss current patient needs and address any barriers to discharge;
- Engage physician advisors to improve communication between providers;
- Introduced alerts in the EMR to show expected discharge date and show patients who are nearing that date;
- Increased discharge planning efforts, including staff levels and IT solutions to ensure entire care team works to discharge patients timely;
- Improved coordination with home health agencies, skilled nursing facilities to facilitate smooth transitions of care; and
- Data analytics to regularly benchmark, monitor, and identify opportunities.

Sepsis Mortality

- Standardized protocol for sepsis patients;
- Introduced alerts for early identification of sepsis, initiation of 'Code Sepsis';
- Monthly steering committees to review sepsis cases and monitor adherence to sepsis protocols and timing of treatment;
- Annual competency exams for early identification, management of sepsis patients
- Outreach to referring nursing homes to aid in earlier detection and response; and
- Data analytics to regularly benchmark, monitor, and identify opportunities.

CAUTI Reduction

- Focused efforts to reduce Foley placements, education and support to stop Foley placements in the ED unless clinically required;
- Patients with Foley placements reviewed daily during multidisciplinary huddles;
- Deep-dive review for every hospital-acquired CAUTI;
- Annual competency for proper urinary catheter maintenance;
- Create IT alerts for day 2+ of Foleys;
- Introduce appropriate indications for Foley insertions in the EMR; and
- Data analytics to regularly benchmark, monitor, and identify opportunities.

Slides depicting significant quality improvement in each of these areas in recent years are attached as Completeness Exhibit C.

15. For the most recent two years, provide CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by Health Quest. Documents may be submitted electronically via e-mail or on a CD accompanying responses.

RESPONSE:

See Completeness Exhibit D attached.

16. In the Study of Community Health Needs Conducted for the Foundation for Community Health, published in October of 2014 (Exhibit I of the Application), it is noted that areas for health concern in the Hospital's service area include mental health, access to health care, substance abuse, obesity, especially among children and youth, and difficulties encountered by the Hispanic community members accessing health care. Please provide a copy of the Implementation Plan that indicates what the Hospital's strategies have been in addressing these areas of concern.

RESPONSE:

The Community Health Needs Assessment ("CHNA") attached to the CON Application as Exhibit I was conducted by FCH. The Hospital did not, therefore, prepare its own Implementation Plan for the community needs identified therein. As a for-profit entity, Sharon is not required by Federal law to conduct its own CHNA. Nevertheless, the Hospital keeps apprised of community health concerns and strives to address these concerns in its treatment of patients on a daily basis.

As a tax-exempt entity, Vassar Connecticut will conduct a CHNA on behalf of Sharon Hospital. As discussed below, Health Quest intends to conduct an initial assessment in FY 2017, and then work Sharon into the 3-year reassessment cycle in place for other System hospitals. In the meantime, representatives of Health Quest have reviewed FCH's CHNA and will look to the foundation for guidance in drafting Sharon Hospital's plan.

17. Is a 2017 CHNA study underway? If so, have preliminary needs have been identified? How is Health Quest taking identified community needs into account in its assessment of current and future needs of the Hospital and the community it serves?

RESPONSE:

No, Health Quest has not yet commenced its 2017 CHNA study for the Sharon area. Health Quest intends to begin its CHNA study immediately post-closing. This initial plan is expected to be in place by the end of FY 2017. The balance of Health Quest's hospitals just completed their CHNA's for the FY 2017 through FY 2019 cycle. Subsequent CHNA's for Sharon will be on the same cycle as the other Health Quest hospitals.

Health Quest has not formally identified any community needs at this time. However, as mentioned above, representatives of Health Quest have reviewed FCH's CHNA and will meet with representatives of FCH in order to better understand the health needs of the Sharon community. Health Quest will look to FCH to help inform its CHNA, similar to how it meets with local boards of health, the American Heart Association, the American Cancer Society, and similar organization in assessing the community health needs of its New York hospitals' service areas.

18. Complete the table below indicating how many patients from the Hospital's Connecticut primary service area towns (North Canaan, Sharon, Salisbury, New Milford, Torrington, Cornwall, Canaan and Kent) received the following services at each of Health Quest's New York-based hospitals:

RESPONSE:

Below is a table showing the number of inpatient discharges for patients residing in Sharon Hospital's Connecticut primary service area who received care at Health Quest's New York hospitals in FY 2016.

	No. of patients originating from the Hospital's CT-based primary service area in FY 2016		
Service	**Vassar Brothers Medical Center**	**Northern Dutchess Hospital**	**Putnam Hospital Center**
Medical/Surgical (adult)	32	3	6
Maternity	--	--	1
Psychiatric	--	--	2
Rehabilitation	--	--	--
Pediatric	--	--	--
Newborn	--	--	1
Total	**32**	**3**	**10**

Note that if you look at patients residing in towns in Sharon's New York primary services area who received inpatient services at Health Quest's other hospitals, the numbers increase dramatically, to more than 700 patients in FY 2016.

	No. of patients originating from the Hospital's NY-based primary service area in FY 2016		
Service	**Vassar Brothers Medical Center**	**Northern Dutchess Hospital**	**Putnam Hospital Center**
Medical/Surgical (adult)	393	154	9
Maternity	27	21	2
Psychiatric	--	--	5
Rehabilitation	--	11	--
Pediatric	25	--	--
Newborn	28	24	2
Total	**473**	**210**	**18**

The chart below reflects the nearly 750 patients from Sharon's primary service area towns in Connecticut and New York who were discharged from Health Quest hospitals in FY 2016.

	No. of patients originating from the Hospital's total primary service area (CT & NY) in FY 2016		
Service	**Vassar Brothers Medical Center**	**Northern Dutchess Hospital**	**Putnam Hospital Center**
Medical/Surgical (adult)	425	157	15
Maternity	27	21	3
Psychiatric	--	--	7
Rehabilitation	--	11	--
Pediatric	25	--	--
Newborn	28	24	3
Total	**505**	**213**	**28**

Moreover, the above tables do not include secondary service area towns from which there were significant additional discharges. For example, the number of patients residing in Sharon's New York primary and secondary service area towns combined discharged from Health Quest system hospitals in FY 2016, totaled more than 2,300.

Based on their medical needs, Health Quest expects to decant a number of patient residing in both Connecticut and New York from its existing system hospitals (some of which are experiencing capacity issues) to Sharon. These will be patients for whom Sharon presents a more accessible location for hospital services. Regardless of where the patients presenting to Sharon reside (whether in Connecticut, New York or elsewhere) their utilization of services will

contribute to the financial strength and viability of the Hospital for the benefit of the Connecticut residents who use it.

19. Regarding the Sharon Hospital Financial Worksheet and related financial assumptions:

    a. The Applicants project incremental gross revenue in FY 2017 of $12.6M, increasing to incremental gross revenue in FY 2018 of $39.1M. Explain in detail how these figures were estimated and how the Applicants specifically took into account the various utilization increases (across the board and/or service specific) in these gross revenue figures. How will prices charged enter into these assumptions?

RESPONSE:

Outlined below is a summary of discharge activity and gross revenue projections broken down by service grouping. Incremental gross revenue is driven solely by utilization increases. No price / chargemaster changes have been planned or contemplated in the "incremental" projections.

Sharon Hosptial - Incremental Growth Projections

Discharges:	2016A	2017	2018	2019	2020
Medical/Surgical/ICU	1,531	1,831	2,513	2,444	2,448
OB	279	299	350	398	406
GeroPsych	325	348	428	471	480
Newborns	276	296	347	395	403
Total (base + incremental)	**2,411**	**2,774**	**3,638**	**3,708**	**3,737**
Organic Growth (w/o CON)		24	48	73	98
Total Discharges		**2,798**	**3,686**	**3,781**	**3,835**

Discharges - Change v. 2016:	2016A	2017	2018	2019	2020
Medical/Surgical/ICU		300	982	913	917
OB		20	71	119	127
GeroPsych		23	103	146	155
Newborns		20	71	119	127
Total (incremental)	**-**	**363**	**1,227**	**1,297**	**1,326**
Organic Growth (w/o CON)		24	48	73	98
Total Discharges Change v Base		**387**	**1,275**	**1,370**	**1,424**

Total Days:	2016A	2017	2018	2019	2020
Acute	6,160	6,921	8,837	8,589	8,315
Psych	3,628	3,885	4,778	5,258	5,363
Total Patient Days	**9,788**	**10,806**	**13,615**	**13,846**	**13,678**
ALOS - Acute	3.0	2.9	2.8	2.7	2.6
ALOS - Psych	11.2	11.2	11.2	11.2	11.2
ALOS - Total	**4.1**	**3.9**	**3.7**	**3.7**	**3.7**
ADC	**27**	**30**	**37**	**38**	**37**

IP Admissions:	2017	2018	2019	2020
Medical/Surgical/ICU	$ 6,230,493	$ 21,340,291	$ 23,994,398	$ 26,489,500
OB	$ 332,580	$ 848,079	$ 798,192	$ 132,367
GeroPsych	$ 722,913	$ 2,514,480	$ 1,351,533	$ 296,080
Newborns	$ 90,360	$ 230,418	$ 216,864	$ 35,692
Total Inpatient (incremental)	**$ 7,376,346**	**$ 24,933,268**	**$ 26,360,987**	**$ 26,953,639**
Outpatient Services:				
Emergency	$ 2,724,865	$ 9,210,495	$ 9,737,903	$ 9,956,832
[1]All Other Outpatient	$ 2,500,000	$ 5,000,000	$ 7,000,000	$ 7,500,000
Total Outpatient (incremental)	**$ 5,224,865**	**$ 14,210,495**	**$ 16,737,903**	**$ 17,456,832**
Total Hospital Incremental	**$12,601,211**	**$ 39,143,763**	**$ 43,098,890**	**$ 44,410,471**

(1) "All Other Outpatient" revenue represents lab, radiology, surgery, etc. Gross revenue for this group was estimated by proxy using the activity of similarly situated physicians in each service group. The physician service group includes cardiology, surgery, pulmonology, oncology, and OB/GYN.

b. Regarding the Projected Payer Mix based on Discharges on page 53 and the Projected Net Patient Revenue (Line A. 5) on page 531, how do the projections specific to Medicare reflect a transition of some or many of the system geropsychiatric patients to the Sharon Hospital site. Do the incremental figures provided for Medicare specific assume an increase for these patients? Why do the Applicants project "stable payer mix" in this regard?

RESPONSE:

A stable payer mix assumes a proportionally similar revenue and net revenue stream as exists today at Sharon Hospital. While geropsychiatric patients are typically Medicare insured (but not exclusively), we also expect non-Medicare insured growth in other service lines (e.g. OB/GYN) being brought to Sharon. The combination of new/expanded service offerings and broader commercial contracting activity with New York health plans results in a stable payer mix projection.

c. The financial projections on page 532 assume "payer contract changes" (page 43). Are the incremental increases in Commercial Insurers Net Patient Service Revenue (Line A. 9) for FY 2017-FY 2018, specifically related to changed payer contracts, overall utilization increases or a combination? Are these factors related to the incremental projections?

RESPONSE:

Incremental increases in Commercial Insurers net patient service revenue relate to both payer contract expansion and utilization. This growth contemplates expanding participation in both service-line offerings (e.g. surgery, acute inpatient, etc.) and direct contracting with New York-based health plans. These activities, in conjunction with general service-line expansion contribute to the projected growth.

d. Why isn't there any Uninsured Net Patient Service Revenue (with or without the CON) listed on Line A. 10? Per the Hospital's financial filings to OHCA, in FY 2015 Sharon Hospital had 1.7% uninsured based on charges and 0.5% uninsured based on payments. Please reconcile.

RESPONSE:

Financial Worksheet B has been revised to separate Uninsured and Self Pay revenue. A copy of the revised Financial Worksheet B is attached as Completeness Exhibit E.

e. What does Line A. 13 "Other" represent for the Sharon Hospital projections?

RESPONSE:

Generally characterized, "Other" represents all other non-direct contract and low-volume payers (e.g.Magnacare, Harvard Pilgrim, etc.).

f. Line B. 4, Supplies and Drugs, is projected to continue to increase throughout the fiscal years presented. How much of the incremental amounts reflect the increased volume projections and how much are these amounts offset by being part of the Health Quest purchasing system?

RESPONSE:

For the most part, all of the incremental amounts for Supplies and Drugs relate to increased volume and acuity. We have projected a 3.5% or approximately $250,000 year-over-year net increase in Supply and Drug cost in the financials. Neutralized for volume, historically we have seen aggregate supply and drug costs increase by 4% - 8% per annum driven primarily by pharmaceuticals. Conservatively, we anticipate saving roughly 2.5% in this category as it relates to being part of the Health Quest purchasing system.

g. Are the increasing incremental operating revenues, as reflected in the financial attachment on page 531 (increasing from approximately $4.6M in FY 2017 to $16.5M in FY 2020) attributable solely to the anticipated average daily census increase of 10 additional patients? Provide a more detailed list of assumptions and explanation.

RESPONSE:

Incremental operating revenues are the result of inpatient admissions, which contribute to the average daily census, as well as increased outpatient visits (section F, line 2) associated with additional admissions (e.g. emergency room, surgeries, etc.) and additional physician services expected to be provided in the community (e.g. cardiology, oncology, orthopedics, pain, etc.) See Response to Question 19.a. above for additional details.

h. The Financial Attachment includes a projection of 48 additional full time employees through FY 2020. How many of these additional employees are physicians? Will these physicians be new to the Health Quest system and dedicated full time to the Hospital or will they be existing doctors rotating into the Hospital?

RESPONSE:

The financials on page 531 line E show full time employees increasing from 257 in FY 2016 to 275 in FY 2020 – a net of 18. Sharon Hospital is projected to add a total eighteen (18) full time employees through FY 2020, all of which are non-physician positions. Any physician hires would be reflected in the Regional Healthcare Associates, LLC ("RHA") change of ownership CON submission (Docket No. 16-32133-CON).

20. There is a discrepancy between Sharon Hospital's total operating expenses on Financial Worksheet (B) of the application in the amount of $48,393,242 and the total operating expense amount of $46,746,699 in the consolidating section of the Sharon Hospital Holding, Inc. FY 2015 audited financial statements. A discrepancy also exists for Net loss amount on Financial Worksheet (B) of ($15,070,778) versus ($18,200,362) on the on the audited financial statements. Correct Worksheet (B) so that the total operating expense amount and net loss amounts for Sharon Hospital agrees with the total operating expense and net loss amounts of the audited financial statements for Sharon Hospital.

RESPONSE:

The discrepancies for FY 2015 between the Financial Worksheet (B) and the audited financial statements for Sharon Hospital Holding, Inc., as they relate to total operating expenses and net loss, reflect traceable adjustments to better represent the financial results of the hospital versus the associated physician practices and services provided at a corporate level. For example, the total operating expenses for Sharon Hospital reported on Financial Worksheet (B) include the $1.7 million RegionalCare management fee. This fee represents actual work performed on behalf of Sharon and not simply a percentage of corporate overhead. Moreover, these types of expenses will be included as Hospital expenses going forward under Health Quest ownership. For these reasons, Sharon included them as expenses in the CON submission. In addition, the Hospital's net loss on Financial Worksheet (B) did not include $3.1 million in losses attributable to the associated physician practices and included as losses on SHHC's consolidated audited financial statements. These losses are reflected in the pro forma included with the CON submission in Docket No. 16-32133-CON, in order to provide a more accurate picture of the financial condition of the practices.

Below is a table that reconciles the difference back to the audited financial statements (relevant excerpt attached as Completeness Exhibit F).

	Essent Healthcare of Connecticut, Inc.	*Clinics	Total
Total Operating Expenses - (AFS)	**$ 46,746,699**	**$ 8,678,392**	**$ 55,425,091**
Adjustments:			
Management Fee from RegionalCare (see ref. A)	$ 1,697,387	$ -	$ 1,697,387
Interest Income (see ref. A)	$ (50,844)	$ -	$ (50,844)
Total Operating Expenses - Financial Worksheet (B)	**$ 48,393,242**	**$ 8,678,392**	**$ 57,071,634**
Net Income / (Loss) - (AFS)	**$ (18,200,362)**	**$ -**	**$ (18,200,362)**
Adjustments			
Intercompany Fees (see ref. B)	$ 3,129,584	$ (3,129,584)	$ -
Total Net Income / (Loss) - Financial Worksheet (B)	**$ (15,070,778)**	**$ (3,129,584)**	**$ (18,200,362)**

Notes:
*Regional Healthcare Associates, Tri State Women's Services and elimnation combined. Eliminations pertain to Tri State Women's Service and therefore is included with clinics.

21. How did the Applicants arrive at the FY 2016 actual amounts for revenues, expenses and utilization for the Health Quest, Inc. system Financial Worksheet (B) when the system's fiscal year will not end until December 31, 2016? Resubmit the Financial Worksheet (B) for Health Quest, Inc. which includes FY 2015 actual numbers for revenues, expenses and utilization.

RESPONSE:

Health Quest used FY 2015 (January 1 through December 31) as a proxy for FY 2016 in Financial Worksheet A so as to have "actual" data against which to project FY 2017 and subsequent years. Per OHCA's request, Health Quest has restated Financial Worksheet A to include the following:

- FY 2015 "actual" results based on Health Quest's audited fiscal year of January 1 through December 31.
- FY 2016 "actual" results based on a fiscal year beginning October 1, 2015 and ending September 30, 2016.
- Projected FYs 2017 through 2020 based on a fiscal year of October 1 through September 30.

FY 2015 results are stated for Health Quest's actual fiscal year so that they can be checked against the company's audited financial statements as provided in the CON submission. FY 2016 results, and FY 2017 through FY 2020 projections, are stated on an October 1 through September 30 fiscal year so that they will tie with Sharon Hospital's financial results and

projections, which are and will continue to be reported to OHCA on an October/September fiscal year.

See Completeness Exhibit G.

22. Of the incremental revenues, expenses and volume as reported on page 532, please indicate what is specifically attributable to acquiring Sharon Hospital by Health Quest Systems, Inc. What is the projected financial and utilization impact of this acquisition on other system providers? Be specific.

RESPONSE:

The Health Quest Financial Worksheet A combined the results of Sharon Hospital and the related physician practices in the incremental columns to reflect the total incremental impact of this transaction to the system. The Financial Worksheet for Health Quest has been revised to reflect Sharon Hospital results only in the incremental columns (see Completeness Exhibit G). All of the incremental revenue, expenses and volumes in the attached Financial Worksheet A are attributable to the Hospital. FY 2017 has been prorated assuming a July 1, 2017 closing date.

Health Quest anticipates the addition of Sharon Hospital and RHA to be fully accretive to the financials. This will be driven primarily through enhanced service availability and access to providers addressing capacity and capabilities issues both in and outside of the Health Quest system. Applicants have not detailed out the impact by facility; however, between the aforementioned activities combined with system synergies Health Quest expects to extract the full value out of the acquisition.

COMPLETENESS EXHIBIT A

GRANT AGREEMENT

This Grant Agreement (this "**Agreement**") is made and entered into effective as of the 8th day of September, 2016 (the "**Effective Date**") by and between **The Foundation for Community Health, Inc.**, a Connecticut non-stock corporation ("**FCH**"), **Health Quest Systems, Inc.**, a New York not-for-profit corporation ("**Health Quest**"), and only with regard to Articles 1, 2, 5, 6 and 7, **Berkshire Taconic Community Foundation, Inc.**, a Connecticut non-stock corporation ("**Berkshire Taconic**"). FCH and Health Quest shall be referred to individually as a "**Party**" and collectively as the "**Parties**."

WITNESSETH

WHEREAS, FCH is an organization described in Sections 501(c)(3) and 509(a)(3) of the Internal Revenue Code of 1986, as amended (the "**Code**"), and is organized and operated exclusively to support certain charitable purposes of Berkshire Taconic, Community Foundations of the Hudson Valley, and The Community Foundation of Northwest Connecticut, Inc. (collectively, the "**Supported Organizations**"), including maintaining and improving the physical and mental health of all residents of the area historically served by Sharon Hospital, Inc.;

WHEREAS, Health Quest is an organization described in Sections 501(c)(3) and 509(a)(2) of the Code that is organized and operated exclusively for charitable purposes;

WHEREAS, Health Quest seeks to acquire substantially all of the assets and operations of Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital ("**Sharon Hospital**") (such Sharon Hospital assets and operations hereafter, the "**Hospital Assets**");

WHEREAS, Health Quest seeks Nine Million Dollars ($9,000,000) from the community ("**Community Fundraising Goal**") to support the acquisition of the Hospital Assets and to fund investments in the tax-exempt entity that will operate the hospital following the acquisition of the Hospital Assets ("**New Sharon Hospital**");

WHEREAS, FCH has determined that the issuance of financial support to Health Quest for the acquisition of the Hospital Assets and future investments in New Sharon Hospital will directly or indirectly further the interests and charitable purposes of the Supported Organizations within the meaning of Treasury Regulations Section 1.509(a)-4(e)(3);

WHEREAS, on behalf of the community, FCH, will advance to Health Quest an amount up to or equal to the requested Nine Million Dollars ($9,000,000) through the grants, and under the conditions, set forth in this Agreement in order to satisfy Health Quest's immediate time constraints;

WHEREAS, FCH, with the assistance of Health Quest and New Sharon Hospital, will launch a community fundraising campaign to raise funds in order to meet the Community Fundraising Goal ("**Capital Campaign Funds**") and therefore minimize or eliminate the amount that FCH has guaranteed to advance in the event of any fundraising shortfall so that FCH may continue its support to maintaining and improving the physical and mental health of the area historically served by Sharon Hospital, Inc.;

WHEREAS, FCH and Health Quest have determined that the establishment of the Community Fundraising Goal and the community fundraising campaign will strengthen the relationship between the community and New Sharon Hospital;

WHEREAS, Health Quest has determined that working collaboratively with FCH following the issuance of the grants will help ensure that all individuals in the area historically served by Sharon Hospital, Inc. have access to, and receive, high quality health care and that the local community's public health needs are considered and best addressed;

WHEREAS, Health Quest believes that FCH serves a significant community role in ensuring that all individuals in the area historically served by Sharon Hospital, Inc. have access to, and receive, high quality health care; and

WHEREAS, Health Quest desires to receive the Asset Purchase Grant and the Working Capital Grant on the terms and conditions set forth in this Agreement.

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

ARTICLE 1

OBLIGATIONS OF FCH

1.1 **Creation of the Restricted Component Fund.** The Parties and Berkshire Taconic hereby agree that Nine Million Dollars ($9,000,000) of FCH funds currently managed by Berkshire Taconic in its Managed Pool are hereby designated restricted funds, that such funds shall be segregated into a distinct and separate component fund, and that such funds shall be disbursed, for the purchase of the Hospital Assets and Investments (as defined in Section 1.3) (the "**Restricted Funds**", and this distinct component fund, the "**Restricted Component Fund**"), only upon instruction by FCH and in accordance with the terms and conditions of this Agreement and any other document agreed upon between FCH and Berkshire Taconic regarding the Restricted Funds (each an "**FCH/Berkshire Agreement**"); provided, however, that in the event of any conflict or inconsistency between this Agreement and any FCH/Berkshire Agreement (including, but not limited to

any amendment to the Services Agreement as contemplated in the next sentence) this Agreement shall control. FCH and Berkshire Taconic shall amend the Services Agreement between FCH and Berkshire Taconic dated March 26, 2014 as necessary to effectuate the obligations of FCH and Berkshire Taconic under this Agreement. Notwithstanding the foregoing, nothing in this Agreement shall otherwise limit FCH's ability to direct the manner in which the Restricted Funds are invested, or to delegate the management and investment of the Restricted Funds, so long as such Restricted Funds are invested and managed in a manner consistent with FCH's management and investment of its unrestricted funds. Capital Campaign Funds shall be treated as Restricted Funds and deposited into the Restricted Component Fund. Income derived from the investment of the Restricted Funds shall not be treated as Restricted Funds. Both (i) the FCH advanced funds that are replaced by Capital Campaign Funds and (ii) the income derived from the investment of all Restricted Funds may be transferred from the Restricted Component Fund and deposited into FCH's primary component fund with Berkshire Taconic that does not contain the Restricted Funds (the "**Primary Fund**") as provided for in the reconciliation process set forth in Section 1.4.

1.2 **Asset Purchase Grant**. No later than one hundred twenty days (120) days before the closing (the "**Closing**") of the transactions contemplated by the asset purchase agreement between Health Quest (and affiliates thereof) and RegionalCare Hospital Partners, Inc. (or affiliates thereof) ("**RCHP**") for the acquisition by Health Quest (or an affiliate of Health Quest) of the Hospital Assets (the "**Asset Purchase Agreement**"), Health Quest will notify FCH of the expected date of the Closing (the "**Closing Date**"). FCH shall promptly notify Berkshire Taconic of its intent to grant Health Quest Three Million Dollars ($3,000,000), as adjusted, if applicable, by Section 1.5 (the "**Asset Purchase Grant**") for Health Quest's use solely as an offset to the final Purchase Price (as defined below) of the Hospital Assets under the Asset Purchase Agreement. The "**Purchase Price**" shall be defined as the cash paid by Health Quest to RCHP at the Closing plus the value of the accrued vacation, holiday/paid time off, recorded sick time liability, and unrecorded extended illness benefits assumed by Health Quest and/or New Sharon Hospital (the "**Assumed Liabilities**"). Health Quest represents and warrants to FCH that the Purchase Price shall be no less than Five Million Dollars ($5,000,000). On the Closing Date, Berkshire Taconic shall disburse from the Restricted Funds the Asset Purchase Grant by wire transfer to an account designated by Health Quest; provided, however, that if the Asset Purchase Agreement expires or terminates prior to the Closing or the Connecticut Office of Health Care Access ("**OHCA**") denies Health Quest's certificate of need application (the "**CON Application**"), then FCH shall have no obligation to make the Asset Purchase Grant, all restrictions on the Restricted Funds shall be deemed met except for restrictions on the Capital Campaign Funds, FCH may notify Berkshire Taconic to transfer to the Primary Fund any such funds where the restrictions shall be deemed met, and thereafter either Party may terminate this Agreement by written notice to the other Party.

1.3 **Working Capital Grant**. The remaining Six Million Dollars ($6,000,000) of the Restricted Funds, as adjusted, if applicable, by Section 1.5 (the "**Working Capital Grant**") are dedicated for actual direct cost outlays associated with Health Quest's strategic investments at New Sharon Hospital including, without limitation, investments in direct physician and provider costs, investments in strategic equipment, facility upgrades, investments in ambulatory networks, investments in information technology infrastructure, and other strategic programmatic investments (collectively, "**Investments**"). For purposes of this Agreement, Investments are limited to expenditures that are a direct benefit to New Sharon Hospital and shall not include any allocation of system-wide improvements even where there is a direct benefit to New Sharon Hospital (e.g., a system-wide software upgrade). However, no secondary or incidental benefit recognized by another Health Quest affiliate as a result of an Investment shall prevent Health Quest from submitting a request for reimbursement from the Working Capital Grant (e.g., medical providers at other Health Quest affiliates may benefit from Investments in the form of medical record software upgrades at New Sharon Hospital). On the first, second, and third anniversary of the Closing, Health Quest shall deliver to FCH an inventory of the prior year Investments made by Health Quest as determined by Health Quest in its reasonable discretion. Upon receipt by FCH of reasonable documentation from Health Quest that the prior year expenditures qualify as Investments, and Health Quest's written certification of same, Berkshire Taconic shall disburse from the Restricted Funds by wire transfer to an account designated by Health Quest an amount equal to fifty percent (50%) of the lesser of: (i) the amount of the prior year Investments minus One Hundred Sixty Six Thousand Six Hundred Sixty Seven Dollars ($166,667), or (ii) two-thirds (2/3) of the Working Capital Grant (the Working Capital Grant amount adjusted, if applicable, by the provisions of Section 1.5). By way of example, if prior year Investments totaled Two Million Six Hundred Sixty Six Thousand Six Hundred Sixty Seven Dollars ($2,666,667), then the reimbursement from the Working Capital Grant shall be One Million Two Hundred Fifty Thousand Dollars ($1,250,000) [$1,250,000 is 50% of the lesser of: (i) $2,500,000 ($2,666,667 - $166,667) or (ii) $4,000,000]. After the third anniversary of the Closing, if the entirety of the Working Capital Grant has not been transferred to Health Quest, an additional year shall be added to the term of this Section 1.3, consistent with the terms and conditions of the initial three (3) years, so that Health Quest may make sufficient Investments in order to receive reimbursements from FCH, in the aggregate, equal to the amount of the Working Capital Grant. If a fourth year anniversary payment would result in the aggregate amount of annual payments exceeding the total Working Capital Grant amount, that fourth year anniversary payment shall be reduced so that the total of the four annual reimbursements equals the amount of the Working Capital Grant. For purposes of this potential fourth year anniversary calculation only, the reimbursement formula is adjusted by removing the language "minus One Hundred Sixty Six Thousand Six Hundred Sixty Seven Dollars ($166,667)" such that this reimbursement shall be an amount equal to fifty percent (50%) of the lesser of: (i) the amount of the prior year Investments, or (ii) two-thirds (2/3) of the

Working Capital Grant (the Working Capital Grant amount adjusted, if applicable, by the provisions of Section 1.5). If the total amount of the Working Capital Grant has not been transferred, in the aggregate, after the fourth anniversary of the Closing, FCH shall have no obligation to grant to Health Quest any remaining portion of the Working Capital Grant. Once FCH has satisfied its obligations with regard to the Working Capital Grant (i.e., either following the third or fourth anniversary of the Closing), FCH may notify Berkshire Taconic that the restrictions on any remaining Restricted Funds have been met other than the restrictions on the Capital Campaign Funds and transfer such funds to the Primary Fund.

1.4 **Reconciliation of Restricted Component Fund.** All payments to Health Quest required by Sections 1.2 and 1.3 shall first be satisfied from the Capital Campaign Funds within the Restricted Component Fund available at the time of payment. No later than thirty (30) days after the Closing Date and no later than thirty (30) days after each of the first through third anniversaries of the Closing (or Closing Date and upon each of the first through fourth anniversaries of the Closing if the Working Capital Grant has not been transferred completely by the third anniversary), the Restricted Component Fund shall be reconciled so as to determine that the outstanding Working Capital Grant requirements may be satisfied and what amounts, if any, that may be transferred from the Restricted Component Fund and deposited into the Primary Fund. If for any reason the then-current remaining balance of the Restricted Component Fund is greater than the amount of FCH's outstanding obligations with regard to the Health Quest reimbursements from the Working Capital Grant (e.g., investment return or FCH funds that are being replaced by Capital Campaign Funds), FCH may cause Berkshire Taconic to transfer any or all such excess funds that are not Capital Campaign Funds from the Restricted Component Fund to the Primary Fund and such transferred funds shall not be treated as Restricted Funds. If for any reason the then-current remaining balance of the Restricted Component Fund is insufficient to satisfy FCH's outstanding obligations with regard to the Health Quest reimbursements from the Working Capital Grant (e.g., due to investment losses), Berkshire Taconic shall transfer funds from the Primary Fund to the Restricted Component Fund in order to satisfy such deficit and those transferred funds shall be treated as Restricted Funds; provided, however, that nothing in this Agreement shall require Berkshire Taconic to transfer funds into the Restricted Component Fund in excess of the amount then in the Primary Fund. By way of example, if on the Closing Date the balance of the Restricted Component Fund is Eleven Million Five Hundred Thousand Dollars ($11,500,000) because Two Million Dollars ($2,000,000) was raised by the community fundraising campaign and investment growth totaled Five Hundred Thousand Dollars ($500,000), then following the payment of the Asset Purchase Grant (assuming there has been no adjustment pursuant to Section 1.5), FCH may elect to transfer Two Million Five Hundred Dollars ($2,500,000) to the Primary Fund such that the balance of the Restricted Component Fund is Six Million Dollars ($6,000,000). If, following the time that FCH has satisfied its obligations for the Working Capital Grant, the Restricted

Component Fund still contains Capital Campaign Funds (due to either fundraising in excess of Nine Million Dollars ($9,000,000) total or because the community fundraising campaign did not satisfy one hundred percent (100%) of FCH's obligations with regard to either or both the Asset Purchase Grant or Working Capital Grant at the time a grant payment was due), FCH shall maintain the Restricted Component Fund to support additional Investments at New Sharon Hospital. Health Quest or New Sharon Hospital may request that FCH grant these additional funds to be utilized solely for Investments. Subject to the restrictions placed on the Capital Campaign Funds by donors (but not subject to Section 1.3 hereof), the administration of these remaining Capital Campaign Funds shall be governed by the general FCH grant procedures then in effect. Neither Health Quest nor New Sharon Hospital shall have any obligation to repay FCH an amount equal to these Capital Campaign Funds remaining after the satisfaction of FCH's obligations with regard to the Working Capital Grant.

1.5 **Adjustments to Amount of Asset Purchase Grant and Working Capital Grant.** The amounts of the Asset Purchase Grant and the Working Capital Grant are calculated based on the Purchase Price being at least Five Million Dollars ($5,000,000) and total FCH grants in the amount of Nine Million Dollars ($9,000,000). If the Purchase Price is less than Four Million Nine Hundred Thousand Dollars ($4,900,000) as a result of the net working capital component of the Purchase Price, then the Asset Purchase Grant and the Working Capital Grant will decrease and increase, respectively, by one hundred percent (100%) of the amount by which the Purchase Price is less than Five Million Dollars ($5,000,000) so that the combined Asset Purchase Grant and Working Capital Grant remain equal to Nine Million Dollars ($9,000,000) total. If the Purchase Price is more than Five Million One Hundred Thousand Dollars ($5,100,000) as a result of the net working capital component of the Purchase Price, then the Asset Purchase Grant and the Working Capital Grant will increase and decrease, respectively, by one hundred percent (100%) of the amount by which the Purchase Price is more than Five Million Dollars ($5,000,000) so that the combined Asset Purchase Grant and Working Capital Grant remain equal to Nine Million Dollars ($9,000,000) total, subject to the restriction that the maximum amount of the Asset Purchase Grant is Five Million Dollars ($5,000,000). By way of example, if the Purchase Price is Four Million Eight Hundred Thousand Dollars ($4,800,000), then the Asset Purchase Grant would be Two Million Eight Hundred Thousand Dollars ($2,800,000) and the Working Capital Grant would be Six Million Two Hundred Thousand Dollars ($6,200,000).

1.6 **Compliance.** FCH will comply in all material respects with all applicable laws, regulations, and policies relating to the making of the Asset Purchase Grant and Working Capital Grant and the solicitation and acceptance of Capital Campaign Funds.

ARTICLE 2

OBLIGATIONS OF HEALTH QUEST

2.1 **Organization of New Hospital.** New Sharon Hospital shall be organized as a Connecticut nonstock corporation. Health Quest shall structure the Asset Purchase Agreement such that New Sharon Hospital receives the Hospital Assets at the Closing. Health Quest shall cause New Sharon Hospital to: (a) apply to the Internal Revenue Service (**"IRS"**) for recognition of exemption from federal income taxation and (b) register with other state tax and regulatory bodies in a manner consistent with New Sharon Hospital's status as a public charity described in Code Sections 501(c)(3), 509(a)(1) and 170(b)(1)(A)(iii). Health Quest shall operate New Sharon Hospital on a non-profit basis and maintain recognition of exemption from federal income taxation.

2.2 **Fair Market Value.** Health Quest shall pay RCHP no more than fair market value for the Hospital Assets in a manner consistent with published IRS guidance. Health Quest shall provide to FCH copies of any appraisals of the Hospital Assets obtained by Health Quest or its affiliates.

2.3 **Annual Payment by Health Quest**.

2.3.1 Subject to Sections 2.3.1 and 2.3.3, within thirty (30) days after each of the first through tenth anniversaries of the Closing, Health Quest or New Sharon Hospital, as selected by Health Quest, shall pay to FCH an amount equal to the Outstanding Grant Amount (as defined below) on the date of such anniversary multiplied by four percent (4%) (the "**Grantee Payment**").

2.3.2 For purposes of the Agreement, the Outstanding Grant Amount shall be the amount, as of thirty (30) days following the prior anniversary date, equal to the aggregate amount of the Asset Purchase Grant and Working Capital Grant paid, less the aggregate amount of Capital Campaign Funds raised (with regard to the first anniversary, references to the prior anniversary mean the Closing). By way of example, if One Million Dollars ($1,000,000) was raised by the community fundraising campaign as of Closing and applied to the Asset Purchase Grant and Two Million Dollars ($2,000,000) was raised during the following year of which One Million Dollars ($1,000,000) was made as a Working Capital Grant within thirty (30) days of the first anniversary, then the Outstanding Grant Amount for the second anniversary shall be One Million Dollars ($1,000,000) ($4,000,000 - $3,000,000. *N.B. The reason the Outstanding Grant Amount is only $1,000,000 even though $2,000,000 of FCH funds were used for the Asset Purchase Grant is because there is $1,000,000 of excess Capital Campaign Funds in the Restricted Component Fund that FCH will invest after satisfying the working capital requirements for year one*]. Only funds donated to FCH through Berkshire

Taconic for the New Sharon Hospital capital campaign will be considered for the purpose of reducing the Outstanding Grant Amount. Health Quest agrees to collaborate with FCH in connection with this capital campaign, including the development of procedures for documenting the amounts attributable to the New Sharon Hospital capital campaign. Neither Health Quest nor New Sharon Hospital shall conduct a capital campaign to raise funds specifically for New Sharon Hospital in the Sharon Hospital catchment area until the earlier to occur of: (a) the time that FCH has raised Nine Million Dollars ($9,000,000) in the aggregate toward the Community Fundraising Goal; or (b) the five (5) year anniversary of the Effective Date. By way of clarification, Health Quest shall not be prohibited, within the Sharon Hospital catchment area or otherwise, from: (a) accepting unsolicited donations (e.g., grateful patients); or (b) soliciting and/or accepting donations that would be dedicated to purposes other than New Sharon Hospital.

2.3.3 The annual Grantee Payment shall be reduced by the amount by which Health Quest or New Sharon Hospital supports or undertakes any current or future FCH programs or grants ("**FCH Programming**") in accordance with to the provisions of this Section 2.3.3.

(a) FCH shall, upon Health Quest's or New Sharon Hospital's reasonable request, provide the requesting party with an inventory of the grants FCH supports and the programs FCH operates (both actively and pending fund distribution), along with the economic terms of such grant(s) and program(s).

(b) Health Quest or New Sharon Hospital may support FCH Programming by: (i) directly funding a grant that FCH desires to fund or is already funding; or (ii) undertaking and operating a program that FCH has approved.

(c) At least sixty (60) days prior to supporting or undertaking FCH Programming, Health Quest or New Sharon Hospital shall notify FCH of its intention regarding the FCH Programming, and the Parties shall meet to establish and agree upon objective and relevant outcome measures for the respective FCH grant or program (both the goal and how results will be measured for purposes of valuation) (the "**Outcome Measures**").

(d) Health Quest or New Sharon Hospital, as applicable, may modify the manner in which the relevant FCH program is administered (e.g., may use internal resources versus external resources to implement the program), so long as the Outcome Measures associated with the program are unchanged or improved.

(e) Health Quest or New Sharon Hospital, as applicable, may fund an existing FCH grant in a manner that does not breach the terms of the grant

agreement then in effect.

(f) At least sixty (60) days prior to the calculation of the annual Grantee Payment, Health Quest or New Sharon Hospital, as applicable, shall provide reasonable documentation to confirm that the above standards for permitting a reduction to the annual Grantee Payment have been met, including satisfying or exceeding the Outcome Measures.

(g) If all conditions of this Section 2.3.3 are met, the annual Grantee Payment shall be reduced by (i) the amount of the direct funds provided to a FCH Programming grantee and/or (ii) the direct cost FCH has foregone for the FCH Programming (not the direct cost to Health Quest or New Sharon Hospital), for the FCH Programming that Health Quest or New Sharon Hospital has provided.

Failure to follow the procedures above or meet the agreed upon Outcome Measures shall prevent Health Quest or New Sharon Hospital from reducing the annual Grantee Payment by its support or undertaking of FCH Programming.

2.3.4 Health Quest shall guarantee the obligations of New Sharon Hospital under this Agreement.

2.4 **Restrictions as to Uses of Grant**. Health Quest shall use the full amount of the Asset Purchase Grant and the Working Capital Grant solely for the purposes of purchasing the Hospital Assets and funding Investments in New Sharon Hospital following the acquisition of the Hospital Assets from RCHP. Health Quest may not use any portion of the Asset Purchase Grant or the Working Capital Grant (a) to participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of or in opposition any candidate for public office (within the meaning of Code Section 501(c)(3)) including, but not limited to, voter registration drives; (b) to carry on propaganda or to otherwise attempt to influence legislation; or (c) to undertake any activity for any purpose other than charitable, scientific, educational or other purposes specified in Code Section 170(c)(2)(B).

2.5 **New Sharon Hospital Programming.** Health Quest shall (and shall cause its affiliates, including New Sharon Hospital, to) comply with any obligations regarding the maintenance of health care service lines currently conducted by Sharon Hospital as are imposed by OHCA in connection with approval of the CON Application.

2.6 **Return of Grant Amount**.

2.6.1 Subject to Section 2.6.2, if, at any time during the five (5) years following the Closing, (i) Health Quest, directly or indirectly, through any affiliate or related party, transfers or sells all or substantially all of the assets and operations of New Sharon Hospital to a third-party, whether through an asset sale, an affiliation

agreement or any transaction where Health Quest no longer controls the operations of the New Sharon Hospital (a "**Sale**"); (ii) Health Quest voluntarily terminates New Sharon Hospital's license as a Connecticut acute-care hospital (a "**Closure**"); or (iii) following its initial determination, New Sharon Hospital is no longer recognized by the IRS as a public charity described in Sections 501(c)(3), 509(a)(1) and 170(b)(1)(A)(iii) of the Code ("**Loss of Exemption**"), then Health Quest shall reimburse FCH (or its successor) for any portion of the Asset Purchase Grant and Working Capital Grant transferred to Health Quest, less any Capital Campaign Funds described in Section 2.3.1 that were applied to the Asset Purchase Grant or Working Capital Grant. Upon any event triggering the reimbursement obligation under this Section 2.6.1, this Agreement would be automatically terminated, FCH may notify Berkshire Taconic that the restrictions on any remaining Restricted Funds have been met other than the restrictions on the Capital Campaign Funds and transfer such funds to the Primary Fund, and FCH would have no further obligations with regard to the Working Capital Grant.

2.6.2 For the avoidance of doubt, the direct or indirect change of ownership or control of New Sharon Hospital, or any transfer of all or substantially all of the assets and operations of New Sharon Hospital to another not-for-profit corporation described in Section 501(c)(3) where FCH has approved of the potential buyer as being similar to Health Quest as of the date of the Agreement with regard to its financial strength and charitable purposes, such approval not to be unreasonably withheld, will not trigger the reimbursement obligation described in Section 2.6.1, but such reimbursement obligation of Health Quest would survive any such transaction until the expiration of five (5) years following the Closing. A subsequent Sale, Closure or Loss of Exemption by such a successor not-for-profit corporation would trigger Health Quest's reimbursement obligation. To avoid the reimbursement obligation described in Section 2.6.1, Health Quest must require any potential buyer to agree that the terms of this Agreement will survive the transaction as if the potential buyer was an assignee of the Agreement.

2.7 Governance.

2.7.1 Promptly following execution of this Agreement, FCH shall provide Health Quest with a list of potential candidates to serve on the Board of Trustees of New Sharon Hospital. If Health Quest determines that such list provided by FCH includes a sufficient number of eligible and capable candidates, then, effective as of the Closing, Health Quest shall appoint no less than twelve (12) individuals from such list to the fifteen (15)-member Board of Trustees of New Sharon Hospital such that these individuals represent at least eighty percent (80%) of the initial Board of Trustees of New Sharon Hospital (each such trustee, a "**FCH Appointed Trustee**"). In the event that Health Quest refuses to appoint a sufficient number of the candidates provided by FCH to constitute eighty percent (80%) of the Board of Trustees of New Sharon Hospital, FCH shall have the

continued opportunity to submit additional candidates for consideration until the requisite number of FCH Appointed Trustees is obtained.

2.7.2 The initial terms of the Board of Trustees of New Sharon Hospital will be staggered such that an equal number (or as near as possible to an equal number) of trustees will serve for an initial term of one (1), two (2), or three (3) years. The initial terms of the FCH Appointed Trustees will be staggered such that an equal number (or as near as possible to an equal number) of FCH Appointed Trustees will serve for an initial term of one (1), two (2), or three (3) years (i.e., four (4) FCH Appointed Trustees shall have one (1) year terms, four (4) FCH Appointed Trustees shall have two (2) year terms, and four (4) FCH Appointed Trustees shall have three (3) year terms).

2.7.3 If a FCH Appointed Trustee (including any replacement FCH Appointed Trustee(s)) does not complete his or her initial term, or is not reapproved for a second three (3) year term, then FCH shall have the opportunity to nominate, in a manner consistent with the preceding, an individual to complete that initial term or second term as the case may be. For purposes of clarification, the result of this Section 2.7.3 is that (4) FCH Appointed Trustees (including their replacements, if any) shall serve no less than four (4) years on the Board of Trustees of New Sharon Hospital, (4) FCH Appointed Trustees (including their replacements, if any) shall serve no less than five (5) years on the Board of Trustees of New Sharon Hospital and (4) FCH Appointed Trustees (including their replacements, if any) shall serve no less than six (6) years on the Board of Trustees of New Sharon Hospital

2.7.4 The role, function and governance of New Sharon Hospital's Board of Trustees shall be consistent with the other hospitals ("**Other Hospitals**") within the Health Quest organization and subject to the prevailing bylaws of Health Quest, which may be modified from time to time. The New Sharon Hospital Board of Trustees shall not be treated any differently than any Other Hospital board. For example, if one Other Hospital board would be dissolved, then all of the Other Hospital boards should be dissolved. The reappointment of trustees shall follow the same governance procedures and protocols as are established for the Other Hospitals. Upon formation, the New Sharon Hospital Board of Trustees shall nominate a slate of officers, including the Chair and Vice Chair to be ratified by the Health Quest Board of Trustees, whose ratification shall not be unreasonably withheld. The Chair of the Board of Trustees of New Sharon Hospital shall serve *ex-officio* on the Health Quest Board of Trustees.

2.8 **Grant Agreement Diligence.** Health Quest shall provide on or before thirty (30) days of the Effective Date, the following documents, and shall have an ongoing obligation to provide updated, amended or revised versions executed up to, and including, the date of the Closing: (i) Health Quest's current IRS determination letter; (ii) the most recent IRS Form 990 filed by Health Quest; (iii) the most recently completed audited financial statements of Health Quest; (iv) the current business plan or other document outlining

planned Investments to New Sharon Hospital following the Closing; and (v) the financial assistance policy that Health Quest plans to implement at New Sharon Hospital.

2.9 **Reporting.** Health Quest is responsible for the expenditure of the Working Capital Grant consistent with the charitable purposes of Health Quest and for maintaining complete financial records consistent with generally accepted accounting practices. If requested by FCH, Health Quest agrees to make the books and records associated with Investments available for inspection by officers, representatives or agents of FCH at reasonable times and upon advance notice.

2.10 **Compliance**. Health Quest will comply in all material respects with all applicable laws, regulations, and policies relating to Health Quest's acceptance and use of the Asset Purchase Grant and Working Capital Grant.

ARTICLE 3

REPRESENTATIONS AND WARRANTIES OF FCH

FCH hereby represents and warrants to Health Quest, that, as of the Effective Date and the Closing:

3.1 It is an organization exempt from federal income taxation under Code Section 501(c)(3) and the IRS has not begun any audit or other administrative proceeding in connection with the entity's exempt status.

3.2 All corporate actions required to authorize and approve the entering into and execution, delivery, and performance of this Agreement have been taken.

3.3 It has the full corporate power, authority, and right to enter into this Agreement and perform its obligations contemplated hereby and thereby.

3.4 Its execution of this Agreement will not conflict with or result in the breach of the provisions of, or any of the terms, conditions or provisions of any contract, lease, instrument, or any other agreement or restriction to which it is a party or by which it is bound.

3.5 The total Asset Purchase Grant and Working Capital Grant directly or indirectly further the interests and charitable purposes of the Supported Organizations in compliance in all material respects with applicable law.

ARTICLE 4

REPRESENTATIONS AND WARRANTIES OF HEALTH QUEST

Health Quest hereby represents and warrants to FCH, that, as of the Effective Date and the Closing, and with regard to the receipt of the Working Capital Grant pursuant to Section 1.3, also at the times any funds are requested and/or received:

4.1 It is an organization exempt from federal income taxation under Code Section 501(c)(3) and the IRS has not begun any audit or other administrative proceeding in connection with the entity's exempt status.

4.2 All corporate actions required to authorize and approve the entering into and execution, delivery, and performance of this Agreement have been taken.

4.3 It has the full corporate power, authority, and right to enter into this Agreement and perform its obligations contemplated hereby and thereby.

4.4 Its execution of this Agreement will not conflict with or result in the breach of the provisions of, or any of the terms, conditions or provisions of any contract, lease, instrument, or any other agreement or restriction to which it is a party or by which it is bound.

4.5 The diligence documents provided pursuant to Section 2.8 are accurate and truthful.

ARTICLE 5

BREACH & INDEMNIFICATION

5.1 **Quantifiable Damages.** Any material breach of Health Quest's obligations under Article 2 involving the improper use of any portion of the Asset Purchase Grant or Working Capital Grant where the amount of the improper use may be quantified shall require Health Quest to return to FCH within thirty (30) days the amount of any misused charitable funds, all restrictions on the Restricted Funds shall be deemed met except for restrictions on the Capital Campaign Funds, FCH may notify Berkshire Taconic to transfer to the Primary Fund any such funds where the restrictions shall be deemed met, and FCH shall be released from any further obligations under the Agreement.

5.2 **Remedies in General.**

5.2.1 FCH shall be entitled to at any time proceed to protect and enforce all rights and remedies available to it under this Agreement or by law, by any other

proceedings, whether for specific performance of any agreement contained in this Agreement, damages, or other relief, whether against Health Quest and/or Berkshire Taconic. The Parties acknowledge FCH's ability to, in addition to the rights described above, suspend or terminate the Agreement, including Health Quest's right to receive any undisbursed Working Capital Grant, at any time by written notice to Health Quest.

5.2.2 Health Quest shall be entitled to at any time proceed to protect and enforce all rights and remedies available to it under this Agreement or by law, by any other proceedings, whether for specific performance of any agreement contained in this Agreement, damages, or other relief, whether against FCH and/or Berkshire Taconic.

5.2.3 Berkshire Taconic shall be entitled to at any time proceed to protect and enforce all rights and remedies available to it under this Agreement or by law, by any other proceedings, whether for specific performance of any agreement contained in this Agreement, damages, or other relief, whether against FCH and/or Health Quest.

5.2.4 All remedies provided for in this Agreement are cumulative and are in addition to any other rights and remedies available to FCH under any law. The exercise of any right or remedy by FCH shall not constitute a cure or waiver of any default, nor invalidate any act done pursuant to any notice of default, nor prejudice FCH in the exercise of those rights.

5.2.5 Notwithstanding any other provision of this Article 5 to the contrary, neither Party (nor Berkshire Taconic) shall be entitled to pursue to remedy for breach unless, such entity has provided written notice of such alleged breach, and such alleged breach has not be cured to the reasonable satisfaction of the notifying entity within thirty (30) days.

5.3 Indemnification.

5.3.1 FCH is a funding source only and does not participate in or direct any of the activities or services of Health Quest or any affiliate. Berkshire Taconic is a community foundation that provides services to FCH but does not participate in or direct any of the activities or services of Health Quest or any affiliate.

5.3.2 FCH agrees to indemnify, defend and hold harmless Health Quest, New Sharon Hospital, Berkshire Taconic and their members, officers, directors, agents and employees, from all claims, losses, or suits accruing or resulting to any contractors, subcontractors, laborers and any person, firm or corporation who may

be injured or damaged by FCH in the performance of the community fundraising campaign or the FCH Programming undertaken by FCH, or otherwise has a claim against FCH relating to breach of this Agreement by FCH (collectively, "**FCH Claims**"). The duty to indemnify, defend and hold harmless extends to all such claims, losses, or suits without regard to whether such FCH Claims may be covered by insurance policies or self-insurance plans. FCH understands and agrees that Health Quest's, New Sharon Hospital's and Berkshire Taconic's insurance policies or self-insurance plans do not extend to or protect FCH or FCH's directors, officers, members, staff or funded-activity participants with respect to any FCH Claims. FCH understands and agrees that neither Health Quest, New Sharon Hospital nor Berkshire Taconic will provide any legal defense for FCH or any such person in the event of any FCH Claim against any or all of them. FCH agrees that while carrying out activities relating to soliciting and accepting Capital Campaign Funds, FCH shall carry sufficient insurance or self-insurance (liability and/or other) as applicable according to the nature of the activities to be conducted so as to hold harmless Health Quest, New Sharon Hospital, Berkshire Taconic and their members, officers, directors, agents and employees, from any FCH Claims. If requested, certificates of such insurance or self-insurance shall be filed with Health Quest and/or Berkshire Taconic.

5.3.3 Health Quest agrees to indemnify, defend and hold harmless FCH, Berkshire Taconic, and their members, officers, directors, agents and employees, from all claims, losses, or suits accruing or resulting to any contractors, subcontractors, laborers and any person, firm or corporation who may be injured or damaged by Health Quest in the performance of the Investments or FCH Programming undertaken by Health Quest, or otherwise has a claim against Health Quest relating to breach of this Agreement by Health Quest (collectively, "**HQ Claims**"). The duty to indemnify, defend and hold harmless extends to all such claims, losses, or suits without regard to whether such HQ Claims may be covered by insurance policies or self-insurance plans. Health Quest understands and agrees that FCH's and Berkshire Taconic's insurance policies or self-insurance plans do not extend to or protect Health Quest or Health Quest's directors, officers, members, staff or funded-activity participants with respect to any HQ Claims. Health Quest understands and agrees that neither FCH nor Berkshire Taconic will provide any legal defense for Health Quest or any such person in the event of any HQ Claim against any or all of them. Health Quest agrees that while carrying out activities relating to Investments and FCH Programming, Health Quest shall carry sufficient insurance or self-insurance (liability and/or other) as applicable according to the nature of the service to be performed so as to hold harmless FCH, Berkshire Taconic, and their members, officers, directors, agents and employees, from any HQ Claims. If requested, certificates of such insurance or self-insurance shall be filed with FCH and/or Berkshire Taconic.

ARTICLE 6

TERM

The term of this Agreement shall commence on the Effective Date. Unless the Agreement is sooner terminated in accordance with its terms, except for the indemnity provisions set forth in Section 5.3 which shall survive the term of this Agreement, this Agreement shall expire (and neither Party shall have any further rights or obligations) on the later of (i) six years or (ii) the date on which Health Quest has satisfied its last payment obligation under Section 2.3.1.

ARTICLE 7

MISCELLANEOUS

7.1 **Communications**. The Parties will jointly develop a mutually agreed upon communication plan to announce the community fundraising campaign and the grants. To the extent the Parties desire to include Berkshire Taconic in that communication, Berkshire Taconic shall be consulted prior to the release of that communication. The communication plan shall grant FCH the right to control the advertisement of, and any other communications related to, the capital campaign described in Section 2.3.2. Health Quest agrees to publicize the Asset Purchase Grant and Working Capital Grant in its relevant publicity and published materials that recognize similarly-situated donors. If Health Quest's donors are listed in printed materials, FCH shall be included in the appropriate contribution category.

7.2 **Entire Agreement.** This Agreement, including any schedules or other exhibits presently or subsequently attached hereto by agreement of the Parties, constitutes the entire agreement among the Parties with respect to the subject matter hereof, and supersedes any prior written or verbal agreements or understandings among the Parties regarding the subject matter of this Agreement.

7.3 **Amendments.** Except as otherwise provided herein, neither this Agreement nor any term or provision hereof may be changed, waived, discharged, or terminated except by the written agreement of the Parties and Berkshire Taconic.

7.4 **Assignment.** Neither Party or Berkshire Taconic may assign this Agreement or their rights or obligations hereunder without the written consent of the other Party and Berkshire Taconic (or the consent of the Parties as the case may be).

7.5 **Binding Effect**. This Agreement, and the Asset Purchase Grant and Working Capital Grant to which it relates, shall be binding upon and inure to the benefit of the Parties and

Berkshire Taconic, their legal representatives, successors, and permitted assigns.

7.6 **Severability.** If any provision of this Agreement shall for any reason be held to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid or unenforceable provision were omitted.

7.7 **No Waiver.** No failure by any Party or Berkshire Taconic to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement shall constitute a waiver of any such breach of such covenant, agreement, term, or condition. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, agreement, term, and condition of this Agreement shall continue in full force and effect.

7.8 **Applicable Law**. This Agreement, and the rights and obligations of the Parties and Berkshire Taconic, will be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Connecticut, without regard to its conflict of laws principles.

7.9 **Relationship of the Parties.** FCH and Health Quest hereby expressly agree that the nature of the relationship created by the grant described herein is that of a charitable grantor (in the case of FCH) and grantee (in the case of Health Quest). Unless otherwise stipulated in writing, the Asset Purchase Grant and Working Capital Grant are made with the understanding that the FCH has no obligation to provide other or additional support to Health Quest.

7.10 **No Third-Party Beneficiaries.** This Agreement shall not confer any rights or remedies upon any person other than the Parties, Berkshire Taconic, and their respective successors and assigns.

7.11 **Nondiscrimination.** Health Quest agrees that in conducting any FCH Programming, persons will be provided services or property without regard to age, race, national origin, ethnicity, gender, disability, sexual orientation, political affiliation, religious belief, or veteran status, except in instances when the criteria is a stated condition of admission to the particular program and is so disclosed in program proposals.

7.12 **Captions.** The captions to this Agreement are for convenience of reference only and in no way define, limit, or describe the scope or intent of this Agreement or any part hereof, nor in any way affect this Agreement or any part hereof.

7.13 **Recitals**. The recitals set forth in the preamble to this Agreement are true and correct in all respects and are hereby incorporated into this Agreement with the same effect as if the same were fully restated herein by this reference.

7.14 **Notices**. Any notice required or permitted to be given pursuant to the terms and provisions hereof will be in writing and will be either hand delivered or sent by overnight delivery service to the Parties and Berkshire Taconic at their respective addresses set forth below. If hand delivered, notice shall be deemed received when actually delivered. If sent by overnight delivery service, notice shall be deemed received by the next business day:

TO FCH:

The Foundation for Community Health, Inc.
478 Cornwall Bridge Road
Sharon, CT 06069
Attn: Chief Executive Officer

TO HEALTH QUEST:

Health Quest Systems, Inc.
1351 Route 55, Suite 200
Lagrangeville, NY 12540
Attn: President

TO BERKSHIRE TACONIC:

Berkshire Taconic Community Foundation, Inc.
800 North Main Street, Box 400
Sheffield, MA 01257
Attn: President

7.15 **Counterparts.** The Parties and Berkshire Taconic agree that this Agreement may be executed in multiple originals, each of which shall be considered an original for all purposes and, collectively, shall be considered to constitute this Agreement. The Parties and Berkshire Taconic further agree that signatures transmitted by facsimile or in Portable Document Format (pdf) may be considered an original for all purposes, including, without limitation, the execution of this Agreement and enforcement of this Agreement.

[SIGNATURES ON NEXT PAGE]

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IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the Effective Date.

THE FOUNDATION FOR COMMUNITY HEALTH, INC.

Name: Nancy Heaton
Its: Chief Executive Officer

HEALTH QUEST SYSTEMS, INC.

Name: Robert Friedberg
Its: President

BERKSHIRE TACONIC COMMUNITY FOUNDATION, INC.

Name: Peter Taylor
Its: President

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the Effective Date.

THE FOUNDATION FOR COMMUNITY HEALTH, INC.

_____

Name: Nancy Heaton
Its: Chief Executive Officer

HEALTH QUEST SYSTEMS, INC.

_____

Name: Robert Friedberg
Its: President

BERKSHIRE TACONIC COMMUNITY FOUNDATION, INC.

_____

Name: Peter Taylor
Its: President

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the Effective Date.

THE FOUNDATION FOR COMMUNITY HEALTH, INC.

_____

Name: Nancy Heaton
Its: Chief Executive Officer

HEALTH QUEST SYSTEMS, INC.

_____

Name: Robert Friedberg
Its: President

BERKSHIRE TACONIC COMMUNITY FOUNDATION, INC.

_____

Name: Peter Taylor
Its: President

COMPLETENESS EXHIBIT B

AMENDED AND RESTATED

BY-LAWS
OF

THE FOUNDATION FOR COMMUNITY HEALTH, INC.

ARTICLE I
THE CORPORATION

Section 1.1 Principal Office. The Foundation for Community Health, Inc. (the "Corporation") shall have its principal office at such other place as may from time to time be determined by the Board of Directors.

Section 1.2 Powers. The Corporation shall have all of the powers enumerated in the Connecticut Non-Stock Corporation Law, as such may be amended from time to time; provided, however, the Corporation shall exercise its powers only in furtherance of its charitable, scientific, and educational purposes as such terms are defined in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and the Treasury Regulations promulgated thereunder and as further specified in the Corporation's Certificate of Incorporation.

Section 1.3 Purposes.

A. The Corporation is organized and shall be operated, exclusively: for charitable, scientific, and educational purposes in the United States and abroad within the meaning of Section 170(c)(2)(B) and 501(c)(3) of the Code, as more specifically set forth in the Corporation's Certificate of Incorporation, to devote itself exclusively to furthering, supporting, benefiting or carrying out the purposes, missions, objectives, operations and activities of its Members, to the extent such purposes, missions, objectives, operations and activities exclusively support or promote the following purposes:

(i) To maintain and improve the physical and mental health of all of the residents of the area historically served by Sharon Hospital, Inc. This includes the communities of: Canaan, Cornwall, Cornwall Bridge, Warren, East Canaan, Falls Village, Goshen, Kent, Lakeville, Lime Rock, Norfolk, Salisbury, Sharon, South Kent, Taconic, West Cornwall in Connecticut, as well as the New York communities of Amenia, Ancram, Ancramdale, Copake, Copake Falls, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic and Wingdale.

(ii) To invest, subject to the appropriate legal, tax and regulatory approval, in the acquisition of all or part of the acute care hospital facilities and operations of Sharon Hospital if the Directors of the Corporation determine that such investment is necessary and appropriate to further the goal of addressing the overall health needs of the constituent community, provided that such authority may be exercised only for the sole purpose of reconverting the hospital to a non-profit form and provided further that the Corporation may not use its funds to purchase or

invest in Sharon Hospital if Sharon Hospital is operating in a for-profit form. The Directors of the Corporation, in carrying out their fiduciary duties, shall give due consideration to the devotion to this purpose of part or all of the Corporation's funds resulting from the transfer of assets from Sharon Hospital if the right of first refusal set forth in the agreement between Sharon Hospital and Essent Healthcare of Connecticut, Inc. becomes exercisable.

(iii) To work in innovative and creative ways to improve the health of all residents in the above communities with particular emphasis on the more vulnerable populations of the poor, the elderly, the disabled and children.

(iv) To support a range of projects to enhance the health of its area residents, including, but not limited to, assessments of health needs and the provision of resources to meet them; preventive health programs; education programs and special assistance to uninsured or underinsured constituents.

(v) To seek and accept additional funds to enhance community health.

(vi) To remain cognizant of and responsive to changing health needs of the area.

(vii) To make grants to non-profit organizations and to develop and operate its own initiatives, all in furtherance of its corporate purposes.

(viii) To make grants to federally qualified health centers and other nonprofit organizations providing charity care, including charitable primary care, to indigent patients in the communities listed above.

(ix) To work cooperatively with Sharon Hospital to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of Sharon Hospital while it is operated as a for profit entity.

(x) To expand and enhance community health care services rather than supplant existing services whether publicly or privately supported.

B. Subject to the limitations set forth herein, the Corporation may engage in any lawful act or activity for which corporations may be formed under Sections 33-1000 to 33-1290, inclusive, of the Connecticut General Statutes.

C. The Corporation's charitable activities shall be serving exclusively the area historically served by Sharon Hospital, Inc., including the following geographic areas: Canaan, Cornwall, Cornwall Bridge, Warren, East Canaan, Falls Village, Goshen, Kent, Lakeville, Lime Rock, Norfolk, Salisbury, Sharon, South Kent, Taconic, West Cornwall in Connecticut, as well as the New York communities of Amenia, Ancram, Ancramdale, Copake, Copake Falls, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic and Wingdale.

D. No substantial part of the activities of the Corporation shall consist of attempting to influence legislation, nor shall this Corporation participate in, or intervene in

(including the publication or distribution of statements), any political campaign on behalf of or in opposition to any candidate for public office.

Section 1.4 Acknowledgement of Sharon Hospital. The Corporation shall use, where appropriate, in connection with the use of the Corporation's name on public documents, letterhead, brochures, press releases and statements the following language: "Initially funded with the net assets of the conversion of Sharon Hospital."

ARTICLE II
MEMBERS

Section 2.1 Membership. As provided in the Certificate of Incorporation, the Corporation shall have three members (each a "Member" and together the "Members"): Berkshire Taconic Community Foundation, Inc., a Connecticut nonstock corporation, The Community Foundation of Northwest Connecticut, Inc., a Connecticut nonstock corporation, and Community Foundations of the Hudson Valley, Inc. , a New York not-for-profit corporation.

Section 2.2 Member Approval Rights. The following actions if approved by the Corporation shall require the approval of the Members:

A. Any sale, pledge, lease or transfer of substantially all of the Corporation's assets;

B. Any merger or consolidation; and

C. Dissolution.

Section 2.3 Meetings of the Members. The annual meeting, and any regular meetings, of the Corporation's Members shall be held at such date, time and place as the Board shall determine, and as shall be set forth in the notice of the meeting. Special meetings may be held at such dates, times and places, and for such specific purposes, as the Board shall determine, and as shall be set forth in the notice of the meeting. Special meetings of the Members shall be called by the Board within fifteen (15) days upon receipt of a written request stating the purpose of the proposed meeting signed by a Member of the Corporation. Written notice of annual, regular or special meetings of the Members shall be provided to the Members and directors at least ten (10) days and no more than sixty (60) days prior to the meeting. At each annual meeting or any special meeting called for such purpose, the Members shall (i) elect directors from a slate of candidates presented to the Members in accordance with these By-laws, (ii) receive reports from the Corporation's directors, officers, agents and committees, and (iii) advise the Board as to any other business relating to the affairs of the Corporation.

Section 2.4 Action and Voting of the Members. A majority of the number of Members then serving who are entitled to vote shall constitute a quorum for the transaction of business at any meeting of the Members. The affirmative vote of a majority of all Members then serving shall constitute an act of the Members. A Member's vote may be cast by the president of the Member or by another officer of the Member in the absence of express notice of the designation of some other person by the board of directors or the by-laws of the Member.. Any action required or permitted to be taken by the Members may be taken without a meeting if all

Members consent in writing to the adoption of a resolution authorizing the action. The resolution and the written consents thereto by all of the Members shall be filed with the minutes of the Corporation.

ARTICLE III
BOARD OF DIRECTORS

Section 3.1 Powers. The property, affairs, and business of the Corporation shall be managed by its Board of Directors, subject to the provisions of the Certificate of Incorporation.

Section 3.2 Number and Qualification. There shall be an uneven number of directors, not fewer than eleven (11) nor more than seventeen (17). The number of directors shall be fixed by resolution of the Board of Directors at any time or, in the absence thereof, shall be the number of directors elected and serving at the most recently held meeting of the Members for such purpose. Directors shall be selected with regard to their potential for active service and support to the Corporation. All directors must show a demonstrated commitment to community health improvement and a record of voluntary service or community leadership experience.

No more than three (3) directors may be individuals also serving on the board of directors of one or more Members. Each director shall maintain a residence or work full-time in one of the following geographic areas: Canaan, Cornwall, Cornwall Bridge, Warren, East Canaan, Falls Village, Goshen, Kent, Lakeville, Lime Rock, Norfolk, Salisbury, Sharon, South Kent, Taconic, West Cornwall in Connecticut, or the New York communities of Amenia, Ancram, Ancramdale, Copake, Copake Falls, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic and Wingdale.

In addition, each director shall exhibit one or more of the following:

Experience as a trustee, director or owner of a health care delivery or financing organization;

A. Knowledge of the health care needs of the constituents of the areas listed in Section 1.3 C above;

B. Significant expertise in any of the following:

(i) health care;
(ii) mental health;
(iii) health ethics;
(iv) health law;
(v) health policy;
(vi) social services;
(vii) welfare;
(viii) financing; or
(ix) general public health issues; or

C. Demonstrated knowledge and commitment to solving community health issues.

In accordance with Connecticut non-profit hospital conversion statute, no person may serve as a director who is affiliated in any way with Sharon Hospital, Inc. as it is currently constituted or once it is purchased by new owners. No director of the Corporation shall serve on a community advisory board of Sharon Hospital if Sharon Hospital is operating in a for-profit form.

Section 3.3 Election. The total number of directors shall be divided into three groups, with each group containing approximately the same percentage of the total, as near as may be. The terms of each group will expire every three years on successive years, so that in any year approximately one-third of all elected directors' terms shall expire. At the first annual meeting of the Members after adoption of these By-laws, and at least annually at any subsequent annual meeting of the Members, directors shall be elected to succeed the directors in the class whose terms expire at that annual meeting. Directors shall be elected in the manner set forth in these By-laws. The Board of Directors, or its Nominating Committee, shall submit to the Members, with notice of the annual meeting of the Members, a slate of candidates to succeed those directors whose terms are then expiring. Candidates shall be selected by the Board of Directors or its Nominating Committee in consultation with the Members. In the event that the Members refuse to elect one or more candidates so nominated, the Board of Directors or its Nominating Committee shall submit the name and qualifications of another candidate for consideration by the Members until a candidate is elected.

Section 3.4 Term and Term Limits. Directors shall be elected to serve for a term of three (3) years. Directors shall be limited to serving three (3) consecutive full three-year terms, and shall thereafter be eligible for reelection to the Board of Directors only after a one-year hiatus of not serving as a director. Any partial term of service, including a partial term of service to fill a vacancy, shall not counted for purposes of the foregoing term limit. Service as a director under these or any prior By-laws shall count for purposes of the term limit applicable to directors. Each director shall hold his or her office until his or her successor has been duly elected and qualified or until such director's earlier death, resignation or removal, as hereinafter provided.

Section 3.5 Place of Meeting. The Board of Directors may hold its meetings at the principal office of the Corporation, or at such place or places within or without the State of Connecticut as the Board of Directors may from time to time by resolution determine.

Section 3.6 Annual Meetings. The Annual Meetings of the Board of Directors shall be held on such day in June and at such hour as the Board may prescribe. At each Annual Meeting, the directors shall elect the officers for the ensuing year and shall transact such other business as may properly come before the meeting.

A notice in writing of the time and place of the Annual Meeting shall be given to each director, not less than ten (10) days nor more than sixty (60) days before such meeting. No such notice need be given to any director who attends such meeting in person without protesting the lack of proper notice prior to or at the commencement of such meeting or who waives such notice in a writing executed and filed with the Secretary of the Corporation either before or after the meeting. The Secretary shall cause any such waiver to be filed with, or entered upon, the records of the meeting.

Section 3.7 Regular Meetings. Regular meetings of the Board of Directors may be held at such times and at such places as may be fixed from time to time by resolution of the Board of Directors.

Section 3.8 Special Meetings. Special meetings of the Board of Directors may be called at any time by the Chair of the Board of Directors or upon written request of at least three (3) directors. The Secretary shall give three (3) days' notice of such special meeting to each director; provided, however, that a special meeting may be called upon twenty-four (24) hours' notice if such notice is given personally, by telephone, by facsimile transmission or by other electronic means, to each director. Notice of a meeting need not be given to any director who submits a signed waiver of notice in accordance with these By-Laws.

Section 3.9 Quorum. A majority of the number of Directors then in office who are entitled to vote shall constitute a quorum for the transaction of business at any meeting of the Board of Directors. A majority of the directors present, whether or not a quorum is present, may adjourn any meeting to another time and place. Notification shall be given to any Director not present.

Section 3.10 Voting. The vote of a majority of the Directors who are entitled to vote at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number of Directors is required by law, by the Certificate of Incorporation of the Corporation, or by these By-Laws.

Section 3.11 Vacancies and New Directorships. Any newly created directorship or vacancy occurring on the Board of Directors may be filled by the Board of Directors, after providing the Members with a reasonable opportunity for prior consultation. The term of a director filling a vacancy expires at the end of the unexpired term that the director is filling, or until his/her successor is elected or appointed and qualified.

Section 3.12 Resignations. Any director may resign at any time by giving written notice to the Board of Directors or to the Chair or Secretary thereof. Such resignation shall take effect at the time specified in such notice, and, unless otherwise specified in said notice, acceptance shall not be necessary to make it effective. If no time is specified in the notice of resignation, then the resignation shall take effect upon delivery. A director who fails to attend three (3) consecutive meetings of the Board shall be deemed to have resigned his or her directorship unless such director notifies the Chair in writing within ten (10) days following the third missed meeting that the director desires to remain a director and such retention is approved by the vote of two-thirds (2/3) of the remaining directors. Notwithstanding the foregoing, if any director shall miss more than seventy-five (75) percent of the meetings in one year, he or she shall be deemed to have resigned from the Board. The Corporation shall provide the Members with written notice within 30 days' of the resignation of a director.

Section 3.13 Removal. A director may be removed from the Board only upon a finding of cause by the Members in accordance with the Certificate of Incorporation. A complaint may be filed by a Member or a director with the Chair or the Secretary alleging that a director should be removed for cause. Within 90 days' of the receipt of such a complaint, the

Board shall call a meeting of the Members with the director present, to discuss all information relevant to the complaint.

Section 3.14 Action by the Board of Directors.

A. Except as otherwise provided by law or in these By-Laws, the act of the Board of Directors means action at any duly constituted meeting of the Board of Directors, by vote of a majority of the directors present at such meeting, provided, however, that in determining such majority, any director who is counted for the purposes of determining the existence of a quorum at such meeting but who is otherwise prohibited from participating and voting thereat in accordance with the provisions of the Corporation's conflict of interest policy shall also be counted for purposes of determining the total number of directors present at such meeting.

B. Any action required or permitted to be taken by the Board of Directors or any committee thereof may be taken without a meeting if all directors or members of the committee consent in writing to the adoption of a resolution authorizing the action. The resolution and the written consents thereto by all of the directors or members of the committee shall be filed with the minutes of the proceedings of the Board or committee.

C. Any one or more directors or members of a committee of the Board of Directors may participate in a meeting of the Board of Directors or committee by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time, and participation in such a meeting shall constitute presence in person at such meeting.

Section 3.15 Compensation. Directors shall receive no compensation for their services as directors, but may be reimbursed for the expenses reasonably incurred by them in the performance of their duties in accordance with policies established by the Board of Directors.

Section 3.16 Annual Report. At the annual meeting of the Members, the Board of Directors shall present a report verified by the Chair and Treasurer or by a majority of the directors, showing in appropriate detail the following:

(i) The assets and liabilities, including the trust funds, of the Corporation as of the end of the twelve-month fiscal period terminating not more than six (6) months prior to said meeting;

(ii) The principal changes in assets and liabilities, including trust funds, during said fiscal period;

(iii) The revenue or receipts of the Corporation both unrestricted and restricted to particular purposes during said fiscal period; and

(iv) The expenses or disbursements of the Corporation for both general and restricted purposes, during said fiscal period.

This report shall be filed with the records of the Corporation and a copy thereof entered

in the minutes of the proceedings of the annual meeting.

ARTICLE IV
COMMITTEES OF THE BOARD OF DIRECTORS

Section 4.1 Executive and Standing Committees. The Board of Directors, by the affirmative vote of a majority of all directors then serving, may designate from among the directors an Executive Committee and one or more standing committees such as a Nominating Committee as may from time to time be deemed suitable, necessary, or convenient to aid in accomplishing the purposes of the Corporation. The duties and powers of any such committee shall be as provided by resolution by the Board of Directors from time to time; provided, however, such committees may not: (1) approve or recommend to the Corporation's Members actions required to be approved by the Members pursuant to the Connecticut Revised Nonstock Corporation Act, as amended (the "Act"); (2) fill vacancies on the Board or on any committee with the power to act on behalf of the Corporation; (3) adopt, amend or repeal these By-laws; (4) approve a plan of merger; (5) approve a sale, lease, exchange or other disposition of all or substantially all, of the property of the Corporation except as provided in Section 33-1101(e)(5) of the Act; or (6) approve a proposal to dissolve.

Section 4.2 Special Committees. The Board of Directors may designate one or more ad hoc or special committees. Non-board members may be appointed to any committee that does not have authority to act on behalf of the Corporation.

Section 4.3 Meetings. Meetings of committees shall be held at such time and place as shall be fixed and noticed by the Chair of the Corporation or the chairperson of the committee or by a vote of a majority of all of the members of the committee.

Section 4.4 Quorum and Manner of Acting. Unless otherwise provided by resolution of the Board of Directors, a majority of all of the members of a committee shall constitute a quorum for the transaction of business and the vote of a majority of all of the members of the committee shall be the act of the committee. The procedures and manner of acting of the committees of the Board of Directors shall be subject at all times to the directions of the Board of Directors.

Section 4.5 Tenure of Members of Committees of the Board of Directors. Each committee of the Board of Directors and every member thereof shall serve at the pleasure of the Board of Directors and for such terms as the Board of Directors shall determine.

Section 4.6 Alternate Committee Members. The Board of Directors may designate one or more directors as alternate members of any standing or special committee of the Board of Directors who may replace any absent member or members at any meeting of such committee.

ARTICLE V
OFFICERS

Section 5.1 Number. The officers of the Corporation shall be a Chair, one or more Vice Chairs, a Treasurer, and a Secretary, each of whom shall be directors. The Corporation shall also have a Chief Executive Officer. The Board of Directors may from time to time elect or

appoint such other officers, including one or more vice or assistant officers, as it may deem necessary or convenient. Any two (2) or more offices may be held by the same person with the exception of the offices of Chair and Secretary.

Section 5.2 Election and Tenure. Each of the officers of the Corporation shall be elected or appointed by the Board of Directors at the Annual Meeting. Each officer of the Corporation shall serve for a term of one (1) year, or until his or her successor shall have been duly elected and qualified or until such officer's earlier death, resignation or removal, as hereinafter provided.

Section 5.3 Removal. Each officer of the Corporation shall serve at the pleasure of the Board of Directors, and may be removed by the Board of Directors at any time with or without cause. Such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer shall not in and of itself create any contract rights.

Section 5.4 Resignations. Any officer may resign at any time by giving written notice to the Board of Directors or to the Chair, Vice Chair, or the Secretary thereof. A resignation shall take effect at the time specified in the notice thereof, and, unless otherwise specified in said notice, acceptance shall not be necessary to make such resignation effective. If no effective date is specified in the notice, resignation shall be effective upon delivery of the notice.

Section 5.5 Vacancies. A vacancy in any office by reason of death, resignation, removal or otherwise may be filled by the Board of Directors for the unexpired portion of the term of such office.

Section 5.6 Duties of Chair. The Chair of the Board of Directors shall: (i) preside at all meetings of the Board of Directors at which the Chair is present; (ii) report at the Annual Meeting on the condition of affairs of the Corporation and make recommendations with respect thereto; (iii) appoint committee Chairs of each standing committee; (iv) appoint Board committees, subject to Board approval; and (v) perform such other duties as the Board of Directors may prescribe from time to time. The Chair will serve as an ex-officio member on all standing committees.

Section 5.7 Duties of Vice Chairs. In the event of the Chair's absence or incapacity to act, the Vice Chair(s) in order of seniority as determined by the Board of Directors shall preside at all meetings of the Board of Directors, and shall perform the duties and exercise the powers of the Chair, subject to the right of the Board of Directors from time to time to extend or confine such powers and duties or to assign them to others. Each Vice Chair shall have such powers and shall perform such other duties as may be prescribed from time to time by the Board of Directors subject to the supervision of the Board of Directors.

Section 5.8 Duties of Treasurer. The Treasurer shall maintain the books of account and shall have charge and custody of, and be responsible for, all funds and securities of the Corporation, and deposit all such funds in the name of and to the credit of the Corporation in such banks, trust companies, or other depositories as shall be selected by the Board of Directors. The Treasurer shall ensure that a true and accurate accounting of the financial transactions of the

Corporation is made and that reports of such transactions are presented to the Board of Directors. The Treasurer shall also perform all other duties customarily incident to the office of Treasurer and such other duties as from time to time may be assigned by the Board of Directors.

Section 5.9 Duties of Secretary. The Secretary shall: (i) keep or cause to be kept the minutes of all meetings of the Board of Directors; (ii) see that all notices required to be given by the Corporation are duly given and served; (iii) be custodian of the seal of the Corporation and of its corporate books; and (iv) make such reports and perform such other duties as are incident to the office of Secretary or as required by the Board of Directors.

Section 5.10 Duties of the Chief Executive Officer. The Chief Executive Officer shall be responsible for the effective implementation of the strategic goals of the Corporation. The Chief Executive Officer shall oversee the day-to-day operations of the Corporation and shall submit regular reports on such operations to the Chair and to the Board of Directors. The Chief Executive Officer may be invited to attend meetings of the Board of Directors, but shall not be entitled to vote and shall not be counted for purposes of quorum. The compensation and terms of employment of the Chief Executive Officer shall be reviewed and determined at least annually by the Board of Directors, or its Executive Committee. The Chief Executive Officer shall perform such other duties as may be assigned to him or her by the Board of Directors.

ARTICLE VI
GENERAL PROVISIONS

Section 6.1 Fiscal Year. The fiscal year of the Corporation shall be determined by the Board of Directors and in the absence of such determination commence on January 1 in each calendar year and shall end on December 31.

Section 6.2 Books and Records. There shall be kept at the office of the Corporation (i) correct and complete books and records of account; (ii) minutes of the proceedings of the Board of Directors and any committee of the Board of Directors; (iii) a current list of the Members, directors, and officers of the Corporation and their residential and business addresses; (iv) a copy of the Certificate of Incorporation of the Corporation and these By-Laws, (v) a copy of the Corporation's application for recognition of exempt status under Section 501(c)(3) of the Code (IRS Form 1023); and (vi) copies of the Corporation's past three (3) years' information returns (IRS Form 990).

Section 6.3 Corporate Seal. The Board of Directors shall have the authority to select the inscription and form of the Corporation's corporate seal.

Section 6.4 Interested Directors. The Board of Directors and the Corporation's officers shall operate in accordance with a conflict of interest policy and in accordance with the provisions of the Act. All directors and officers of the Corporation shall complete annually a disclosure statement that describes the material facts concerning any transaction or arrangement that could reasonably give rise to a conflict of interest. If, after submitting an annual disclosure statement, an apparent or potential conflict arises within the spirit of the Corporation's policy or under the Act, the director or officer shall immediately disclose the situation (whether or not specifically addressed herein) to the Chair or the Board of Directors.

Section 6.5 Written Notice and Signature. Any written notice required hereunder may, without limitation, be issued by regular mail, hand delivery, electronic means or facsimile. Any written signature required under these By-laws or the Corporation's Certificate of Incorporation or by Connecticut law may be evidenced by manual, facsimile or electronic signature, any of which shall have the same legal effect as the manual signature of the signing party.

Section 6.6 Waiver of Notice. Written waiver signed at any time by a Member, director or committee member entitled to notice shall be equivalent to the giving of notice. A written waiver shall be delivered to the Corporation and filed with the minutes or corporate records. The attendance by any member, director or committee member at a meeting without protesting the lack of proper notice prior to the commencement of, at the beginning of, or promptly upon the member's, director's or committee member's arrival to the meeting shall be deemed to be a waiver by such person of notice of the meeting.

Section 6.7 Minutes. Minutes shall be taken at all meetings of the Members, Board of Directors and of all committee meetings, including a record of attendance, and shall be filed in the office of the Corporation designated for such purposes and maintained as a permanent record. Such minutes shall reflect all business conducted, including findings, conclusions and recommendations.

ARTICLE VII
INDEMNIFICATION

Section 7.1 Indemnification of Employees, Officers, Directors and Members of Committees. The Corporation shall indemnify its officers, employees and members of committees to the same extent that the Corporation indemnifies its directors as provided in the Certificate of Incorporation.

Section 7.2 Insurance. The Corporation is not required to purchase directors' and officers' liability insurance, but the Corporation may purchase such insurance if authorized and approved by the Board of Directors. To the extent permitted by law, such insurance may insure the Corporation for any obligation it incurs as a result of its obligations to indemnify directors, officers, employees and committee members, and it may insure directly the directors, officers, employees, or committee members of the Corporation for liabilities against which they are not entitled to indemnification under this Article VII as well as for liabilities against which they are entitled or permitted to be indemnified by the Corporation.

ARTICLE VIII
CONTRACTS, CHECKS, DRAFTS, AND BANK ACCOUNTS

Section 8.1 Execution of Contracts. The Board of Directors, except as otherwise provided in these By-Laws, may authorize any officer or officers, agent or agents, in the name or on behalf of the Corporation to enter into any contract or execute and deliver any instrument, and such authority may be general or confined to specific instances; but, unless so authorized by the Board of Directors, or expressly authorized by these By-Laws, no officer, agent or employee

shall have any power or authority to bind the Corporation by any contract or engagement or to pledge its credit or to render it liable in any amount for any purpose.

Section 8.2 Loans. No loans shall be contracted on behalf of the Corporation unless specifically authorized by the Board of Directors.

Section 8.3 Checks, Drafts, etc. All checks, drafts and any other orders for the payment of money out of the funds of the Corporation, and all notes or other evidences of indebtedness of the Corporation shall be signed on behalf of the Corporation in such manner as shall from time to time be determined by resolution of the Board of Directors.

Section 8.4 Deposits. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may select.

ARTICLE IX
AMENDMENTS

Section 9.1 Amendments. Subject to Section 9.2, these By-Laws may be altered, amended or repealed by a resolution adopted by two-thirds of all directors then serving; provided, however, the notice for the meeting includes the proposals for amendments and that amendment which alters, expands or contracts the Corporation's stated corporate purposes or otherwise materially modifies Sections 1.3 and 1.4 of Article I, Article II, Sections 3.2 or 3.3 of Article III, or Article IX of these By-Laws shall be approved by the Attorney General and, if appropriate, the Superior Court of Litchfield, Connecticut.

Section 9.2 Notice of Certain Amendments. In the event that any proposed amendment of these By-laws or the Corporation's Certificate of Incorporation would remove a Member, the Board of Directors shall provide such Member with 30 days' prior written notice of its intent to consider such an amendment. Notwithstanding the foregoing, the Board of Directors may amend the Corporation's Certificate of Incorporation and By-laws to remove a Member immediately upon the loss of such Member's status as an organization recognized by the Internal Revenue Service as described in Sections 501(c)(3) and 509(a)(1) of the Code.

Section 9.3 Amendments by the Board of Directors. These By-laws and Certificate of Incorporation of the Corporation are adopted by the Board of Directors and, in accordance with the Certificate of Incorporation, may only be amended by action of the Board of Directors except as otherwise required by the Act.

Adopted: June 4, 2003
Revised: October 4, 2004
Revised: November 15, 2010

Amended and Restated:
Effective as of March 26, 2014

FILING #0005073464 PG 01 OF 07 VOL B-01920
FILED 03/26/2014 12:00 PM PAGE 01264
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

SECRETARY OF THE STATE OF CONNECTICUT
MAILING ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, P.O. BOX 150470, HARTFORD, CT 06115-0470
DELIVERY ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, 30 TRINITY STREET, HARTFORD, CT 06106
PHONE: 860-509-6003 WEBSITE: www.concord-sots.ct.gov

CERTIFICATE OF AMENDMENT
NONSTOCK CORPORATION

USE INK COMPLETE ALL SECTIONS PRINT OR TYPE ATTACH 8/12 X 11 SHEETS IF NECESSARY.

FILING PARTY *(CONFIRMATION WILL BE SENT TO THIS ADDRESS):*	**FILING FEE: $20**
NAME: Eileen B. Nelson, Paralegal ADDRESS: Robinson & Cole LLP, 280 Trumbull Street CITY: Hartford STATE: CT ZIP: 06103	MAKE CHECKS PAYABLE TO "SECRETARY OF THE STATE"

1. NAME OF CORPORATION:

The Foundation for Community Health, Inc.

2. THE CERTIFICATE OF INCORPORATION IS (check A, B or C):

☐ A. AMENDED

☐ B. RESTATED

☒ C. AMENDED AND RESTATED

THE RESTATED CERTIFICATE CONSOLIDATES ALL AMENDMENTS INTO A SINGLE DOCUMENT

3. TEXT OF EACH AMENDMENT/RESTATEMENT:

The Foundation for Community Health, Inc. (the "Corporation") is hereby amending and restating its certificate of incorporation. The Corporation is updating its certificate of incorporation in its entirety (with the exception of the Corporation's name which shall be unchanged) to provide more detailed language in compliance with the Connecticut Revised Nonstock Corporation Act. The Corporation is further updating its certificate of incorporation to reflect that the Corporation shall be a membership corporation with one class of members. The Corporation has also changed the composition of the board of directors and specified that directors may be removed only for cause.

The full text of the Amended and Restated Certificate of Incorporation is set forth on *Exhibit A*, attached hereto and made a part hereof.

The Amended and Restated Certificate of Incorporation was approved by the Corporation's Board of Directors on February 24, 2014.

4. VOTE INFORMATION (CHECK A, B or C)

☐ **A. THE AMENDMENT WAS DULY APPROVED BY THE MEMBERS IN THE MANNER REQUIRED BY SECTIONS 33-1140 TO 33-1147 OF THE CONNECTICUT GENERAL STATUTES, AND BY THE CERTIFICATE OF INCORPORATION.**

☐ **B. THE AMENDMENT WAS DULY APPROVED BY THE INCORPORATORS AND MEMBER APPROVAL WAS NOT REQUIRED.**

☒ **C. THE AMENDMENT WAS DULY APPROVED BY THE BOARD OF DIRECTORS AND MEMBER APPROVAL WAS NOT REQUIRED.**

5. EXECUTION:

DATED THIS 11th **DAY OF** March **, 2014**

NAME OF SIGNATORY	CAPACITY/TITLE OF SIGNATORY	SIGNATURE
Nancy L. Heaton	Chief Executive Officer	Nancy L. Heaton

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FILED 03/26/2014 12:00 PM PAGE 01266
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION OF THE FOUNDATION FOR COMMUNITY HEALTH, INC.

1. **Name.** The name of the corporation is The Foundation for Community Health, Inc. (hereinafter referred to as the "Corporation").

2. **Purposes.**

(a) The Corporation is organized, and shall be operated, exclusively: for charitable, scientific and educational purposes in the United States and abroad within the meaning of Sections 170(c)(2)(B) and 501(c)(3) of the United States Internal Revenue Code of 1986, as amended from time to time (the "Code"), to devote itself exclusively to furthering, supporting, benefiting or carrying out the purposes, missions, objectives, operations and activities of Berkshire Taconic Community Foundation, Inc., a Connecticut nonstock corporation ("BTCF"), The Community Foundation of Northwest Connecticut, Inc., a Connecticut nonstock corporation ("Northwest"), and Community Foundations of the Hudson Valley, Inc. , a New York not-for-profit corporation ("Hudson") to the extent such purposes, missions, objectives, operations and activities exclusively support or promote the following purposes:

(i) To maintain and improve the physical and mental health of all of the residents of the area historically served by Sharon Hospital, Inc. This includes the communities of: Canaan, Cornwall, Cornwall Bridge, Warren, East Canaan, Falls Village, Goshen, Kent, Lakeville, Lime Rock, Norfolk, Salisbury, Sharon, South Kent, Taconic, West Cornwall in Connecticut, as well as the New York communities of Amenia, Ancram, Ancramdale, Copake, Copake Falls, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic and Wingdale.

(ii) To invest, subject to the appropriate legal, tax and regulatory approval, in the acquisition of all or part of the acute care hospital facilities and operations of Sharon Hospital if the Directors of the Corporation determine that such investment is necessary and appropriate to further the goal of addressing the overall health needs of the constituent community, provided that such authority may be exercised only for the sole purpose of reconverting the hospital to a non-profit form and provided further that the Corporation may not use its funds to purchase or invest in Sharon Hospital if Sharon Hospital is operating in a for-profit form. The Directors of the Corporation, in carrying out their fiduciary duties, shall give due consideration to the devotion to this purpose of part or all of the Corporation's funds resulting from the transfer of assets from Sharon Hospital if the right of first refusal set forth in the agreement between Sharon Hospital and Essent Healthcare of Connecticut, Inc. becomes exercisable.

(iii) To work in innovative and creative ways to improve the health of all residents in the above communities with particular emphasis on the more vulnerable populations of the poor, the elderly, the disabled and children.

(iv) To support a range of projects to enhance the health of its area residents, including, but not limited to, assessments of health needs and the provision of resources to meet them; preventive health programs; education programs and special assistance to uninsured or underinsured constituents.

(v) To seek and accept additional funds to enhance community health.

(vi) To remain cognizant of and responsive to changing health needs of the area.

(vii) To make grants to non-profit organizations and to develop and operate its own initiatives, all in furtherance of its corporate purposes.

(viii) To make grants to federally qualified health centers and other non-profit organizations providing charity care, including charitable primary care, to indigent patients in the communities listed above.

(ix) To work cooperatively with Sharon Hospital to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of Sharon Hospital while it is operated as a for profit entity.

(x) To expand and enhance community health care services rather than supplant existing services whether publicly or privately-supported.

(b) Subject to the limitations set forth herein, the Corporation may engage in any lawful act or activity for which corporations may be formed under sections 33-1000 to 33-1290, inclusive, of the Connecticut General Statutes, as amended (the "Nonstock Act") ..

(c) The Corporation's charitable activities shall be serving exclusively the area historically served by Sharon Hospital, Inc., including the following geographic areas: Canaan, Cornwall, Cornwall Bridge, Warren, East Canaan, Falls Village, Goshen, Kent, Lakeville, Lime Rock, Norfolk, Salisbury, Sharon, South Kent, Taconic, West Cornwall in Connecticut, as well as the New York communities of Amenia, Ancram, Ancramdale, Copake, Copake Falls, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic and Wingdale.

3. **Nonprofit Corporation**. The Corporation is nonprofit and it shall not have or issue shares of stock, make distributions or pay dividends.

4. **Registered Agent**. The Corporation's registered agent is on file with the office of the Secretary of the State of Connecticut. The Corporation's registered agent is Douglas K. O'Connell, Esq., with a business address of 682 Main Street, Winsted, CT 06098 and a residence address of 156 Red Oak Hill, Torrington, CT 06790.

5. **Membership**. The Corporation is a membership corporation. The Corporation shall have one class of members. The members of the Corporation shall be BTCF, Northwest and Hudson (each a "Member" and together, the "Members"). The Members shall have such rights, privileges, and obligations which are accorded to Members under the Corporation's bylaws (the "Bylaws") or under Connecticut law. Members shall not be entitled to vote on amendments to this Certificate of Incorporation or the Bylaws except as otherwise required by the Nonstock Act.

6. **Board of Directors**. The general management of the powers, business, property and affairs of the Corporation shall be vested in a board of an uneven number of directors that is no fewer than eleven and no more than seventeen directors as may be further provided in the Bylaws. No more than three directors shall be persons who are also serving on the board of directors of one or more Members. No director of the Corporation shall serve on a community advisory board of Sharon Hospital if Sharon Hospital is operating in a for-profit form. A director may be removed by the Members as may be further provided in the Bylaws only upon a finding of cause. For these purposes, cause shall be found as a result of incapacity, conviction of a crime of moral turpitude, disregard of duty to act and/or acting against the Corporation's best interests, or conduct which may have a negative impact on the reputation of the Corporation.

7. **Limitations**. No part of the assets or net earnings of the Corporation shall inure to the benefit of or be distributed to its incorporators, directors, officers, employees, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services actually rendered and to make reimbursement for expenses reasonably and necessarily incurred in carrying out the purposes set forth in Article 2 hereof. No part or portion of the assets or net earnings of the Corporation shall be used, nor shall the Corporation ever be operated for objects or purposes other than those set forth in or contemplated by Article 2 hereof. Neither the Corporation nor any recipient of its funds shall participate in or intervene in any political campaign on behalf of any candidate for public office while acting on behalf of the Corporation. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not engage in any activity that would be inconsistent with its classification as a corporation entitled to exemption from Federal income tax under Section 501(c)(3) of the Code. No substantial part of the activities of this Corporation shall consist of attempting to influence legislation, nor shall this Corporation participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of or in opposition to any candidate for public office.

8. **Amendment**. This Certificate of Incorporation may be amended from time to time by a resolution adopted by two-thirds of all members of the Board then serving; provided, however, that any amendment which alters, expands, or contracts the Corporation's stated corporate purposes or otherwise materially modifies Articles 2, 5, 6, 8 or 10 hereof shall first be approved by the Attorney General, and, if appropriate, the Superior Court of Litchfield County, Connecticut.

9. **Permanent Existence**. The Corporation shall have an indefinite period of existence, subject to dissolution under the laws of the State of Connecticut or by resolution adopted by two-thirds of the directors present at a meeting of the Board of at which a quorum is present and further approved by the Members.

10. **Dissolution.** Upon dissolution of the Corporation, the Corporation shall, after paying or making provision for the payment of all of the liabilities of the Corporation, and after notice to the Attorney General, distribute all of the assets of the Corporation to such organization or organizations which are selected by the Superior Court of the judicial district in which the principal office of the Corporation is then located and which are organized and operated exclusively for charitable healthcare purposes as shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Code.

11. **Private Foundation Rules.** In accordance with Section 508(e) of the Code, if in any taxable year the Corporation is a private foundation as defined in Section 509(a) of the Code, then in such year:

(a) The Corporation shall distribute such amounts for each taxable year at such time and in such manner so as not to subject the Corporation to tax on undistributed income under Section 4942 of the Code;

(b) The Corporation shall not engage in any act of self-dealing which is subject to tax under Section 4941(d) of the Code;

(c) The Corporation shall not retain any excess business holdings which are subject to tax under Section 4943(c) of the Code;

(d) The Corporation shall not make any investments in such manner so as to subject the Corporation to tax under Section 4944 of the Code; and

(e) The Corporation shall not make any taxable expenditures which are subject to tax under Section 4945 of the Code.

12. **Limitation on Liability of Directors.** The directors of the Corporation shall be protected from personal liability to the fullest extent permitted from time to time under Connecticut law, including, without limitation, the Nonstock Act, as the same may be amended or supplemented, and, accordingly, unless and until the relevant provisions of the Nonstock Act are amended or supplemented to further limit or extend the ability of the Corporation to limit the personal liability of directors of the Corporation, the personal liability of a director to the Corporation for monetary damages for breach of duty as a director shall be limited to the amount of the compensation received by the director of serving the Corporation during the year of the violation if such breach did not (A) involve a knowing and culpable violation of law by the director, (B) enable the director or an associate, as defined in Section 33- 840 of the Connecticut General Statutes, to receive an improper personal economic gain, (C) show a lack of good faith and a conscious disregard for the duty of the director to the Corporation under circumstances in which the director was aware that his or her conduct or omission created by an unjustifiable risk of serious injury to the Corporation, or (D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the director's duty to the Corporation. The modification or repeal of this Article 12 shall not affect the restrictions hereunder of a director's personal liability for any act or omission occurring prior to such modification or repeal.

13. **Indemnification.**

(a) The Corporation shall indemnify, to the fullest extent permitted by Section 33-1116 to 33-1124 of the Nonstock Act, as the same may be amended or supplemented, all directors and officers of the Corporation from and against any and all of the expenses, liabilities or other matters referred to in or covered by said sections both as to action in his or her official capacity while holding such office and to action while serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise; and such indemnification shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of the heirs, executors and administrators of such a person; provided, however, that the Corporation shall indemnify any such indemnitee in connection with a proceeding initiated by such indemnitee only if such proceeding was authorized by the Board.

(b) Without limiting the foregoing, the Corporation shall indemnify its directors against liability to any person for any action taken, or any failure to take any action, as a director, except liability of a sort for which indemnification is not permitted by Section 33-1026(b)(5) of the Nonstock Act; provided, however, that the Corporation's duty to so indemnify shall extend to an indemnitee in connection with a proceeding initiated by such indemnitee only if such proceeding was authorized by the Board. In addition, the Corporation may indemnify and advance expenses to officers, employees and agents of the Corporation who are not directors to the same extent as directors, and may further indemnify such officers, employees and agents to the extent provided by the specific action of the Corporation and permitted by law. The Corporation may also procure insurance providing greater indemnification as provided by law.

(c) The indemnification provided for herein shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any Bylaw, agreement, vote of disinterested directors, or otherwise and shall not be deemed to limit the ability of the Corporation to indemnify or advance expenses to any person pursuant to contract, any Bylaw, or a general or specific action of the Board of Directors consistent with applicable law.

FOUNDATION FOR COMMUNITY HEALTH, INC.
Audited Financial Statements
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For the Year Ended December 31, 2015

KING, KING & ASSOCIATES
CERTIFIED PUBLIC ACCOUNTANTS

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Winsted, CT 06098

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of the
Foundation for Community Health, Inc.

We have audited the accompanying financial statements of the Foundation for Community Health, Inc. (a nonprofit organization), which comprise the statement of financial position as of December 31, 2015, and the related statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation for Community Health, Inc. as of December 31, 2015, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Summarized Comparative Information

We have previously audited the Foundation for Community Health, Inc.'s 2014 financial statements, and we expressed an unmodified opinion on those financial statements in our report dated August 4, 2015. In our opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2015, is consistent, in all material respects, with the audited financial statements from which is has been derived.

King, King & Associates

King, King & Associates, CPAs
Winsted, CT
September 21, 2016

Foundation for Community Health, Inc.

Statements of Financial Position
December 31, 2015 and 2014

	2015	2014
ASSETS		
Current Assets:		
Cash and Cash Equivalents	$ 12,960	$ 34,117
Prepaid Expenses	14,256	6,813
Total Current Assets	27,216	40,930
Fixed Assets, Net	16,650	24,204
Other Assets:		
Cash Held in Escrow	33,614	33,597
Investments	24,462,375	25,177,590
Contribution Receivable - CRT	13,489	14,132
Security Deposit	5,000	5,000
Total Other Assets	24,514,478	25,230,319
Total Assets	**$ 24,558,344**	**$ 25,295,453**
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Grants Payable	$ 211,072	$ 35,475
Accounts Payable & Accrued Expenses	67,691	58,611
Total Currrent Liabilities	278,763	94,086
Total Liabilities	278,763	94,086
Net Assets:		
Unrestricted-Undesignated	20,776,729	21,273,494
Unrestricted-Designated	33,614	333,597
Temporarily Restricted	1,183,339	1,308,377
Permanently Restricted	2,285,899	2,285,899
Total Net Assets	24,279,581	25,201,367
Total Liabilities and Net Assets	**$ 24,558,344**	**$ 25,295,453**

The accompanying notes are an integral part of this financial statement.

Foundation for Community Health, Inc.

Statement of Activities
For the Year Ended December 31, 2015
With Comparative Totals for 2014

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total 2015	Total 2014
Support and Revenue:					
Contributions	$ 311,868	$ -	$ -	$ 311,868	$ 595,627
Investment Income	135,510	23,858	-	159,368	1,469,957
Change in Value of CRT	-	(643)	-	(643)	(41)
Other Revenues	-	555	-	555	310
Net Assets Released From Restrictions:					
Satisfaction of Donor Restrictions	148,808	(148,808)	-	-	-
Total Support and Revenue	596,186	(125,038)	-	471,148	2,065,853
Expenses:					
Grants and Disbursements	718,247	-	-	718,247	2,588,293
Program Expenses	470,802	-	-	470,802	460,857
Management and General	203,885	-	-	203,885	211,451
Total Expenses	1,392,934	-	-	1,392,934	3,260,601
Change in Net Assets Before Other Changes	(796,748)	(125,038)	-	(921,786)	(1,194,748)
Other Changes in Net Assets:					
Loss on Disposal of Fixed Assets	-	-	-	-	(17,805)
Total Other Changes in Net Assets	-	-	-	-	(17,805)
Change in Net Assets	(796,748)	(125,038)	-	(921,786)	(1,212,553)
Net Assets, Beginning	21,607,091	1,308,377	2,285,899	25,201,367	26,413,920
Net Assets, Ending	$ 20,810,343	$ 1,183,339	$ 2,285,899	$ 24,279,581	$ 25,201,367

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The accompanying notes are an integral part of this financial statement.

Foundation for Community Health, Inc.

Statements of Cash Flows
December 31, 2015 and 2014

	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in Net Assets	$ (921,786)	$ (1,194,748)
Adjustments:		
Depreciation	7,554	6,415
Realized and Unrealized (Gain) Loss on Investments	137,849	(1,122,909)
Decreases/(Increases) in Assets:		
Prepaid Expenses	(7,443)	367
Contribution Receivable - CRTs	643	41
Security Deposit	-	2,600
Increases/(Decreases) in Liabilities		
Grants Payable	175,597	(171,879)
Accounts Payable and Accrued Expenses	9,080	(15,408)
Total Adjustments	323,280	(1,300,773)
Net Cash Used by Operating Activities	(598,506)	(2,495,521)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Proceeds from Sales of Investments	1,186,451	3,336,216
Purchase of Investments	(609,085)	(828,672)
Payments for Property and Equipment	-	(16,013)
Net Cash Provided by Investing Activities	577,366	2,491,531
CASH FLOWS FROM FINANCING ACTIVITIES:	-	-
Net Increase (Decrease) in Cash and Cash Equivalents	(21,140)	(3,990)
Cash and Cash Equivalents at Beginning of Year	67,714	71,704
Cash and Cash Equivalents at End of Year	$ 46,574	$ 67,714
Supplemental Information:		
Interest Paid	$ -	$ -
Income Taxes Paid	$ -	$ -

The accompanying notes are an integral part of this financial statement.

Foundation for Community Health, Inc.

Statement of Functional Expenses
For the Year Ended December 31, 2015
With Comparative Totals for 2014

	Management and General	Programs	Totals 2015	Totals 2014
Grants and Disbursements	$ -	$ 718,247	$ 718,247	$ 588,293
Grants to Supported Organizations (Note 10)	-	-	-	2,000,000
Salaries	70,634	164,814	235,448	221,246
Employee Benefits	13,378	31,216	44,594	43,122
Payroll Taxes	5,297	12,358	17,655	16,827
Unemployment	248	579	827	1,032
Legal Services	3,833	-	3,833	13,028
Administrative Services	8,095	18,887	26,982	27,000
Investment Management Fees	61,012	142,361	203,373	204,799
Program Bank Fees	-	-	-	500
Program Consultants	-	34,747	34,747	16,799
Insurance	1,884	4,395	6,279	6,132
Rent	9,000	21,000	30,000	37,929
Utilities and Fuel	1,246	2,907	4,153	10,265
Telephone	1,145	2,671	3,816	5,544
Postage and Shipping	61	938	999	1,028
Office and Computer Supplies	2,574	6,005	8,579	13,415
Dues & Subscriptions	1,000	-	1,000	904
Meetings, Luncheons, Dinners	648	4,755	5,403	7,248
Staff Development	2,185	5,100	7,285	7,392
Travel	998	2,330	3,328	4,257
Depreciation	2,266	5,288	7,554	6,415
Accounting	9,270	-	9,270	9,000
Computer Maintenance Contract	710	1,657	2,367	2,309
Software Support	1,652	3,855	5,507	2,400
Payroll Service Fees	459	1,070	1,529	1,279
Equipment Rental and Maintenance	990	2,311	3,301	3,074
Marketing	5,300	1,558	6,858	9,364
Totals	$ 203,885	$ 1,189,049	$ 1,392,934	$ 3,260,601

The accompanying notes are an integral part of this financial statement.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of the Foundation

The Foundation for Community Health, Inc. (FCH) was formed to maintain and improve the physical and mental health of all residents of the area historically served by Sharon Hospital, Inc. FCH was created under mandate of the Attorney General and the Superior Court of the State of Connecticut. During 2014, FCH changed its status as a Type III Supporting Organization of BTCF to a Type I Supporting Organization to three local community foundations: Berkshire Taconic Community Foundation, Inc., Community Foundation of Northwest Connecticut, Inc. and The Community Foundations of the Hudson Valley, Inc. As required by its by-laws, this change was pre-approved by the State of Connecticut's Attorney General. While FCH has decided to keep the balance of it funds in the BTCF Managed Pool, as a good-will measure it funded two $1,000,000 grants to donor-advised funds at each of the other two community foundations. While FCH has surrendered ownership of the money deposited into the funds, it has maintained an advisory control over how grants are distributed to charities. FCH is a separate, independent corporation governed by its own board of directors.

FCH was created as a result of the sale of Sharon Hospital, Inc. (a not-for-profit corporation) to Essent Healthcare, Inc. (a for-profit corporation) based on a lengthy approval process governed by the Attorney General and the Litchfield County Superior Court.

Basis of Accounting

The financial statements of FCH have been prepared on the accrual basis of accounting and accordingly reflect all significant receivables, payables, and other liabilities. Revenue is recognized when earned and expenses are recognized when incurred.

Financial Statement Presentation

FCH is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. In addition, FCH is required to present a statement of cash flows. A description of the three net asset categories follows:

Unrestricted – Net assets that are not subject to donor-imposed restrictions. Unrestricted net assets may be designated for specific purposes by action of the Board of Directors.

Temporarily Restricted – Net assets whose use by FCH is subject to donor-imposed restrictions that can be fulfilled by actions of the FCH pursuant to those restrictions or that expire by the passage of time. Charitable Remainder Trusts are included in Temporarily Restricted Net Assets.

Permanently Restricted - Net assets subject to donor-imposed restrictions that they be maintained permanently by FCH.

Comparative Financial Information

The financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with generally accepted accounting principles. Accordingly, such information should be read in conjunction with FCH's financial statements for the year ended December 31, 2014, from which the summarized information was derived.

Estimates
The preparation of financial statements in accordance with generally accepted accounting principles requires estimates by management. The actual results of operations may differ from management's estimates.

Income Taxes
FCH is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code; therefore, there is no provision for income taxes.

Cash and Cash Equivalents
For purposes of the statement of cash flows, FCH considers all unrestricted highly liquid investments with an initial maturity of three months or less to be cash equivalents. Cash equivalents maintained in investment accounts for re-investment are excluded from cash and are reported as investments.

Endowment
The Financial Accounting Standards Board (FASB) issued staff position No. FAS 117-1: *Endowments of Not-For-Profit Organizations: Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act, and Enhanced Disclosures for all Endowment Funds* (FAS 117-1). FAS 117-1 provides accounting standards on the net asset classification of donor-restricted endowment funds for a not-for-profit organization that are subject to an enacted version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA). FAS 117-1 also provides for other disclosures concerning an organization's endowment funds and whether or not the organization is subject to UPMIFA. The State of Connecticut adopted its version of UPMIFA, which became effective October 1, 2007 (CTPMIFA). The State of New York has also adopted its version (NYPMIFA) in September, 2010. Prior to the issuance of FAS 117-1, accumulated gains and income on donor restricted endowment assets were classified as unrestricted net assets in accordance with the Uniform Management of Institutional Funds Act (UMIFA). Under SP No. 117-1, accumulated gains and income on donor-restricted endowment assets of perpetual duration are classified as temporarily restricted net assets until appropriated for expenditure.

Investments
Investments consist of FCH's share of the Berkshire Taconic Community Foundation's "Managed Pool," which consists of various types of investments. The Managed Pool has significant investments in equity and debt securities and is therefore subject to concentrations of credit and market risk. Investments are managed by investment advisors who are selected and engaged by the Investment Committee of the Board of Directors of the Berkshire Taconic Community Foundation (BTCF). The policies regarding investment composition, valuation, and spending are those of BTCF, reviewed and adopted by FCH. BTCF engages its own auditors who issued an unqualified opinion on their financial statements for the year ended December 31, 2015.

Marketable investments in equities and debt securities are carried at fair value based upon quoted market prices. For limited marketability investments, including alternative investments which are principally absolute return strategies, private equity and real estate, the carrying value is the estimated fair value. Because alternative investments are not immediately marketable given the nature of the underlying strategies and the terms of the governing partnership agreements, the estimated fair value is subject to uncertainty and, therefore, may differ from the value that may be received if a ready market for the investments had been in existence, and the difference could be material. FCH's alternative investments accessed through limited partnerships are determined by the general partner to be at fair value pursuant to FASB ASC 820-10, as further discussed below, after it considers certain pertinent factors, including, but not limited to, the partner's share of the underlying limited partnership's net assets, liquidity features of the partnership, the underlying portfolio of holdings, the current market conditions for observable, corroborated or correlated transactions, comparable or similar products' fair valuations, external assessments of the limited partnerships' holdings, and the audit opinion from the independent auditor of the limited partnership.

Fair Value of Financial Instruments
In accordance with FASB ASC 820-10, FCH is required to measure the fair value of its assets and liabilities under a three-level hierarchy, as follows:

Level 1: Values are based on quoted prices in active markets for identical assets.

Level 2: Values are based on significant observable market inputs, such as:

a. Quoted prices for similar assets or liabilities in active markets;
b. Quoted prices for similar assets or liabilities in market that are not active;
c. Observable inputs other than quoted prices for the asset or liability;
d. Inputs derived principally from, or corroborated by, observable market data by correlation or by other means.

Level 3: Values are based on significant unobservable inputs for the asset or liability should be used to the extent that observable inputs are not available. Fair value inputs used for absolute return investment, private equity investments, and nonearning assets have been estimated using the estimated net asset value per share of the investments.

Observable inputs reflect the assumptions market participants would use in pricing the asset or liability developed from sources independent of the reporting entity; and unobservable inputs reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset or liability developed based on the best information available in the circumstances. The valuation levels are not necessarily an indication of the risk or liquidity associated with the underlying investment.

In accordance with FASB ASC 820-10, FCH's carrying amount of cash and cash equivalents and grants payable approximate fair value under Level 1. Investments are carried at fair value and are presented in Note 9. Split-interest agreements are reported at fair value based on the life expectancy of the beneficiary and the net present value of the expected cash flows using a discount rate, which are Level 3 unobservable inputs. Agency funds are carried at fair value based on the underlying investments. Derivatives instruments held in the managed pool are measured at fair value based on Level 2 input. FCH does not directly pursue derivatives or speculative investments; however, in the ordinary course of investing activities, BTCF, pursuant to their investment policies, may hold these investments in the managed pool, of which FCH is a participant.

Spending Policy
The Board adopted spending cap is presently at 4.5% on the average asset base over the past 20 quarters, plus any income received from two permanent trusts and any other unrestricted income received during the year. A schedule calculating the spending policy will be reviewed and approved by the Board of Directors annually.

Investment Policy
Through BTCF, FCH has adopted investment and spending policies for endowment assets in an effort to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Under this policy, the endowment assets are invested in a manner that is intended to produce on average, over long-term horizons, returns that will offset spending plus inflation plus administrative fees.

To satisfy its long-term rate-of-return objectives, BTCF relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). BTCF targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Property and Equipment
All acquisitions of property and equipment and expenditures for repairs, maintenance, renewals, and betterments that materially prolong the useful lives of assets in excess of $1,000 are capitalized. Property and equipment are carried at cost or, if donated, at the approximate fair value at the date of donation. Depreciation is computed using the straight-line method over the following estimated useful lives of the assets.

Website	3 years
Furniture and Fixtures	7 years
Computer Equipment and Software	5 years
Leasehold Improvements	15 years

Contributions and Classification of Net Assets
Gifts of cash and other assets received are reported as unrestricted revenue and net assets, unless subject to time restrictions. When a donor-stipulated time restriction ends, restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as restrictions satisfied by payment. Restricted contributions are reported as increases to unrestricted net assets when restrictions expire (that is, when a stipulated restriction of time ends or purpose is accomplished) in the reporting period that the contributions are reported as revenues.

Investment Income
Investment income includes interest and dividends earned on savings accounts, as well as any other form of investment income, such as realized and unrealized gains. Restricted gains and investment income whose restrictions are met in the same reporting period are reported as unrestricted support.

Grant Awards
Grant awards are recorded as expenses when approved by FCH and when grant terms do not include material conditions.

Expense Allocation
Unless expenses can be specifically identified, most expenses are allocated 30% to Management and General and 70% to Programs based on management's estimate and historical experience.

Advertising Expense
All advertising and marketing costs are expensed in the period incurred as any future economic benefit cannot be quantified.

Review for Subsequent Events
In connection with the preparation of the financial statements of FCH, as of and for the year ended December 31, 2015, events and transactions subsequent to December 31, 2015 through September 21, 2016, the date the financial statements were available to be issued, have been evaluated by FCH management for possible adjustment and/or disclosure.

NOTE 2 – DETAIL NOTES ON ASSETS, LIABILITIES, AND NET ASSETS

Cash and Cash Equivalents
At December 31, 2015, the carrying amounts of FCH's deposits were $46,574, and the bank balance was $228,815 all of which is FDIC insured. Included in this amount is $33,614 held in escrow to support the Dial-A-Ride Transportation Service, as further described in this note under Board Designated Net Assets.

Investments
Investment return on the investment pool and its classification in the statement of activities consisted of the following:

	2015	2014
Dividends and Interest	$ 297,217	$ 347,048
Unrealized Gains (Losses)	(622,024)	(36,046)
Realized Gains (Losses)	484,175	1,158,955
	$ 159,368	$ 1,469,957

Fixed Assets
Fixed Assets consist of the following

	2015	2014
Equipment	$ 64,903	$ 65,276
Website	5,228	5,228
	70,131	70,504
Accumulated Depreciation	(53,481)	(46,300)
	$ 16,650	$ 24,204

Depreciation Expense was $7,554 and $6,415 for the years ended December 31, 2015 and 2014.

Grants Payable
As of December 31, grants payable are committed as follows:

	2015	2014
Due in one year or less	$ 178,072	$ 33,475
Due in one to five years	33,000	2,000
	$ 211,072	$ 35,475

Board Designated Net Assets
Board Designated Net Assets consist of a cash account, currently $33,614, held to guarantee a Line of Credit between a Town and a grantee to support the Dial-a-Ride Transportation Program. In the event the grantee is not able to make payments, the escrow account could be used for satisfaction of the debt.

Temporarily Restricted Net Assets
Temporarily Restricted Net Assets consists of the following:

	2015	2014
Contribution Receivable - CRT's	$ 13,489	$ 14,132
Field of Interest Funds	82,153	81,425
Income on Permanently Restricted Funds:		
Per Adoption of UPMIFA	1,087,697	1,212,820
	$ 1,183,339	$ 1,308,377

Permanently Restricted Net Assets
Permanently Restricted Net Assets consist of the following:

	2015	2014
Field of Interest Funds	$ 423,062	$ 423,062
"Unrestricted Funds"	1,862,837	1,862,837
	$ 2,285,899	$ 2,285,899

NOTE 3 – BENEFICIARY INTEREST IN PERPETUAL TRUSTS

FCH is an income beneficiary of two irrevocable perpetual trusts, the assets of which are managed by and are in the possession of Bank of America. The assets held in these trusts were valued at $6,860,888 and $7,339,024 respectively as of December 31, 2015 and 2014. FCH has interests in the income only, and no provision to receive any principal. FCH received $311,768 and $332,527 in income distributions based on the fund's income after certain trust expenses for the years ending December 31, 2015 and 2014.

NOTE 4 – CHARITABLE REMAINDER TRUSTS

FCH has a split-interest in a charitable remainder trust, administered by a trustee outside FCH. The charitable remainder trust provides for the payment of distributions to the designated beneficiaries over the trust's term (the beneficiaries' lifetime). At the end of the trust's term, FCH will receive 10% of remaining assets. An asset is reported in the Statement of Financial Position representing the present value of the expected future benefits using a 2.0% discount rate and the Joint and Last survivor table. On an annual basis, FCH revalues the asset. It is reported as Contribution Receivable – CRT.

There are Charitable Remainder trusts which name Sharon Hospital as the beneficiary. FCH is the logical successor; however, it has not yet been named as beneficiary. No contributions from these trusts have been recorded.

NOTE 5 – LEASE COMMITMENTS

FCH leases a copier that requires monthly payments of $191 through March 2017. In addition, FCH renewed a lease for a postage meter that requires quarterly payments of $114 through July 2019. Total lease expense for 2015 and 2014 amounted to $2,784 and $2,820. Future minimum lease payments under these leases are as follows as of December 31, 2015:

2016	2,748
2017	1,029
2018	456
2019	228

During January 2015, FCH entered into a new office space lease requiring monthly payments of $2,500 for 5 years through January 14, 2020. The prior lease requiring monthly payments of $2,600 expired during April 2014. Rent expense for 2015 and 2014 totaled $30,000 and $37,929. Lease payments for the next five years are as follows:

2016	30,000
2017	30,000
2018	30,000
2019	1,250

NOTE 6 – TAX DEFERRED ANNUITY

FCH has adopted a 403(b)(7) Tax Deferred Annuity Plan for its employees and has voluntarily contributed 7% of annual salaries for eligible employees. Investment companies maintain the invested assets. The employer contributions to the plan for the years ending December 31, 2015 and 2014 were $15,199 and $15,419.

NOTE 7 – RELATED PARTY TRANSACTIONS

FCH received investment management and administrative services from BTCF. FCH is a type-one supporting organization of BTCF. The total fees paid for 2015 and 2014 were $135,507 and $136,443. The Investment fees of $108,525 and $109,443 were based on average assets in the BTCF Managed Pool Fund of $25,008,469 and $25,314,367 for the years 2015 and 2014 respectively. Administrative fees were $26,982 and $27,000 for 2015 and 2014. In 2014, administrative fees were renegotiated and are based on the CRI index. Amounts owed to BTCF were $33,112 and $33,895 at December 31, 2015 and 2014.

NOTE 8 – ENDOWMENT FUNDS

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total Endowment Assets
Donor-Restricted Endowment Funds	$ -	$ 1,169,850	$ 2,285,899	$ 3,455,749
Board-Designated Endowment Funds	20,727,861	-	-	20,727,861
Total Funds	$ 20,727,861	$ 1,169,850	$ 2,285,899	$ 24,183,610

Changes in Endowment Assets as of December 31, 2015 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total Endowment Assets
Endowment Assets at 12/31/14	$ 21,503,358	$ 1,294,245	$ 2,285,899	$ 25,083,502
Contributions	312,423	555	-	312,978
Investment Income	692,726	108,862	-	801,588
Net Appreciation	(537,020)	(85,004)	-	(622,024)
Amounts Appropriated for Expenditure	(1,243,626)	(148,808)	-	(1,392,434)
Endowment Assets at 12/31/15	$ 20,727,861	$ 1,169,850	$ 2,285,899	$ 24,183,610

BTCF regularly reports the liquidity of invested assets. Applying FCH's percentage ownership in the BTCF pool results in the following projected table of liquidity.

Redemption Terms	Amount of Invested Pool	% of Invested Pool
Daily	$ 10,933,424	44.7%
Monthly	2,103,522	8.6%
Quarterly	6,750,839	27.6%
Annually	3,155,284	12.9%
Illiquid	1,516,493	6.2%
Total	$ 24,459,562	100.0%

Requests of funds by FCH during each calendar year of up to 10% of the value of the FCH Fund will be disbursed within 10 days. FCH must provide BTCF with 120 days written notice for any request of funds in excess.

NOTE 9 – FAIR VALUE INFORMATION

Description	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest in Berkshire Taconic Community Foundation	$ 24,459,562	$ -	$ 24,459,562	$ -
Money Market Funds	2,813	2,813		
Beneficial Interest in Remainder Trusts	13,489	-	-	13,489
Reported as:				
Investments	$ 24,462,375			
Contribution Receivable	13,489			

The interest in Berkshire Taconic Community Foundation is reported as valued using Level 2 measurements because FCH owns an interest in an investment pool which is periodically measured by BTCF. The intermediation of BTCF results in some assets being classified as Level 2 assets in the table above when they would otherwise be deemed as Level 1 or Level 3 if held as direct investments by FCH. BTCF measures approximately 47.1%($11,511,589) of the $24,462,375 using Level 1 measurements and 18.3% ($4,479,249) using Level 3 measurements in its December 31, 2015 financial statements. The balance is reported as Level 2 measurements.

Assets Measured at Fair Value on a Recurring Basis Using Significant Unobservable Inputs (Level 3)

The following is a summary of the changes in the balances of assets measured at fair value on a recurring basis using significant unobservable inputs:

Balance, beginning of year	$	14,132
Total gains or losses (realized and unrealized) included in the change in net assets		(643)
Purchases and Sales		-
Transfers in and/or out of Level 3		-
Balance, end of year	$	13,489
The amount of total gains (losses) for the period included in change in net assets attributable to the change in unrealized gains related to assets still held at end of year	$	-
The amount reported as Change in Value of Split-Interest Agreements Related to Assets Held at Year-end		(643)

NOTE 10 – SUPPORTED ORGANIZATIONS

In 2014, FCH established two $1,000,000 donor-advised funds, one at Community Foundation of Northwest Connecticut and the other at Community Foundations of the Hudson Valley. No grant disbursements were made during the year. All remaining funds are held at its third supporting organization, the Berkshire Taconic Community Foundation.

NOTE 11 – SUBSEQUENT EVENTS

In August 2016, FCH deemed it to be in the best interest of the community and in furtherance of its charitable purposes to commit to Health Quest a grant divided into two parts, which in aggregate will not be more than $9 million. The first grant is a commitment of up to $3 million toward the acquisition of Sharon Hospital, which will be transferred to Health Quest upon the closing of the transaction. The second part of the grant is a 50% matching grant of approximately $6 million. This approximately $6 million will be distributed to Health Quest over the following 4 years to support significant investments in Sharon Hospital and its services. Funds will be disbursed annually in approximately $2 million increments after proof of Heath Quest investment.

2015 Exempt Org. Return
prepared for:

FOUNDATION FOR COMMUNITY HEALTH, INC.
478 Cornwall Bridge Rd.
SHARON, CT 06069

KING, KING & ASSOCIATES, CPAS
170 HOLABIRD AVE
WINSTED, CT 06098-1727

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
► Do not enter social security numbers on this form as it may be made public.
► Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning , 2015, and ending ,

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C
FOUNDATION FOR COMMUNITY HEALTH, INC.
478 CORNWALL BRIDGE RD.
SHARON, CT 06069

D Employer identification number [redacted]

E Telephone number
860-364-5157

G Gross receipts $ 1,093,815.

F Name and address of principal officer: NANCY HEATON
SAME AS C ABOVE

H(a) Is this a group return for subordinates? ☐ Yes ☒ No
H(b) Are all subordinates included? ☐ Yes ☐ No
If 'No,' attach a list. (see instructions)

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◄ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ► FCHEALTH.ORG

H(c) Group exemption number ►

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ► L Year of formation: 2003 M State of legal domicile: CT

Part I Summary

1 Briefly describe the organization's mission or most significant activities: TO MAINTAIN AND IMPROVE THE PHYSICAL AND MENTAL HEALTH OF ALL RESIDENTS OF THE AREA HISTORICALLY SERVED BY SHARON HOSPITAL INC.

2 Check this box ► ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	15
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	4
6	Total number of volunteers (estimate if necessary)	6	15
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	595,627.	311,868.
9	Program service revenue (Part VIII, line 2g)		
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,488,198.	781,392.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	310.	555.
12	Total revenue – add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,084,135.	1,093,815.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	2,588,293.	718,247.
14	Benefits paid to or for members (Part IX, column (A), line 4)		
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	282,227.	298,524.
16a	Professional fundraising fees (Part IX, column (A), line 11e)		
b	Total fundraising expenses (Part IX, column (D), line 25) ►		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	390,081.	376,163.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	3,260,601.	1,392,934.
19	Revenue less expenses. Subtract line 18 from line 12	-1,176,466.	-299,119.

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	25,295,453.	24,558,344.
21	Total liabilities (Part X, line 26)	94,086.	278,763.
22	Net assets or fund balances. Subtract line 21 from line 20	25,201,367.	24,279,581.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer — Date 11/11/16

NANCY HEATON — EXECUTIVE DIREC CEO
Type or print name and title.

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
ROBERT E. KING, CPA	ROBERT E. KING, CPA			[redacted]

Firm's name ► KING, KING & ASSOCIATES, CPAS
Firm's address ► 170 HOLABIRD AVE
WINSTED, CT 06098-1727
Firm's EIN ► [redacted]
Phone no. (860) 379-0215

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III ☐

1 Briefly describe the organization's mission:

TO MAINTAIN AND IMPROVE THE PHYSICAL AND MENTAL HEALTH OF ALL RESIDENTS OF THE AREA HISTORICALLY SERVED BY SHARON HOSPITAL INC.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If 'Yes,' describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If 'Yes,' describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 1,189,049. including grants of $ 718,247.) (Revenue $)

IMPROVE THE PHYSICAL AND MENTAL HEALTH OF ALL RESIDENTS OF THE AREA HISTORICALLY SERVED BY SHARON HOSPITAL

4b (Code:) (Expenses $ including grants of $) (Revenue $)

4c (Code:) (Expenses $ including grants of $) (Revenue $)

4d Other program services. (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ► 1,189,049.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If 'Yes,' complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If 'Yes,' complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If 'Yes,' complete Schedule C, Part II*	4		X
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If 'Yes,' complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If 'Yes,' complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If 'Yes,' complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If 'Yes,' complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If 'Yes,' complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If 'Yes,' complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is 'Yes', then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings and equipment in Part X, line 10? *If 'Yes,' complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments – other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If 'Yes,' complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments – program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If 'Yes,' complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If 'Yes,' complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If 'Yes,' complete Schedule D, Part X*	11e		X
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If 'Yes,' complete Schedule D, Part X*	11f		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If 'Yes,' complete Schedule D, Parts XI, and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If 'Yes,' and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b		X
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If 'Yes,' complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If 'Yes,' complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If 'Yes,' complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If 'Yes,' complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If 'Yes,' complete Schedule G, Part I* (see instructions)	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If 'Yes,' complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If 'Yes,' complete Schedule G, Part III*	19		X

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If 'Yes', complete Schedule H*	20a		X
b	If 'Yes' to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b		
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If 'Yes,' complete Schedule I, Parts I and II*	21	X	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If 'Yes,' complete Schedule I, Parts I and III*	22		X
23	Did the organization answer 'Yes' to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If 'Yes,' complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If 'Yes,' answer lines 24b through 24d and complete Schedule K. If 'No, 'go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an 'on behalf of' issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If 'Yes,' complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If 'Yes,' complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If 'Yes', complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If 'Yes,' complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If 'Yes,' complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If 'Yes,' complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If 'Yes,' complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If 'Yes,' complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If 'Yes,' complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If 'Yes,' complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If 'Yes,' complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If 'Yes,' complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If 'Yes,' complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		X
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If 'Yes,' complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If 'Yes,' complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If 'Yes,' complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V. ☐

			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	1a 7		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.	2a 4		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)			
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X
b	If 'Yes' has it filed a Form 990-T for this year? *If 'No' to line 3b, provide an explanation in Schedule O.*	3b		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X
b	If 'Yes,' enter the name of the foreign country: ►			
	See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts. (FBAR)			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		X
c	If 'Yes,' to line 5a or 5b, did the organization file Form 8886-T?	5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a		X
b	If 'Yes,' did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b		
7	**Organizations that may receive deductible contributions under section 170(c).**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X
b	If 'Yes,' did the organization notify the donor of the value of the goods or services provided?	7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c		X
d	If 'Yes,' indicate the number of Forms 8282 filed during the year.	7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8		
9	**Sponsoring organizations maintaining donor advised funds.**			
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
10	**Section 501(c)(7) organizations.** Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12	10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b		
11	**Section 501(c)(12) organizations.** Enter:			
a	Gross income from members or shareholders	11a		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b		
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a		
b	If 'Yes,' enter the amount of tax-exempt interest received or accrued during the year	12b		
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**			
a	Is the organization licensed to issue qualified health plans in more than one state?	13a		
	Note. See the instructions for additional information the organization must report on Schedule O.			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b		
c	Enter the amount of reserves on hand	13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a		X
b	If 'Yes,' has it filed a Form 720 to report these payments? *If 'No,' provide an explanation in Schedule O*	14b		

Part VI Governance, Management, and Disclosure *For each 'Yes' response to lines 2 through 7b below, and for a 'No' response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI ..... [X]

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year ..... If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a 15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 15		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? SEE SCH O	4	X	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders? SEE SCHEDULE O	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? SEE SCHEDULE O	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b		X
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If 'Yes,' provide the names and addresses in Schedule O.*	9		X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If 'Yes,' did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990. SEE SCHEDULE O			
12a	Did the organization have a written conflict of interest policy? *If 'No,' go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If 'Yes,' describe in Schedule O how this was done* SEE SCHEDULE O	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official SEE SCHEDULE O	15a	X	
b	Other officers or key employees of the organization SEE SCHEDULE O	15b	X	
	If 'Yes' to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		X
b	If 'Yes,' did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ► CT NY

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

[X] Own website [X] Another's website [X] Upon request [ ] Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year. SEE SCHEDULE O

20 State the name, address, and telephone number of the person who possesses the organization's books and records: ►

BERKSHIRE TACONIC COMM FND 800 NORTH MAIN STREET SHEFFIELD MA 01257 413-528-8039

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII. ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1 a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of 'key employee.'
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KARREN GARRITY DIRECTOR	1 0	X						0.	0.	0.
(2) KATHRYN E PALMER-HOUSE SECRETARY	2 0	X		X				0.	0.	0.
(3) ALICE YOAKUM DIRECTOR	1 0	X						0.	0.	0.
(4) NANCY MURPHY CHAIRMAN	2 0	X		X				0.	0.	0.
(5) ROBERT KUHBACH DIRECTOR	1 0	X						0.	0.	0.
(6) DR. EUGENE CHIN DIRECTOR	1 0	X						0.	0.	0.
(7) EVELYN GARZETTA DIRECTOR	2 0	X		X				0.	0.	0.
(8) EILEEN MULLIGAN DIRECTOR	1 0	X						0.	0.	0.
(9) JOHN CHARDE DIRECTOR	1 0	X						0.	0.	0.
(10) SYTSKE ARNASON DIRECTOR	1 0	X						0.	0.	0.
(11) SALLY BERG DIRECTOR	1 0	X						0.	0.	0.
(12) KENNETH SCHECHTER VICE CHAIRMAN	2 0	X		X				0.	0.	0.
(13) TOM QUINN DIRECTOR	1 0	X						0.	0.	0.
(14) JOHN GALLUP DIRECTOR	1 0	X						0.	0.	0.

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) MIRIAM TANNEN	1									
DIRECTOR	0	X						0.	0.	0.
(16) NANCY HEATON	40									
EXECUTIVE DIREC	0			X				118,200.	0.	37,183.
(17)										
(18)										
(19)										
(20)										
(21)										
(22)										
(23)										
(24)										
(25)										
1 b Sub-total ►								118,200.	0.	37,183.
c Total from continuation sheets to Part VII, Section A ►								0.	0.	0.
d Total (add lines 1b and 1c) ►								118,200.	0.	37,183.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ► 1

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If 'Yes,' complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If 'Yes' complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If 'Yes,' complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ► 0

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	311,868.			
	g Noncash contributions included in lines 1a-1f: $					
	h Total. Add lines 1a-1f		311,868.			
Program Service Revenue		Business Code				
	2a					
	b					
	c					
	d					
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f					
Other Revenue	3 Investment income (including dividends, interest and other similar amounts)		297,217.			297,217.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross rents					
	b Less: rental expenses					
	c Rental income or (loss)					
	d Net rental income or (loss)					
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	484,175.				
	b Less: cost or other basis and sales expenses					
	c Gain or (loss)	484,175.				
	d Net gain or (loss)		484,175.			484,175.
	8a Gross income from fundraising events (not including $ ____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less: direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	Business Code				
	11a MISC. RECEIPTS	900099	555.			555.
	b					
	c					
	d All other revenue					
	e Total. Add lines 11a-11d		555.			
	12 Total revenue. See instructions		1,093,815.	0.	0.	781,947.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	718,247.	718,247.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	155,383.	108,768.	46,615.	0.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.	0.	0.	0.
7 Other salaries and wages	117,248.	82,074.	35,174.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,943.	4,860.	2,083.	
9 Other employee benefits	468.	328.	140.	
10 Payroll taxes	18,482.	12,937.	5,545.	
11 Fees for services (non-employees):				
a Management				
b Legal	3,833.		3,833.	
c Accounting	9,270.		9,270.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	203,373.	142,361.	61,012.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	61,729.	53,634.	8,095.	
12 Advertising and promotion	6,858.	1,558.	5,300.	
13 Office expenses	8,579.	6,005.	2,574.	
14 Information technology	7,874.	5,512.	2,362.	
15 Royalties				
16 Occupancy	37,969.	26,578.	11,391.	
17 Travel	3,328.	2,330.	998.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	5,403.	4,755.	648.	
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,554.	5,288.	2,266.	
23 Insurance	6,279.	4,395.	1,884.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a STAFF DEVELOPMENT	7,285.	5,100.	2,185.	
b EQUIPMENT RENTAL	3,301.	2,311.	990.	
c PAYROLL FEES	1,529.	1,070.	459.	
d DUES & SUBSCRIPTIONS	1,000.		1,000.	
e All other expenses	999.	938.	61.	
25 Total functional expenses. Add lines 1 through 24e	1,392,934.	1,189,049.	203,885.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ► ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X. ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash – non-interest-bearing		34,117.	1	12,960.
	2	Savings and temporary cash investments		33,597.	2	33,614.
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net			4	
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use			8	
	9	Prepaid expenses and deferred charges		6,813.	9	14,256.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 70,130.			
	b	Less: accumulated depreciation	10b 53,480.	24,202.	10c	16,650.
	11	Investments – publicly traded securities		25,177,590.	11	24,462,375.
	12	Investments – other securities. See Part IV, line 11			12	
	13	Investments – program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		19,134.	15	18,489.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		25,295,453.	16	24,558,344.
Liabilities	17	Accounts payable and accrued expenses		58,611.	17	67,691.
	18	Grants payable		35,475.	18	211,072.
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D			25	
	26	**Total liabilities.** Add lines 17 through 25		94,086.	26	278,763.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ► [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		21,607,091.	27	20,810,343.
	28	Temporarily restricted net assets		1,308,377.	28	1,183,339.
	29	Permanently restricted net assets		2,285,899.	29	2,285,899.
		Organizations that do not follow SFAS 117 (ASC 958), check here ► ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		25,201,367.	33	24,279,581.
	34	Total liabilities and net assets/fund balances		25,295,453.	34	24,558,344.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,093,815.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,392,934.
3	Revenue less expenses. Subtract line 2 from line 1	3	-299,119.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	25,201,367.
5	Net unrealized gains (losses) on investments	5	-622,024.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O) SEE SCHEDULE O	9	-643.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	24,279,581.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII .....

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____			
	If the organization changed its method of accounting from a prior year or checked 'Other,' explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☒ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
c	If 'Yes' to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If 'Yes,' did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

SCHEDULE A
(Form 990 or 990-EZ)

epartment of the Treasury
nternal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

► **Attach to Form 990 or Form 990-EZ.**

► **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 [ ] A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 [ ] A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)

3 [ ] A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 [ ] A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:

5 [ ] An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 [ ] A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 [ ] An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 [ ] A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 [ ] An organization that normally receives: (1) more than 33-1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions – subject to certain exceptions, and (2) no more than 33-1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 [ ] An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 [X] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.

a [X] **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b [ ] **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c [ ] **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d [ ] **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e [ ] Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations 3

g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
(A) SEE PART VI						
(B)						
(C)						
(D)						
(E)						
Total					1,189,049.	0.

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any 'unusual grants.')						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ► ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2014 Schedule A, Part II, line 14	15	%

16a **33-1/3% support test – 2015.** If the organization did not check the box on line 13, and line 14 is 33-1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ► ☐

b **33-1/3% support test – 2014.** If the organization did not check a box on line 13 or 16a, and line 15 is 33-1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ► ☐

17a **10%-facts-and-circumstances test – 2015.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the 'facts-and-circumstances' test, check this box and **stop here.** Explain in Part VI how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ► ☐

b **10%-facts-and-circumstances test – 2014.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the 'facts-and-circumstances' test, check this box and **stop here.** Explain in Part VI how the organization meets the 'facts-and-circumstances' test. The organization qualifies as a publicly supported organization ► ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions and membership fees received. (Do not include any 'unusual grants.')						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513.						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ► ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2015** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2014** Schedule A, Part III, line 17	18	%

19a **33-1/3% support tests – 2015.** If the organization did not check the box on line 14, and line 15 is more than 33-1/3%, and line 17 is not more than 33-1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ► ☐

b **33-1/3% support tests – 2014.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33-1/3%, and line 18 is not more than 33-1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ► ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ► ☐

Part IV Supporting Organizations
(Complete only if you checked a box in line 11 on Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

		Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If 'No,' describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain*	1	X	
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If 'Yes,' explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		X
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If 'Yes,' answer (b) and (c) below.*	3a		X
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If 'Yes,' describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If 'Yes,' explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ('foreign supported organization')? *If 'Yes' and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		X
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If 'Yes,' describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If 'Yes,' explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If 'Yes,' answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI****, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		X
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If 'Yes,' provide detail in* ***Part VI.***	6		X
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If 'Yes,' complete Part I of Schedule L (Form 990 or 990-EZ).*	7		X
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If 'Yes,' complete Part I of Schedule L (Form 990 or 990-EZ).*	8		X
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If 'Yes,' provide detail in* ***Part VI.***	9a		X
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If 'Yes,' provide detail in* ***Part VI.***	9b		X
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If 'Yes,' provide detail in* ***Part VI.***	9c		X
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If 'Yes,' answer 10b below.*	10a		X
b	Did the organization, have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

		Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?			
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		X
b A family member of a person described in (a) above?	11b		X
c A 35% controlled entity of a person described in (a) or (b) above? *If 'Yes' to a, b, or c, provide detail in* **Part VI**	11c		X

Section B. Type I Supporting Organizations

		Yes	No
1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If 'No,' describe in* **Part VI** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	1	X	
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If 'Yes,' explain in* **Part VI** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		X

Section C. Type II Supporting Organizations

		Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If 'No,' describe in* **Part VI** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	1		

Section D. All Type III Supporting Organizations

		Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If 'No,' explain in* **Part VI** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If 'Yes,' describe in* **Part VI** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year* **(see instructions):**

a ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* **line 3** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

		Yes	No
2 Activities Test. ***Answer (a) and (b) below.***			
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If 'Yes,' then in* **Part VI** ***identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If 'Yes,' explain in* **Part VI** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3 Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* **Part VI.**	3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If 'Yes,' describe in* **Part VI** *the role played by the organization in this regard.*	3b		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on November 20, 1970. **See Instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A – Adjusted Net Income

		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 **Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	8		

Section B – Minimum Asset Amount

		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d **Total** (add lines 1a, 1b, and 1c)	1d		
e **Discount** claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 **Minimum Asset Amount** (add line 7 to line 6)	8		

Section C – Distributable Amount

		Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2 Enter 85% of line 1	2	
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4 Enter greater of line 2 or line 3	4	
5 Income tax imposed in prior year	5	
6 **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations *(continued)*

Section D – Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**). See instructions.	
7 **Total annual distributions.** Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	
9 Distributable amount for 2015 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E – Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2015**	**(iii) Distributable Amount for 2015**
1 Distributable amount for 2015 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2015 (reasonable cause required – see instructions)			
3 Excess distributions carryover, if any, to 2015:			
a			
b			
c			
d From 2013			
e From 2014			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2015 distributable amount			
i Carryover from 2010 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2015 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2015 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2016.** Add lines 3j and 4c			
8 Breakdown of line 7:			
a			
b			
c Excess from 2013			
d Excess from 2014			
e Excess from 2015			

Part VI Supplemental Information. Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

SCHEDULE A, PART I, LINE 11
NAME(S) OF SUPPORTED ORGANIZATION(S)

NAME OF SUPPORTED ORGANIZATION	FEDERAL EIN	TYPE OF ORGANI-ZATION	LISTED IN GOVERNING DOCUMENT? YES	NO	AMOUNT OF MONETARY SUPPORT	AMOUNT OF OTHER SUPPORT
BERKSHIRE TACONIC COMMUNITY FOUND	[redacted]	7	X		$ 1,189,049.	$ 0.
COMMUNITY FOUNDATION OF NW CT	[redacted]	7	X		0.	0.
COMMUNITY FOUNDATION OF DUTCHESS	[redacted]	8	X		0.	0.
					$ 1,189,049.	$ 0.

Schedule B (Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

► Attach to Form 990, Form 990-EZ, or Form 990-PF.
► Information about Schedule B (Form 990, 990-EZ, 990-PF) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Name of the organization	Employer identification number
FOUNDATION FOR COMMUNITY HEALTH, INC.	[redacted]

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**

Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33-1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) $5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year..... ► $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer 'No' on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) Number	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	I KENT FULTON FUND 99 FOUNDERS PLAZA EAST HARTFORD, CT 06108	$ 289,532.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2	WILLIAM & MARY RAYNSFORD TRUST 99 FOUNDERS PLAZA EAST HARTFORD, CT 06108	$ 22,236.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
	N/A	$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

Part III ***Exclusively*** **religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ► $ N/A

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
	N/A		

(e) Transfer of gift: Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift: Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift: Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift: Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered 'Yes' on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
► Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

		Held at the End of the Tax Year
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►

4 Number of states where property subject to conservation easement is located ►

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►$

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ►$

(ii) Assets included in Form 990, Part X ►$

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ►$

b Assets included in Form 990, Part X ►$

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered 'Yes' on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1 a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If 'Yes,' explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1 c	
d Additions during the year	1 d	
e Distributions during the year	1 e	
f Ending balance	1 f	

2 a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If 'Yes,' explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐

Part V Endowment Funds. Complete if the organization answered 'Yes' on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1 a Beginning of year balance	25,083,502.	26,287,282.	23,876,038.	22,199,793.	23,853,612.
b Contributions	312,978.	595,937.	295,511.	283,693.	426,687.
c Net investment earnings, gains, and losses	179,564.	1,476,710.	3,583,235.	2,857,053.	-709,103.
d Grants or scholarships					
e Other expenditures for facilities and programs	1,392,434.	3,276,427.	1,467,502.	1,464,501.	1,371,403.
f Administrative expenses					
g End of year balance	24,183,610.	25,083,502.	26,287,282.	23,876,038.	22,199,793.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ► 85.71 %
b Permanent endowment ► 9.45 %
c Temporarily restricted endowment ► 4.84 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3 a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)	X	
b If 'Yes' on line 3a(ii), are the related organizations listed as required on Schedule R?	3b	X	

4 Describe in Part XIII the intended uses of the organization's endowment funds. SEE PART XIII

Part VI Land, Buildings, and Equipment.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1 a Land				
b Buildings				
c Leasehold improvements				
d Equipment		35,608.	22,950.	12,658.
e Other		34,522.	30,530.	3,992.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ►				16,650.

Part VII Investments – Other Securities. N/A
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. *(Column (b) must equal Form 990, Part X, column (B) line 12.)* ▶		

Part VIII Investments – Program Related. N/A
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. *(Column (b) must equal Form 990, Part X, column (B) line 13.)* ▶		

Part IX Other Assets. N/A
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, column (B) line 15.)* ▶	

Part X Other Liabilities.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25

(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, column (B) line 25.)* ▶	

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	471,148.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a	-622,024.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.) SEE PART XIII	2d	-643.		
e	Add lines 2a through 2d			2e	-622,667.
3	Subtract line 2e from line 1			3	1,093,815.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	1,093,815.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	1,392,934.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d			
e	Add lines 2a through 2d			2e	
3	Subtract line 2e from line 1			3	1,392,934.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	1,392,934.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4 - INTENDED USES OF ENDOWMENT FUND

ENDOWMENT FUNDS ARE USED TO ACCOMPLISH THE MISSION OF THE ORGANIZATION: TO MAINTAIN AND IMPROVE THE PHYSICAL AND MENTAL HEALTH OF ALL RESIDENTS OF THE AREA HISTORICALLY SERVED BY SHARON HOSPITAL INC.

SCHEDULE D, PART XI, LINE 2D
OTHER REVENUE INCLUDED IN F/S BUT NOT INCLUDED ON FORM 990

CHANGE IN VALUE OF CRT	$	-643.
TOTAL	$	-643.

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered 'Yes' on Form 990, Part IV, line 21 or 22.
► Attach to Form 990.
► Information about Schedule I (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States. SEE PART IV

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered 'Yes' on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) CATHOLIC CHARITIES COMM SERVI 1011 FIRST AVENUE 6TH FLOOR NEW YORK, NY 10022	[redacted]	501C3	45,000.	0.			KINSHIP CIRCLES OF SUPPORT PROGRAM
(2) COLUMBIA CTY HEALTHCARE CONSO 325 COLUMBIA ST HUDSON, NY 12534	[redacted]	501C3	14,250.	0.			PRESCRIPTION ASSISTANCE
(3) COLUMBIA CTY HEALTHCARE CONSO 325 COLUMBIA ST HUDSON, NY 12534	[redacted]	501C3	25,000.	0.			C.A.R.T.S.
(4) COLUMBIA MEMORIAL HOSPITAL 71 PROSPECT AVENUE HUDSON, NY 12534	[redacted]	501C3	40,000.	0.			COMMUNITY OUTREACH DENTAL SERVICES
(5) COMMUNITY ACTION PARTNERSHIP 77 CANNON STREET POUGHKEEPSIE, NY 12601	[redacted]	501C3	75,000.	0.			PRESCRIPTION ASSISTANCE
(6) COMMUNITY HEALTH & WELLNESS C 469 MIGEON AVENUE TORRINGTON, CT 06790	[redacted]0	501C3	50,000.	0.			PLANNING FOR NORTH CANAAN CLINIC
(7) EMS INSTITUTE ONE LOW ROAD SHARON, CT 06069	[redacted]	501C3	39,272.	0.			TRAINING FOR CARE PROVIDERS
(8) GEER ADULT DAY CENTER 83 SOUTH CANAAN RD, POB 819 CANAAN, CT 06018	[redacted]	501C3	35,000.	0.			DIAL-A-RIDE

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ► 17

3 Enter total number of other organizations listed in the line 1 table ..... ► 2

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01/17/2017

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

Part IV **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

PART I, LINE 2 - PROCEDURES FOR MONITORING USE OF GRANTS FUNDS IN U.S.

GRANTEES ARE REQUIRED TO FILE REPORTS WITH THE DONOR REFLECTING HOW THE FUNDS WERE SPENT.

Continuation Sheet for Schedule I (Form 990)

► Attach to Form 990 to list additional information for Schedule I (Form 990), Part II and Part III.

2015

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number [redacted]

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments. (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HUDSON RIVER HEALTHCARE INC 1037 MAIN ST PEEKSKILL, NY 10566	[redacted]	501C3	50,000.				SCHOOL-BASED PREVENTATIVE DENTAL
MARIA SEYMOUR BROOKER MEMORIA 157 LITCHFIELD ST TORRINGTON, CT 06790	[redacted]2	501C3	32,800.				ORAL HYGIENE PROGRAM
NAMI CONNECTICUT 576 FARMINGTON AVENUE HARTFORD, CT 06105	[redacted]	501C3	15,000.				CHILDREN'S MENTAL HEALTH INITIATIVE
NAMI MID-HUDSON CHAPTER PO BOX 787 POUGHKEEPSIE, NY 12602	[redacted]	501C3	15,000.				ENHANCING GRANT WRITING
NORTHEAST COMMUNITY COUNCIL I PO BOX 35, 51 S. CENTER STREE MILLERTON, NY 12546	[redacted]	501C3	64,000.				TRAN. FOR SNRS AND DISABLED PERSONS
NW HILLS COUNCIL OF GOV'TS 59 TORRINGTON ROAD, SUITE A-1 GOSHEN, CT 06756	[redacted]		60,750.				PRESCRIPTION ASSISTANCE
PHARMACARES 136 CENTRAL AVENUE CLARK, NJ 07066	[redacted]	501C3	60,000.				COMMUNITY ASSISTER PROGRAM
PHARMACARES 6 RAILROAD STREET WEST CORNWALL, CT 06796	[redacted]	501C3	20,750.				PROTOCOL CREATION FOR RX ASSISTANCE
ST OF CT OFFICE OF HLTHCARE PO BOX 1543 HARTFORD, CT 06144	[redacted]		25,000.				HEALTHCARE COST CONTAINMENT MODELS
SUSAN B ANTHONY PROJECT 179 WATER STREET TORRINGTON, CT 06790	[redacted]	501C3	20,000.				PROMOTING HEALTHY RELATIONSHIPS

Continuation Sheet for Schedule I (Form 990)

► Attach to Form 990 to list additional information for Schedule I (Form 990), Part II and Part III.

2015

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part II Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments. (Schedule I (Form 990), Part II.)

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WOMEN'S SUPPORT SERVICES POB 341, 158 GAY ST SHARON, CT 06069	[redacted]	501C3	20,000.				PROMOTING HEALTHY RELATIONSHIPS

SCHEDULE J (Form 990)

Department of the Treasury Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

► **Complete if the organization answered 'Yes' on Form 990, Part IV, line 23.**

► **Attach to Form 990.**

► **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part I Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel		
	☐ Travel for companions		
	☐ Tax indemnification and gross-up payments		
	☐ Discretionary spending account		
	☐ Housing allowance or residence for personal use		
	☐ Payments for business use of personal residence		
	☐ Health or social club dues or initiation fees		
	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If 'No,' complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee			
	☐ Independent compensation consultant			
	☐ Form 990 of other organizations			
	☐ Written employment contract			
	☒ Compensation survey or study			
	☒ Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If 'Yes' to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If 'Yes' to line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If 'Yes' on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described on lines 5 and 6? If 'Yes,' describe in Part III	7		X
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If 'Yes,' describe in Part III	8		X
9	If 'Yes' to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns(B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	NANCY HEATON EXECUTIVE DIREC	(i) (ii)	118,200. 0.	0. 0.	0. 0.	8,256. 0.	28,927. 0.	155,383. 0.	0. 0.
2		(i) (ii)							
3		(i) (ii)							
4		(i) (ii)							
5		(i) (ii)							
6		(i) (ii)							
7		(i) (ii)							
8		(i) (ii)							
9		(i) (ii)							
10		(i) (ii)							
11		(i) (ii)							
12		(i) (ii)							
13		(i) (ii)							
14		(i) (ii)							
15		(i) (ii)							
16		(i) (ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury Internal Revenue Service

Transactions With Interested Persons

► Complete if the organization answered 'Yes' on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
► Attach to Form 990 or Form 990-EZ.
► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open To Public Inspection

Name of the organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered 'Yes' on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	(d) Corrected? No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ► $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ► $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered 'Yes' on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

	(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? No
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total						► $							

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 27.

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part IV Business Transactions Involving Interested Persons.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SYTSKE ARNASON	COMMON DIRECTOR		SEE SCHED A 11H		X
(2) ALICE YOAKUM	COMMON DIRECTOR		SEE SCHED A 11H		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information
Provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE O (Form 990 or 990-EZ)	Supplemental Information to Form 990 or 990-EZ	OMB No. 1545-0047
Department of the Treasury Internal Revenue Service	Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information. ▶ Attach to Form 990 or 990-EZ. ▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.	2015 Open to Public Inspection

Name of the organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

FORM 990, PART VI, LINE 4 - SIGNIFICANT CHANGES TO ORGANIZATIONAL DOCUMENTS

THE PENSION PROTECTION ACT OF 2009 REQUIRED THAT THE IRS MAKE SIGNIFICANT CHANGES TO THE RULES AND REGULATIONS REGARDING TYPE III FUNCTIONALLY INTEGRATED SUPPORTING ORGANIZATIONS. THOSE CHANGES WERE FINALLY APPROVED AND WERE SCHEDULED TO GO INTO EFFECT ON JANUARY 2014. A LEGAL REVIEW OF THESE CHANGES AGAINST THE FCH BY-LAWS AND ARTICLES OF INCORPORATION FOUND FCH NEEDED TO CHANGE ITS STRUCTURE IN ORDER TO BE IN COMPLIANCE WITH THE SUPERIOR COURT AND THE CT ATTORNEY GENERAL LEGAL DECISIONS. AS A RESULT, FCH REVIEWED ITS OPTIONS AND FOUND THAT CHANGING TO A TYPE I SUPPORTING ORGANIZATION THAT SUPPORTED THE THREE DIFFERENT COMMUNITY FOUNDATION COVERING ITS AREA WAS THE GOVERNING STRUCTURE THAT KEPT IT AS CLOSE TO ITS ORIGINAL STRUCTURE AS IT COULD BE. THE CHANGES WERE FIRST APPROVED BY THE CT ATTORNEY GENERAL AND THEN BY THE IRS.

FORM 990, PART VI, LINE 6 - EXPLANATION OF CLASSES OF MEMBERS OR SHAREHOLDER

AS A TYPE I SUPPORTING ORGANIZATION FCH HAS 3 MEMBERS.

FORM 990, PART VI, LINE 7A - HOW MEMBERS OR SHAREHOLDERS ELECT GOVERNING BODY

THE THREE MEMBERS COLLECTIVELY VOTE ANNUALLY ON A SLATE OF NEW AND RENEWED TERM MEMBERS OF THE FCH BOARD FROM A POOL OF FCH BOARD APPROVED CANDIDATES.

FORM 990, PART VI, LINE 11B - FORM 990 REVIEW PROCESS

THE AUDIT COMMITTEE OF THE BOARD REVIEWS THE 990 AND RECOMMENDS ITS ACCEPTANCE TO THE FULL BOARD WHO HAVE THE OPTION OF REVIEWING IT PERSONALLY.

FORM 990, PART VI, LINE 12C - EXPLANATION OF MONITORING AND ENFORCEMENT OF CONFLICTS

POLICY REVIEWED ANNUALLY WITH BOARD.

FORM 990, PART VI, LINE 15A - COMPENSATION REVIEW & APPROVAL PROCESS - CEO & TOP MANAGEMENT

EXECUTIVE COMMITTEE CONDUCTS ANNUAL PERFORMANCE EVALUATION AND COLLECTS INFORMATION FROM GRANTMAKER SALARY TABLES LIKE THE COUNCIL OF PHILANTHROPY TO REVIEW PRIOR TO MAKING DECISIONS REGARDING COMPENSATION.

Name of the organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number: [redacted]

FORM 990, PART VI, LINE 15B - COMPENSATION REVIEW & APPROVAL PROCESS - OFFICERS & KEY EMPLOYEES

REVIEWED ANNUALLY BY BOARD.

FORM 990, PART VI, LINE 19 - OTHER ORGANIZATION DOCUMENTS PUBLICLY AVAILABLE

DOCUMENTS ARE AVAILABLE ON THE ORGANIZATION'S WEB SITE, 990 IS AVAILABLE ON GUIDESTAR.COM, AND ARE PROVIDED UPON REQUEST.

FORM 990, PART XI, LINE 9
OTHER CHANGES IN NET ASSETS OR FUND BALANCES

CHANGE IN VALUE OF CRT	$ -643.
TOTAL	$ -643.

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

► Complete if the organization answered 'Yes' on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
► Attach to Form 990.
► Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer identification number

[redacted]

Part I Identification of Disregarded Entities Complete if the organization answered 'Yes' on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered 'Yes' on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Sec 512(b)(13) controlled entity? Yes	(g) Sec 512(b)(13) controlled entity? No
(1) BERKSHIRE TACONIC COMMUNITY FOUNDA 800 NORTH MAIN STREET SHEFFIELD, MA 01257-0400 [redacted]	SUPPORT FOR CHARITABLE ORGANIZATIONS	MA	501(C)(3)	7	BERKSHIRE TACONIC COMMUNITY FOUNDATION		X
(2)							
(3)							
(4)							

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Part III Identification of Related Organizations Taxable as a Partnership Complete if the organization answered 'Yes' on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												

Part IV Identification of Related Organizations Taxable as a Corporation or Trust Complete if the organization answered 'Yes' on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Sec 512(b)(13) controlled entity? Yes	(i) No
(1)									
(2)									
(3)									

Part V Transactions With Related Organizations Complete if the organization answered 'Yes' on Form 990, Part IV, line 34, 35b, or 36.

		Yes	No
	Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b	Gift, grant, or capital contribution to related organization(s)		X
c	Gift, grant, or capital contribution from related organization(s)		X
d	Loans or loan guarantees to or for related organization(s)		X
e	Loans or loan guarantees by related organization(s)		X
f	Dividends from related organization(s)		X
g	Sale of assets to related organization(s)		X
h	Purchase of assets from related organization(s)		X
i	Exchange of assets with related organization(s)		X
j	Lease of facilities, equipment, or other assets to related organization(s)		X
k	Lease of facilities, equipment, or other assets from related organization(s)		X
l	Performance of services or membership or fundraising solicitations for related organization(s)	X	
m	Performance of services or membership or fundraising solicitations by related organization(s)		X
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o	Sharing of paid employees with related organization(s)		X
p	Reimbursement paid to related organization(s) for expenses		X
q	Reimbursement paid by related organization(s) for expenses		X
r	Other transfer of cash or property to related organization(s)		X
s	Other transfer of cash or property from related organization(s)		X

2 If the answer to any of the above is 'Yes,' see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	BERKSHIRE TACONIC COMMUNITY FOUNDATION	L	135,507.	ACTUAL COST
(2)				
(3)				
(4)				
(5)				
(6)				

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Part VI Unrelated Organizations Taxable as a Partnership Complete if the organization answered 'Yes' on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

FORM 990, PART III, LINE 4E
PROGRAM SERVICES TOTALS

	PROGRAM SERVICES TOTAL	FORM 990	SOURCE
TOTAL EXPENSES	1,189,049.	1,189,049.	PART IX, LINE 25, COL. B
GRANTS	718,247.	718,247.	PART IX, LINES 1-3, COL. B
REVENUE	0.	0.	PART VIII, LINE 2, COL. A

FORM 990, PART IX, LINE 11G
OTHER FEES FOR SERVICES

	(A) TOTAL	(B) PROGRAM SERVICES	(C) MANAGEMENT & GENERAL	(D) FUND-RAISING
ADMINISTRATIVE FEES	26,982.	18,887.	8,095.	
CONTRACT SERVICES	34,747.	34,747.		
TOTAL	$ 61,729.	$ 53,634.	$ 8,095.	$ 0.

FORM 990, PART IX, LINE 24E
OTHER EXPENSES

	(A) TOTAL	(B) PROGRAM SERVICES	(C) MANAGEMENT & GENERAL	(D) FUNDRAISING
POSTAGE AND SHIPPING	999.	938.	61.	
TOTAL	$ 999.	$ 938.	$ 61.	$ 0.

2015 FEDERAL BOOK DEPRECIATION SCHEDULE

FOUNDATION FOR COMMUNITY HEALTH, INC.

[redacted]

NO.	DESCRIPTION	DATE ACQUIRED	DATE SOLD	COST/ BASIS	BUS. PCT.	CUR 179 BONUS	SPECIAL DEPR. ALLOW.	PRIOR 179/ BONUS/ SP. DEPR.	PRIOR DEC. BAL DEPR.	SALVAG /BASIS REDUCT	DEPR. BASIS	PRIOR DEPR.	METHOD	LIFE	RATE	CURRENT DEPR.
FORM 990/990-PF																
FURNITURE AND FIXTURES																
1	OFFICE FURNITURE	2/02/04		3,434							3,434	3,432	S/L HY	7		0
2	DESK	3/31/04		270							270	270	S/L HY	7		0
3	FURNITURE	7/19/04		1,800							1,800	1,799	S/L HY	7		0
4	BOOKCASES	7/26/04		3,242							3,242	3,241	S/L HY	7		0
5	TABLE	11/29/04		160							160	161	S/L HY	7		0
6	SHADE	12/30/04		725							725	727	S/L HY	7		0
7	FURNITURE	12/31/04		315							315	315	S/L HY	7		0
8	CABINETS & SHELVES	12/31/04		795							795	797	S/L HY	7		0
19	OFFICE FURNITURE	3/17/09		336							336	224	S/L	7		75
20	OFFICE FURNITURE	4/15/09		3,970							3,970	1,926	S/L	7		1,114
21	UPHOLSTERY SHED	4/28/09		1,625							1,625	1,315	S/L	7		232
22	CONFERENCE ROOM CHAIRS	5/01/09		918							918	743	S/L	7		131
23	DAVE'S TV - AUDIO	7/01/11		6,579							6,579	4,438	S/L	5		1,316
24	DAVE'S TV - TV FOR OFFICE	12/27/11		3,325							3,325	1,995	S/L	5		665
29	FILE CABINETS	4/09/14		1,802							1,802	129	S/L	7		257
30	OFFICE EQUIPMENT DISPOSAL	4/15/09	7/01/15	372							372	372	S/L	7		0
	TOTAL FURNITURE AND FIXTURE			29,668		0	0	0	0	0	29,668	21,884				3,790
MACHINERY AND EQUIPMENT																
9	LED PROJECTOR	12/31/04		1,373							1,373	1,373	S/L HY	5		0
10	PROJECTION SCREEN	12/31/04		444							444	444	S/L HY	5		0
11	EQUIPMENT	1/10/05		445							445	445	S/L HY	5		0
12	TOSHIBA LAPTOP	2/20/06		1,948							1,948	1,948	S/L HY	5		0

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

NO.	DESCRIPTION	DATE ACQUIRED	DATE SOLD	COST/ BASIS	BUS. PCT.	CUR 179 BONUS	SPECIAL DEPR. ALLOW.	PRIOR 179/ BONUS/ SP. DEPR.	PRIOR DEC. BAL DEPR	SALVAG /BASIS REDUCT	DEPR. BASIS	PRIOR DEPR.	METHOD	LIFE	RATE	CURRENT DEPR.
13	ACER FLAT PANEL MONITOR	2/20/06		259							259	259	S/L HY	5		0
14	COMPUTERS	10/31/07		5,104							5,104	5,104	S/L MQ	5		0
15	CISCO ROUTER SETUP	1/15/08		1,234							1,234	1,234	S/L MQ	5		0
16	HP COMPUTER DOCK STATION	12/31/08		1,446							1,446	1,446	S/L MQ	5		0
18	SERVER & SETUP	12/01/09		4,095							4,095	4,095	S/L	5		0
25	INNOVATIVE BUSINESS SYST	12/18/13		5,050							5,050	1,010	S/L	5		1,010
26	SERVER	1/13/14		5,741							5,741	1,148	S/L	5		1,058
27	PROGRAMMING BY IBS	3/31/14		3,488							3,488	523	S/L	5		698
28	IBS	9/09/14		4,981							4,981	159	S/L	5		996
	TOTAL MACHINERY AND EQUIPME			35,608		0	0	0	0	0	35,608	19,188				3,762
	MISCELLANEOUS															
17	WEBSITE DEVELOPMENT	1/01/09		5,228							5,228	5,228	S/L	5		0
	TOTAL MISCELLANEOUS			5,228		0	0	0	0	0	5,228	5,228				0
	TOTAL DEPRECIATION			70,504		0	0	0	0	0	70,504	46,300				7,552
	GRAND TOTAL DEPRECIATION			70,504		0	0	0	0	0	70,504	46,300				7,552
	DEPRECIATION ASSETS SOLD			372		0	0	0	0	0	372	372				0
	DEPR REMAINING ASSETS			70,132		0	0	0	0	0	70,132	45,928				7,552

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

FORMS NEEDED FOR THIS RETURN

FEDERAL: 990, SCH A, SCH B, SCH D, SCH I, SCH J, SCH L, SCH O, SCH R, 8868
8868 P2
NEW YORK: CHAR500

CARRYOVERS TO 2016

NONE

2015 FEDERAL EXEMPT ORGANIZATION TAX SUMMARY PAGE 1

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

	2015	2014	DIFF
REVENUE			
CONTRIBUTIONS AND GRANTS	311,868	595,627	-283,759
INVESTMENT INCOME	781,392	1,488,198	-706,806
OTHER REVENUE	555	310	245
TOTAL REVENUE	1,093,815	2,084,135	-990,320
EXPENSES			
GRANTS AND SIMILAR AMOUNTS PAID	718,247	2,588,293	-1,870,046
SALARIES, OTHER COMPEN., EMP. BENEFITS	298,524	282,227	16,297
OTHER EXPENSES	376,163	390,081	-13,918
TOTAL EXPENSES	1,392,934	3,260,601	-1,867,667
NET ASSETS OR FUND BALANCES			
REVENUE LESS EXPENSES	-299,119	-1,176,466	877,347
TOTAL ASSETS AT END OF YEAR	24,558,344	25,295,453	-737,109
TOTAL LIABILITIES AT END OF YEAR	278,763	94,086	184,677
NET ASSETS/FUND BALANCES AT END OF YEAR	24,279,581	25,201,367	-921,786

CHAR500

NYS Annual Filing for Charitable Organizations
www.CharitiesNYS.com

Send with fee and attachments to:
NYS Office of the Attorney General
Charities Bureau Registration Section
120 Broadway
New York, NY 10271

2015

Open to Public Inspection

1. General Information

For Fiscal Year Beginning (mm/dd/yyyy) 01/01 /**2015** and Ending (mm/dd/yyyy) 12/31/2015

Check if Applicable:
- ☐ Address Change
- ☐ Name Change
- ☐ Initial Filing
- ☐ Final Filing
- ☐ Amended Filing
- ☐ Reg ID Pending

Name of Organization: FOUNDATION FOR COMMUNITY HEALTH, INC.

Employer Identification Number (EIN): [redacted]

Mailing Address: 478 CORNWALL BRIDGE RD.

NY Registration Number: [redacted]

City/State/Zip: SHARON, CT 06069

Telephone: 860-364-5157

Website: FCHEALTH.ORG

Email:

Check your organization's registration category: ☒ 7A only ☐ EPTL only ☐ DUAL (7A & EPTL) ☐ EXEMPT

Confirm your Registration Category in the Charities Registry at ***www.CharitiesNYS.com***

2. Certification

See instructions for certification requirements. Improper certification is a violation of law that may be subject to penalties.

We certify under penalties of perjury that we reviewed this report, including all attachments, and to the best of our knowledge and belief, they are true, correct and complete in accordance with the laws of the State of New York applicable to this report.

	Signature	Printed Name	Title	Date
President or Authorized Officer:		NANCY HEATON	EXECUTIVE DIREC	
Chief Financial Officer or Treasurer:				

3. Annual Reporting Exemption

Check the exemption(s) that apply to your filing. If your organization is claiming an exemption under one category (7A or EPTL only filers) or both categories (DUAL filers) that apply to your registration, complete only parts 1, 2, and 3, and submit the certified Char500. No fee, schedules, or additional attachments are required. If you cannot claim an exemption or are a DUAL filer that claims only one exemption, you must file applicable schedules and attachments and pay applicable fees.

☐ **3a. 7A filing exemption:** Total contributions from NY State including residents, foundations, government agencies, etc did not exceed $25,000 **and** the organization did not engage a professional fund raiser (PFR) or fund raising counsel (FRC) to solicit contributions during the fiscal year. Or the organization qualifies for another 7A exemption (see instructions).

☐ **3b. EPTL filing exemption:** Gross receipts did not exceed $25,000 and the market value of assets did not exceed $25,000 at any time during the fiscal year.

4. Schedules and Attachments

See the following page for a checklist of schedules and attachments to complete your filing.

☐ Yes ☒ No 4a. Did your organization use a professional fund raiser, fund raising counsel or commercial co-venturer for fund raising activity in NY State? If yes, complete Schedule 4a.

☐ Yes ☒ No 4b. Did the organization receive government grants? If yes, complete Schedule 4b.

5. Fee

See the checklist on the next page to calculate your fee(s). Indicate fee(s) you are submitting here:

7A filing fee:	EPTL filing fee:	Total fee:	Make a single check or money order payable to:
$ 25.	$ 0.	$ 25.	***'Department of Law'***

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

CHAR500 Annual Filing Checklist	Simply submit the certified CHAR500 with no fee, schedule, or additional attachments IF: - Your organization is registered as 7A only and you marked the 7A filing exemption in Part 3. - Your organization is registered as EPTL only and you marked the EPTL filing exemption in Part 3. - Your organization is registered as DUAL and you marked **both** the 7A and EPTL filing exemption in Part 3.

Checklist of Schedules and Attachments

Check the schedules you must submit with your CHAR500 as described in Part 4:

☐ If you answered 'yes' in Part 4a, submit Schedule 4a: Professional Fund Raisers (PFR), Fund Raising Counsel (FRC), Commercial Co-Venturers (CCV)

☐ If you answered 'yes' in Part 4b, submit Schedule 4b: Government Grants

Check the financial attachments you must submit with your CHAR500:

☒ IRS Form 990, 990-EZ, or 990-PF, and 990-T if applicable

☒ All additional IRS Form 990 Schedules, including Schedule B (Schedule of Contributors).

☐ Our organization was eligible for and filed an IRS 990-N e-postcard. We have included an IRS Form 990-EZ for state purposes only.

If you are a 7A only or DUAL filer,submit the applicable independent Certified Public Accountant's Review or Audit Report:

☐ Review Report if you received total revenue and support greater than $250,000 and up to $500,000.

☒ Audit Report if you received total revenue and support greater than $500,000

☐ No Review Report or Audit Report is required because total revenue and support is less than $250,000

☐ We are a DUAL filer and checked box 3a, no Review Report or Audit Report is required

Calculate Your Fee

For 7A and DUAL filers, calculate the 7A fee:

☐ $0, if you checked the 7A exemption in Part 3a

☒ $25, if you did not check the 7A exemption in Part 3a

For EPTL and DUAL filers, calculate the EPTL fee:

☐ $0, if you checked the EPTL exemption in Part 3b

☐ $25, if the NET WORTH is less than $50,000

☐ $50, if the NET WORTH is $50,000 or more but less than $250,000

☐ $100, if the NET WORTH is $250,000 or more but less than $1,000,000

☐ $250, if the NET WORTH is $1,000,000 or more but less than $10,000,000

☐ $750, if the NET WORTH is $10,000,000 or more but less than $50,000,000

☐ $1500, if the NET WORTH is less $50,000,000 or more

Is my Registration Category 7A, EPTL, DUAL or EXEMPT?
Organizations are assigned a Registration Category upon registration with the NY Charities Bureau:

7A filers are registered to solicit contributions in New York under Article 7-A of the Executive Law ('7A')

EPTL filers are registered under the Estates, Powers & Trusts Law ('EPTL') because they hold assets and/or conduct activities for charitable purposes in NY.

DUAL filers are registered under both 7A and EPTL.

EXEMPT filers have registered with the NY Charities Bureau and meet conditions in ***Schedule E - Registration Exemption for Charitable Organizations.*** These organization are not required to file annual financial reports but may do so voluntarily.

Confirm your Registration Category and learn more about NY law at ***www.CharitiesNYS.com***

Where do I find my organization's NET WORTH?
NET WORTH for fee purposes is calculated on:
- IRS Form 990 Part I, line 22
- IRS Form 990 EZ Part I line 21
- IRS Form 990 PF, calculate the difference between Total Assets at Fair Market Value (Part II, line 16(c)) and Total Liabilities (Part II, line 23(b)).

Send Your Filing

Send your CHAR500, all schedules and attachments, and total fee to:

NYS Office of the Attorney General
Charities Bureau Registration Section
120 Broadway
New York, NY 10271

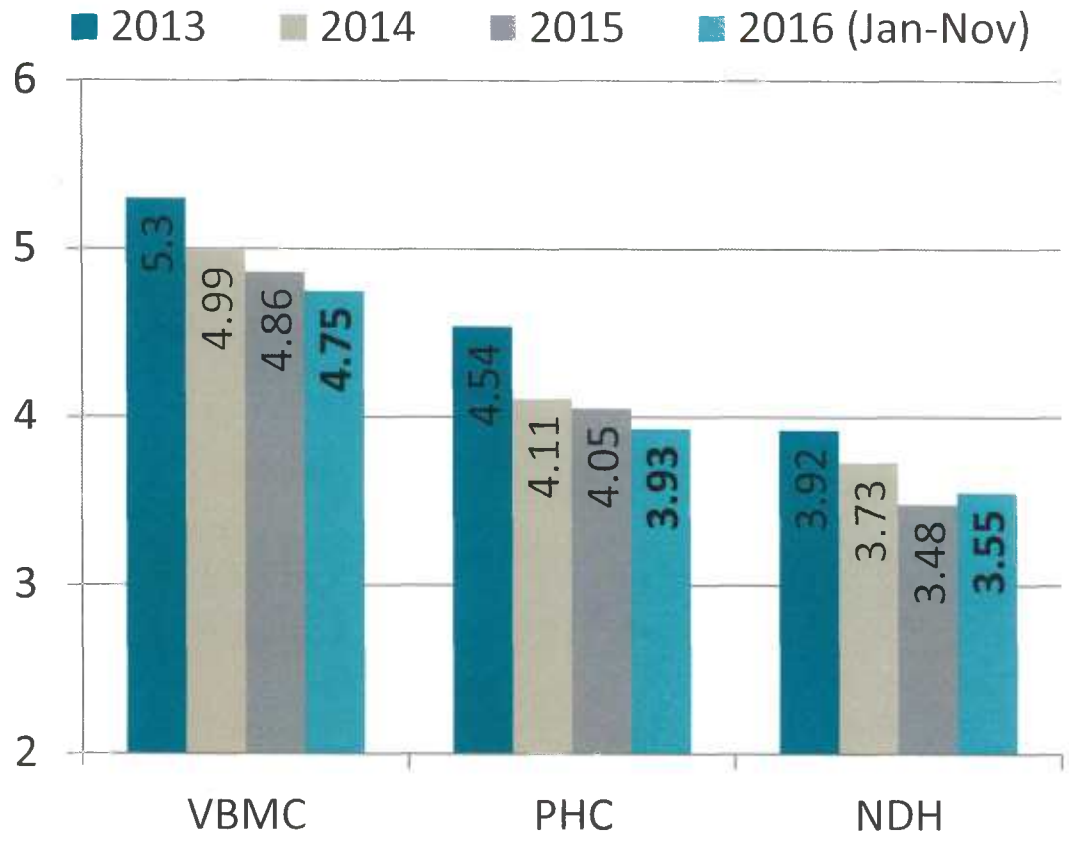
CHAR500 Annual Filing for Charitable Organizations (Updated December 2015)

FOUNDATION FOR COMMUNITY HEALTH, INC. [redacted]

	2015	2014	DIFF
FINANCIAL INFORMATION			
TOTAL SUPPORT AND REVENUE (ARTICLE 7-A)	1,093,815	2,084,135	-990,320
NET WORTH AT END OF YEAR (EPTL)	0	0	0
FILING FEES			
ARTICLE 7-A FILING FEE	25	25	0
EPTL FILING FEE	0	0	0
TOTAL FILING FEES	25	25	0

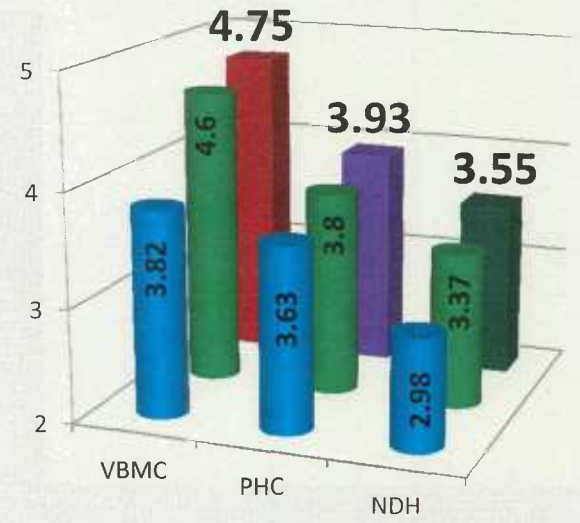
COMPLETENESS EXHIBIT C

Length of Stay

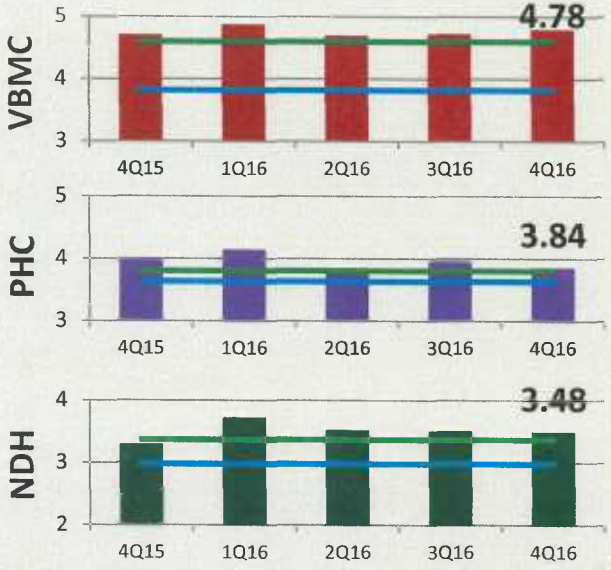


HEALTHQUEST

Year-To Date



Quarterly Trends



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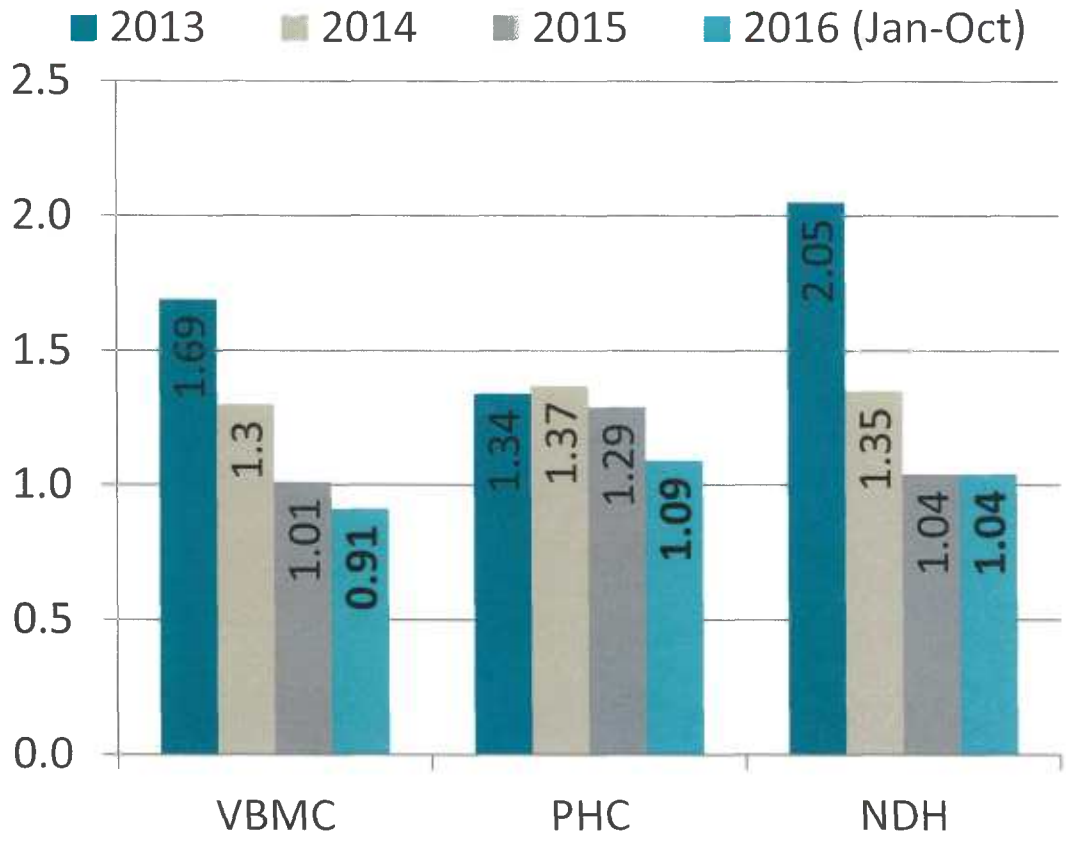
01/17/2017

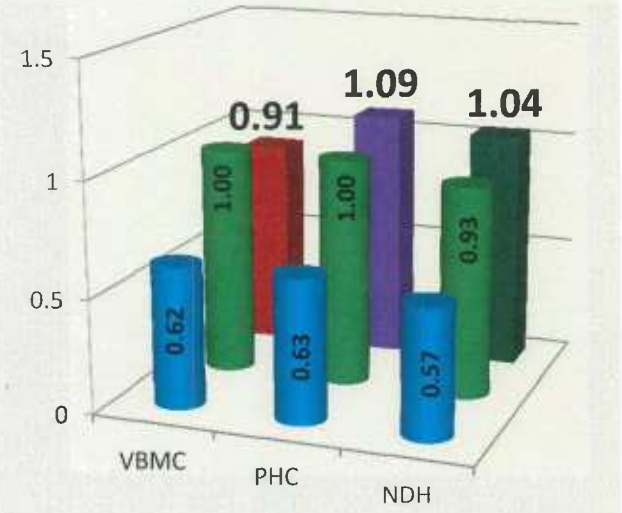
Target Goal Top Decile Goal

Mortality Ratio

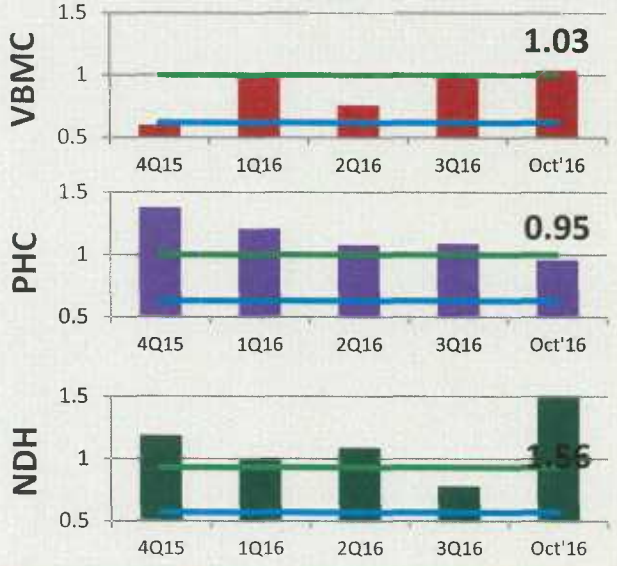


HEALTHQUEST

Year-To Date



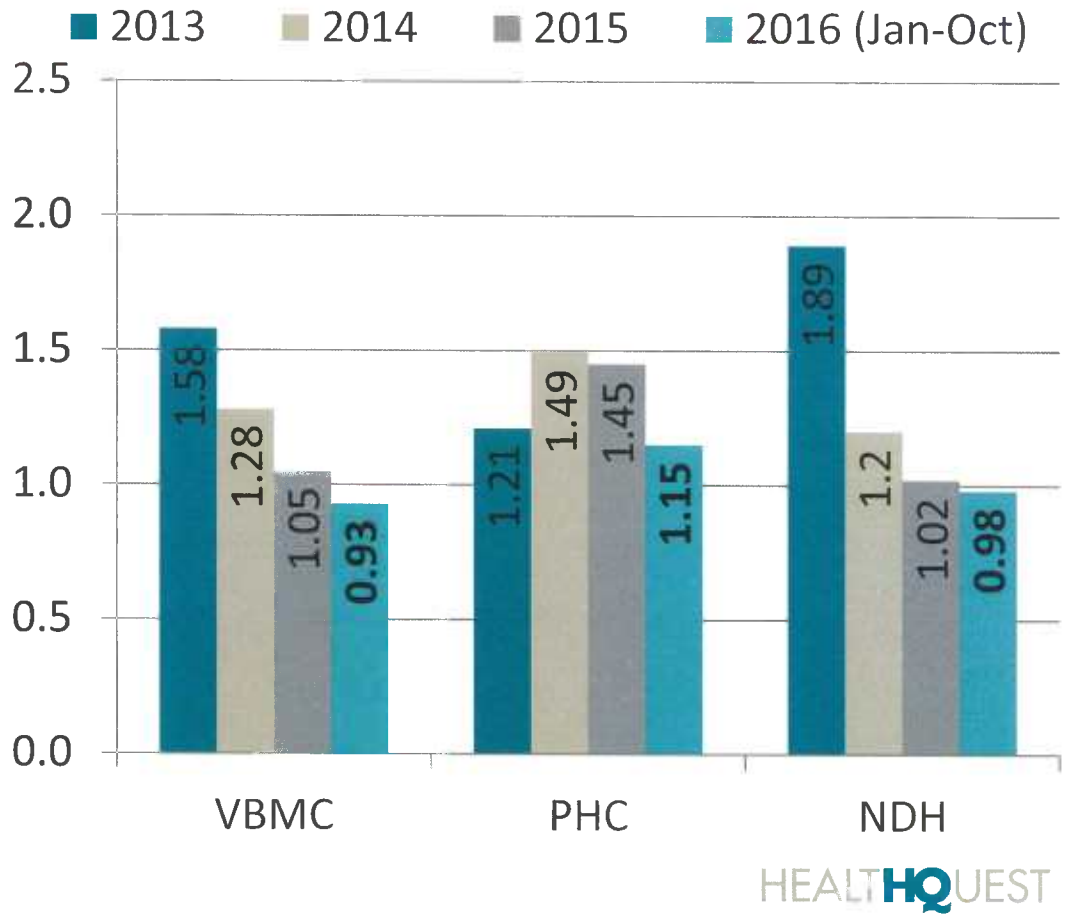
Quarterly Trends



SH0007776
01/17/2017

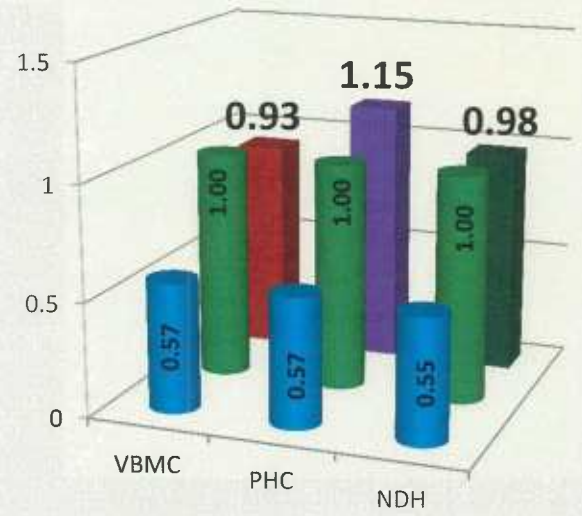
Target Goal Top Decile Goal

Sepsis Mortality Ratio

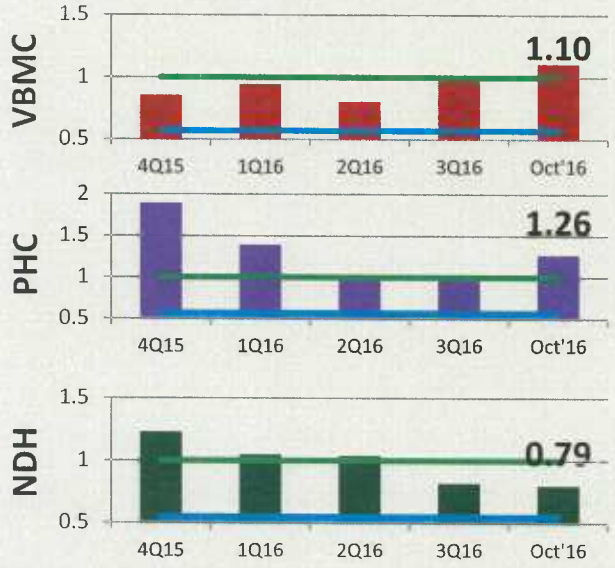


HEALTHQUEST

Year-To Date



Quarterly Trends

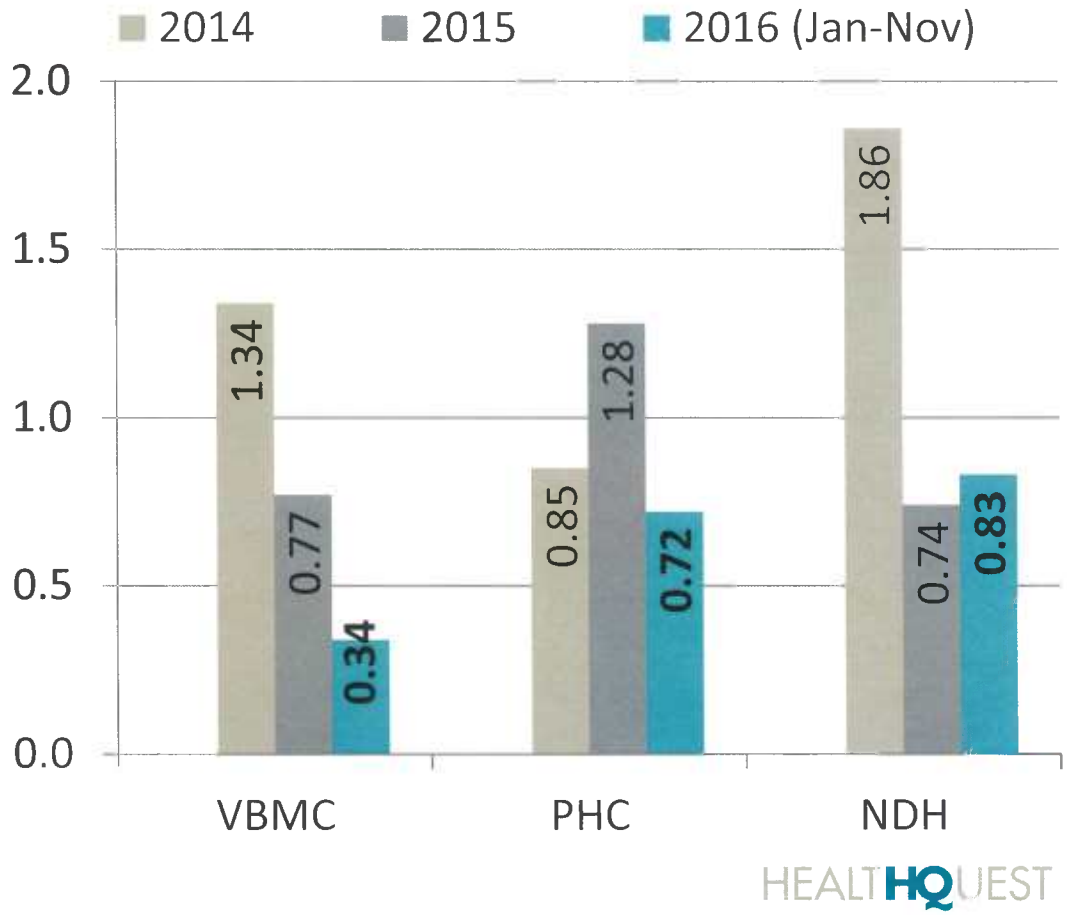


SH000777
01/17/2017

Target Goal Top Decile Goal

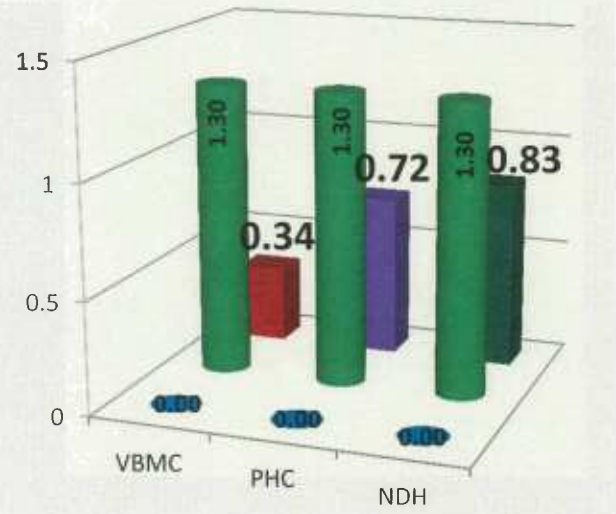
Catheter-Associated UTI

(CAUTI)

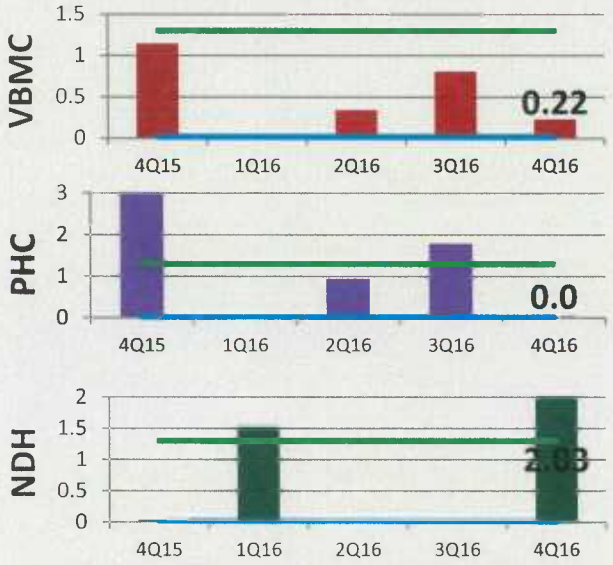


HEALTHQUEST

Year-To Date



Quarterly Trends



Target Goal Top Decile Goal

SH000778
01/17/2017

COMPLETENESS EXHIBIT D

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

10/03/2016

Ms. Ann McMackin
President & SVP
Vassar Brothers Medical Center
45 Reade Place
Poughkeepsie, NY 12601

Agency: **Vassar Brothers Medical Center**
Medicare Provider #: **[Medicare Provider ID (33-0023)]**
Type of Survey: **Allegation Non Deemed (New Title 18 Allegation Complaint # NY00180847-IC)**
Event ID #: **M17H11**
Survey Exit Date: **09/19/2016**

Dear Ms. McMackin:

Staff from the New York State Department of Health conducted an onsite survey at Vassar Brothers Medical Center on 09/12/2016 to 09/19/2016. The purpose of the survey was to conduct a complaint investigation at the facility, assessing compliance with Part 482 (Hospital), Title 42 of the Code of Federal Regulations.

No regulatory violations were identified associated with this new complaint. However, standard level deficiencies were associated with the Health and Life Safety Completion Survey for which a Plan of Correction has been requested (cross-refer to details in letter regarding the Full Survey).

If you have any questions, you may contact this office at (212) 417-5990. Written correspondence should be sent to the New York State Department of Health, Metropolitan Area Regional Office (MARO), 90 Church Street, 15th Floor, New York, N.Y., 10007.

Sincerely,

Kathleen Gaine, MPA
Regional Program Director
Bureau of Hospitals and Diagnostic and Treatment Centers, MARO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BLDG. _____ B. WING _____	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	**INITIAL COMMENTS** The deficiencies cited below are a result of a Title 18 Full Survey following Complaint Recertification Survey conducted on 9/12, 9/13, 9/14, 9/15, 9/16, and 9/19/16, to determine compliance in accordance with 42 CFR Part 482 Conditions of Participation for Hospitals: in conjunction with a Title 18 Allegation Survey (NY00180847). The plan of correction must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates (X5) and the mechanism(s) established to assure ongoing compliance must be included.	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital's Governing Body did not ensure; (1) patient grievances are reviewed for resolutions and, (2) the responsibility for grievance resolution was formally delegated to a Grievance Committee in writing. Findings include:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: PRESIDENT (X6) DATE: 10/13/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 119	Continued From page 1 During interview on 9/15/16, at approximately 10:30 AM, Staff A, Assistant Vice President of Quality and Improvement, stated that the Board of Trustees delegated the responsibility of reviewing and resolving grievances to a Grievance Committee, and that the Grievance Committee was recently established in May 2016. Review of the Grievance Committee Minutes noted that the first meeting to review, investigate and resolve patient complaints was held on 5/20/16. The hospital was unable to provide written proof that the Board of Trustees delegated the responsibility of reviewing and resolving grievances to a "Grievance Committee." During interview with the Assistant Vice President of Quality and Improvement, on 9/15/16, there was no indication that the Board of Trustees reviewed and monitored complaints and grievances for resolutions, prior to May 20, 2016. The facility policy and procedure titled "Patient Complaint /Grievance Resolution," last revised May 2016, stated; "It is the policy of Vassar Brothers Medical Center to provide a formal process reviewing the patient complaints and to help resolve concerns and conflicts. The governing body at Vassar Brothers Medical Center has delegated the responsibility to review and resolve all patient complaints to the Grievance Committee, a subcommittee of the Quality Performance Improvement Committee of the Board of Trustee." The hospital was unable to provide evidence that	A 119	A 119 Grievance Designation Plan of Correction: Prior to May 20, 2016, the Director of Patient Experience provided a grievance report on a semi-annual basis to the VBMC Quality and Performance Improvement Committee of the Board. The minutes of the VBMC Quality and Performance Improvement Committee are presented at the VBMC Board of Trustees meeting. The Grievance Committee was established in May 2016. The minutes of these meetings are part of the consent agenda for the VBMC Quality and Patient Safety Committee and the Board of Trustees, and the Director of Patient Experience continues to report on a semi-annual basis to the VBMC Quality and Performance Improvement Committee. A letter of designation authorizing the VBMC Grievance Committee to resolve grievances was signed by the VBMC President and Vice President for Medical Affairs. The designation letter was approved by the VBMC Board of Trustees and the letter will be presented at the VBMC Quality and Performance Improvement Committee of the Board. Members of the VBMC Grievance Committee will be notified of the letter of designation at the Grievance Committee meeting. Beginning December 2016, the Director of Patient Experience will present a report on complaints and grievances to the Board of Trustees on a semiannual basis.	9/22/16 9/29/16 10/19/16 10/31/16

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A 119	Continued From page 2 the formal process for reviewing patient complaints was fully implemented.	A 701	A 701 Operating Room Plan of Correction: 1. Blank electrical outlet plates were placed on the 4 affected electrical outlets on the electrical beam by the Manager of Facility Operations. Electrical outlets will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	9/14/16
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, document review and staff interview, the hospital did not ensure that the condition of the physical plant and the overall hospital environment is maintained in such a manner that the safety and well-being of patients are assured. Findings include: On 9/12/2016, during a tour of the facility, the following were identified: Operating Rooms: 1. There were 4 electrical outlets that were observed being covered by surgical adhesive tape and a written warning stating do not use those 4 outlets, and advised the use of other outlets on the same electrical beam. 2. The ceiling tiles of the isolation room in the Post-Operative unit was found to be from the regular type instead of the washable ceiling tiles that is required for this type of room. Intensive Care Units (ICU): 1. The cove base (a type of trim that is installed along the base of an interior wall) on some of the		2. The acoustic tiles in the isolation room in the Post-Operative Unit will be replaced with washable tiles by the Manager of Facility Operations. An Infection Control construction risk assessment was completed by the Infection Control Officer. Ceiling tiles will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The minutes of the Environment of Care Committee will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	11/11/16 10/5/16

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A 701	Continued From page 3 walls of the ICU rooms were broken, and there were many cracked floor tiles in the ICU rooms. 2. There were broken parts of the walls of the nurse station and broken Formica of the countertop of the hand wash sinks. The broken areas of the floor tiles, cove base and countertops, prevent the proper cleaning of these surfaces and is a potential for transmission of infection. 3. The Anteroom of the Isolation Room #6 was found to have a positive air flow to the corridor, instead of the negative air flow that is required for this type of room. Vassar Ambulatory Surgical Center (VASC): During a tour of the same day surgery on the morning of 9/13/2016, in the presence of the Vice President of Operation, the following were identified: 1. The floor at the entrance of the corridor to the operating room, was found to be bulging at least in three different areas, which present a tripping hazard. 2. Two J- boxes (Electrical Boxes) on the ceiling right above the table where the clean instruments are assembled, were observed lacking their covers. 3. There was no hand-wash sink provided at the decontamination room of the central sterile area for the staff to wash their hands. 4. The decontamination room was found to have a positive air-flow to the corridor, instead of the required negative air-flow for this type of room. This presents an infection control concern.	A 701	A 701 ICU Plan of Correction 1 & 2 All of the repairs to the damaged cove bases and floor tiles in patient rooms, the walls of the nursing station, and formica countertop of the hand wash sinks in ICU will be completed by the Manager of Facility Operations in a manner to minimize the impact on patient care in this high-census unit. An Infection Control construction risk assessment was completed by the Infection Control Officer. The integrity of fixtures will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board. 3 Isolation room #6 in the ICU is no longer used as a negative pressure isolation room. ICU staff were educated by the ICU Director of Patient Care to ensure staff do not place negative air pressure isolation patients in that room. ICU rooms will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	1/11/17 10/5/16 10/6/16 10/13/16

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A 701	Continued From page 4 Outpatient Physical Therapy and Occupation Therapy- (VASC): PT/OT: Two hydro collators in the PT area were found to be rusted at their inside surfaces. MRI Suite: 1. Items containing metal material were observed in the zone (the area immediately outside the MRI room) and in the Control Room, which is a potential for causing injury to patients if one of those items are accidentally taken inside the MRI Room. Items included but were not limited to: a. Metallic Pediatric Cart for pediatric anesthesia, b. Stationary items in the Control Room; paper clips, paper holder clips, pens, etc. The above findings were identified in the presence of the Vice President Operation, who acknowledged the findings.	A 701	A 701 VASC Plan of Correction 1 A contractor evaluated the needed repairs to the operating room flooring. All repairs to the flooring will be completed with oversight by the Manager of Facility Operations. An Infection Control construction risk assessment was completed by the Infection Control Officer. The integrity of flooring will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	9/19/16 11/11/16 10/5/16
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain facilities, supplies and equipment in such a way to ensure acceptable levels of safety and quality. The finding is: 1) During a tour of the facility on 9/12 and 9/13/16, multiple rooms throughout the hospital were observed to be lacking identifying signage.		2 Covers were placed on J-box electrical boxes by the Manager of Facility Operations. The integrity of J-box electrical boxes will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board. 3 The eye wash station will be relocated in the decontamination room to accommodate the installation of a hand wash sink which will be installed by the Manager of Facility Operations. An alcohol based hand sanitizer dispenser was installed as an interim step by the Manager of Environmental Services. An Infection Control construction risk assessment was completed by the Infection Control Officer. Hand wash sinks will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The minutes of the Environment of Care Committee will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	9/13/16 11/11/16 10/4/16 10/5/16

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A 724	Continued From page 5 Examples include but are not limited to several supply storage closets in the Neonatal Intensive Care Unit, the staff lounge in the Orthopedics Unit and an electrical closet in the South Circle 7 wing. Failure to ensure that rooms throughout the hospital can be readily identified may result in injury to patients. This finding was verified by the Director of Engineering and Facilities Manager, who were present during the tour. 2) On 09/12/16, at 12:45 PM, during the tour of Four South Unit, two (2) emergency intubation boxes were inspected. It was noted that one of the box was missing Magill forceps (used when advanced life support measures are being undertaken). On 09/12/2016, at 12:50 PM, during the interview with Staff K, Director of Patient Care Services, she stated that only one Magill forceps is required to be on the unit. Review of the "Code Cart Inventory" revealed that Magill forceps are required to be in the intubation boxes.		4 The air balance in the decontamination room was corrected by the Manager of Facility Operations. Air balance is assessed daily and documented on a log. Completion of the daily logs will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	9/13/16 10/11/16
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to identify infection control hazards, to reduce the potential for transmission of infection.	A 701	A 701 Outpatient PT/OT Plan of Correction A purchase order for 2 new hydrocollator units was placed by the Director of Physical Medicine. The old units were removed from service and the new units were put into service. A cleaning schedule and log were established following the manufacturer's guidelines. The hydrocollator cleaning log will be audited with the data presented at the Infection Control Committee. The Infection Control Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee monthly for 3 months beginning in November 2016.	10/5/16 10/12/16
		A701	A 701 MRI Suite Plan of Correction 1a A latch was placed on the pediatric anesthesia cart to be able to chain the cart to the wall by the Manager of Facility Operations. 1b All metal items were removed from the MRI Zone 3 by the Clinical Imaging Manager. A daily checklist to assess for the presence of metal in the MRI area was developed – all MRI technicians were educated on the daily checklist and the process was implemented. The data from the daily checklists will be aggregated and presented at the Radiology PI meeting. The Radiology PI meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board meetings monthly for a period of 3 months beginning November 2016.	10/10/16 9/14/16 10/10/16

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A 749	Continued From page 6 Findings: During a tour of the facility on 9/12, 9/13 and 9/14/16, the following were identified: 1. The isolation room in the Core Emergency Department was lacking a patient toilet. 2. The Neonatal Intensive Care Unit #1 lacked the required one hundred square feet per space around each patient bed. 3. The soiled utility room in the Pediatrics Unit was lacking the required hand washing sink. See additional findings: Tag A 701. Failure to identify infection control hazards may result in the spread of illness among patients. These findings were identified in the presence of the hospital Vice President Operation, Director of Engineering and the Facilities Manager, who acknowledged the findings.	A 724	**A 724 Facilities, Supplies, Equipment Maintenance Plan of Correction** 1 Assessment of signage for all rooms in patient care areas will be completed by the Safety and Emergency Preparedness Coordinator. All needed changes to signage will be completed by the Director of Environmental Services. Assessments of room signage will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board. 2 McGill forceps were ordered and received by the Manager of Central Sterile Processing. The equipment was placed into all adult intubation boxes and the Education Coordinator for Critical Care inspected all of the adult intubation boxes to ensure the contents were complete. Daily logs of the inspection of adult intubation boxes will be aggregated and data presented at the Code Blue Committee. The Code Blue Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee monthly for a period of 3 months beginning November 2016. **A 749 Infection Control Program Plan of Correction** 1 The isolation room in the Core Emergency Department was decommissioned as an isolation room by the Interim Director of the Emergency Department. The staff of the ED were educated on the change to the room by the Interim Director of the ED. The Manager of Facility Operations removed the air balance monitoring "ball in the wall" removed.	10/14/16 11/30/16 10/6/16 10/7/16 10/5/16 10/13/16 10/10/16

			2 There are a maximum of 7 patient beds in NICU #1, which is a 737 square foot room confirmed by the Manager of Facility Operations. An Infection Control risk assessment was completed by the Infection Control Officer. Staff were educated on the revised bed capacity. Census in NICU will be monitored with daily log. The log will be audited by the Director of NICU for a period of 3 months with data reported at the NICU Performance Improvement Committee. The minutes of the NICU Performance Improvement Committee will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	10/7/16 10/7/16 10/17/16 10/1/16
			3 The Manager of Facilities Operations will order a sink for the Pediatrics soiled utility room which will be installed by the Manager of Facilities Operations. An alcohol based hand sanitizer dispenser was installed in the pediatric soiled utility room as an interim step by the Manager of Environmental Services. The soiled utility room will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care Committee meeting minutes will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	10/13/16 11/11/16 10/5/16

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President & SVP
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Agency: **Vassar Brothers Medical Center**
Medicare Provider #: **[Medicare Provider ID (33-0023)]**
Type of Survey: **Full Survey Recertification following Condition level noncompliance (follow up of original Complaint # NY00176890)**
Event ID #: **M17H11 (Health Survey), M17H21 (Life Safety Survey)**
Survey Exit Date: **09/19/2016**

Dear Ms. Ann McMackin:

Staff from the New York State Department of Health conducted an onsite survey at Vassar Brothers Medical Center on 09/12/2016 to 09/19/2016. The purpose of the survey was to review all Conditions of Participation or Coverage, assessing compliance with Part 482 (Hospital), Title 42 of the Code of Federal Regulations.

Enclosed is the Statement of Deficiencies (FORM CMS-2567) detailing the survey findings.

Your hospital has been found to be in substantial compliance with the Conditions of Participation, but standard level deficiencies were identified for both Health and Life Safety Full Surveys.

An acceptable Plan of Correction is due to this office within ten (10) calendar days of the date of this letter or no later than 10/13/2016.

An acceptable Plan of Correction must relate to the care of all patients and prevent such occurrences in the future. It must contain the following elements:

1. The plan for correcting each specific deficiency cited;
2. The plan for improving the processes that led to the deficiency cited;
3. The procedure for implementing the acceptable plan of correction for each deficiency cited;
4. The title of the person responsible for implementing the acceptable plan of correction; and
5. The process for how the facility has incorporated the improvement action into its Quality Assessment and Performance Improvement (QAPI) program, including monitoring and tracking procedures to ensure the plan of correction is effective, and that specific deficiencies cited remain corrected.

As you prepare a specific Plan of Correction on the Statement of Deficiencies (FORM CMS-2567), please ensure the following:

1. Corrective actions and the title of the party responsible for each corrective action are entered in

the column labeled "Provider's Plan of Correction,"
2. Completion date for each action plan is entered in the (X5) column, and
3. The first page of the Plan of Correction is signed by a duly authorized representative of your facility in the (X6) section.

If you require additional space, you may note "See attachment" on the form and attach sheets, which clearly identify, by tag number, the citation being addressed.

If you have any questions, you may contact this office at (212) 417-5990. Written correspondence should be sent to the New York State Department of Health, Metropolitan Area Regional Office (MARO), 90 Church Street, 15th Floor, New York, N.Y., 10007.

Sincerely,

Kathleen Gaine, MPA
Regional Program Director
Bureau of Hospitals and Diagnostic and Treatment Centers, MARO

(Enclosures: 2567's for #M17H11 and M17H21)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The deficiencies below are cited as a result of a Life Safety Survey conducted on 9/13, 9/14, 9/15, 9/16, and 9/19/16. This survey was conducted in conjunction with a Recertification Survey to determine compliance in accordance with 42 CFR Part 482 Conditions of Participation for Hospitals. The plan of correction, however, must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates (X5) and the mechanism(s) established to assure ongoing compliance must be included.	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to continuously maintain the automatic sprinkler system in a reliable operating condition. Findings: 1. On September 12, 2016 at approximately 2:30 PM, during a tour of the third floor of the Community Wing of the facility, it was observed that the top of a rack serving the Information Technology System, was located approximately 2 inches below a sprinkler head. 2. On September 13, 2016 at approximately 11:30 AM, it was observed that the facility did not have an adequate supply of	K 062	K 062 1 The obstructed sprinkler head found during the tour will be moved away from the IT rack to comply with all Life Safety regulations. Obstruction of sprinkler heads will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The Environment of Care meeting minutes will be forwarded to VBMC Quality and Performance Improvement Committee of the Board. 2 Spare sprinkler heads and sprinkler wrenches were ordered by the Supervisor of Fire and Life Safety and the supplies were received. A master inventory with par levels for sprinkler heads and wrenches was developed by the Supervisor of Fire and Life Safety.	10/28/16 9/21/16 9/28/16 10/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT — (X6) DATE: 10/13/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/19/2016

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K 062	Continued From page 1 heads and sprinkler wrenches. Failure to maintain the sprinkler system in reliable operating condition may result in injury to patients in the event of a fire emergency. This finding was verified on September 12, 2016, by the Director of Engineering and the Facilities Manager.			
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain electrical wiring and equipment in accordance with the National Electrical Code, 9-1.2 and NFPA 99 18.9.1 and 19.9.1. Findings:: During a tour of the second floor of the Community Wing of the facility, on September 12, 2016 at approximately 2:45 PM, a relocatable power tap was observed affixed to the wall of the soiled utility room. The cord to the power tap was running through a ceiling tile and was plugged in above the ceiling. In addition, the power tap was not of the type approved for use in hospitals. Failure to use relocatable power taps in an appropriate manner may result in a fire, or in electrical shocks to staff or patients. This finding was verified by the Director of Engineering and the Facilities Manager.	K 147	K 147 The non-compliant relocatable power tap identified during the tour was removed by the VP of Hospitality Services. The AVP of Quality sent an email communication to all department heads alerting to the use of relocatable power taps with instructions to contact the Facilities Department if any were found. Non-compliant relocatable power taps will be monitored during the SAFE rounds coordinated by the Safety and Emergency Preparedness Coordinator. The findings of the SAFE rounds will be reported to the Environment of Care Committee. The minutes of the Environment of Care Committee will be forwarded to the VBMC Quality and Performance Improvement Committee of the Board.	9/13/16 10/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING _____ B. WING _____	R-C 09/16/2016

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{A 000}	INITIAL COMMENTS A Revisit to a Federal Allegation Survey (NY00176890) was conducted on 9/16/16, in order to determine compliance in accordance with 42 CFR part 482 Conditions of Participation for Hospitals. The facility was found to have implemented the Plan of Correction and no new deficiencies were identified. The Condition of Participation for Quality Assessment and Performance Improvement is restored to compliance.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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VASSAR BROTHERS
MEDICAL CENTER

45 Reade Place
Poughkeepsie, NY 12601

845.454.8500
healthquest.org/VBMC

May 19, 2016

Kathleen Gaine, MPA
Regional Program Director
Metropolitan Area Regional Office
New York State Department of Health
Division of Hospitals and Diagnostic & Treatment Centers

Dear Ms. Gaine

Enclosed is our Plan of Correction in response to the Statement of Deficiencies for Complaint #NY00179250 received May 13, 2016. If you have any questions or concerns regarding this submission please contact our Director of Patient Safety, Paul Corish. He may be reached at (845) 483-6835 or by e-mail pcorish@health-quest.org.

Sincerely

Ann McMackin
President
Vassar Brothers Medical Center
45 Reade Place
Poughkeepsie, NY 12601

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING _____ B. WING _____	C 04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	INITIAL COMMENTS The standard level deficiencies cited below are a result of a Federal Title 18 Allegation Survey (NY00178730 and NY00179250), conducted in conjunction with an EMTALA Survey (NY00180340) on April 27 - 29, 2016, in accordance with 42 CFR part 482 Conditions of Participation for Hospitals. The Plan of Correction must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates (X5) and the mechanism(s) established to assure ongoing compliance must be included.	A 000		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on medical record (MR) review, document review and interview, it was determined the facility failed to ensure that the medical staff provided quality medical care consistent with prevailing standards of practice. This was found in one (1) of 10 medical records reviewed. (Patient #2) Findings include: Review of medical record for Patient #2 noted the following: Patient #2 was brought to the Emergency Department (ED) by EMS at 11:49 PM on April 14, 2016, with a complaint of	A 049	482.12(a)(5) MEDICAL STAFF – ACCOUNTABILITY All patients will be assessed and reassessed as prescribed in Vassar Brothers Medical Center Department of Emergency Medicine Policies: "DEM: Notification of Medical Provider When Patient Condition Changes" and "DEM: Vital Signs". The DEM policy "DEM Notification of Medical Provider When Patient Condition Changes" will be amended by Emergency Department Leadership to define respiratory assessment and reassessment including escalation of care instructions for staff caring for patients with respiratory illness by June 13, 2016	6/27/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President | (X6) DATE: 5/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING _____ B. WING _____	C 04/29/2016

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A 049 Continued From page 1

progressive shortness of breath, wheezing and productive cough which was getting worse. Review of the Emergency Medical Service report noted the patient's oxygen saturation was in the 70's on oxygen. (The normal range is 96-100% on room air).
The physician's notes documented on April 14, 2016 at 11:50 PM, stated the patient had developed shortness of breath 15 minutes after he awoke that morning and upon arrival in the Emergency Department he was alert but was in moderate respiratory distress with labored breathing and retractions. Previous medical history included Asthma, Cancer of the Tonsil, Hypertension and Kidney failure.

During the patient's stay in the ED, the respiratory rate remained above 30 (normal range 12-20) and the heart rate was above 100 (normal range 60-100), with a high of 132. At 1:57 AM on April 15, 2016, oxygen saturation was 81% on a high concentration of oxygen (BiPAP) and was 82% at 5:28, with the heart rate at 117 and the respiratory rate at 37 breaths per minute. The oxygen saturation decreased to 77% at 6:13 AM. The patient was intubated at 6:40 AM when the patient's oxygen saturation decreased to 53% ,with the blood pressure at 170/137 (normal adult range 120/80 mmHg). The patient was subsequently diagnosed with acute hypoxic respiratory failure and metabolic and respiratory acidosis. The patient sustained a cardiac arrest at 10:08 AM and despite resuscitative measures remained hypoxic and in asystole. He was pronounced dead at 10:36 AM that morning.

The physician's monitoring of the patient's blood

(Continued from page1)

A 049 All Department of Emergency Medicine providers and RN staff will be reeducated to the policies and procedures for assessment and reassessment of patients and the documentation requirement and escalation reporting process based assessment of changes in condition by Emergency Department Medical and Nursing Leadership by June 20, 2016

Evidence of education will be submitted to the Emergency Department Performance Improvement Committee and to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees, then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees.

Monitoring
70 patient records triaged ESI 1 or 2 will be reviewed monthly for 3 months to assess compliance with policy. Initially 2 records daily for month one followed by 17 records per week for month two and then 70 records for month three by ED Department Leadership Measure of success is >90% compliance. Audits begin July 1, 2016 ending September 3, 2016

These audits will be submitted to Emergency Department Leadership daily during month one, weekly, month two and then monthly for month three, during the audit period. Results including those not compliant with policy requirements along with plans for correction will be reported to the monthly Emergency Department Performance Improvement Committee for review with results reported to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees
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Responsible Parties: Vice President of Medical Affairs or designee, Chief Nursing Officer or designee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 049	Continued From page 2 gases and intubation were not performed in a timely manner. This patient presented to the ED with a complaint of progressive shortness of breath; the patient experienced labored breathing and hypoxia (insufficient concentration of oxygen in the blood) for almost twenty-four hours. The physician's documented reassessment occurred at 5:58 AM on April 15, 2016, more than 6 hours after the patient's arrival to the ED. There was no documented evidence that the physicians monitored the patient's cardiac and respiratory status continuously and modified the plan care in a timely manner. The findings were shared with the Director, Patient Safety at 3:30 PM on April 29, 2016.	A 049		
A1104	482.55(a)(3) EMERGENCY SERVICES POLICIES [If emergency services are provided at the hospital --] (3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff . This STANDARD is not met as evidenced by: Based on medical record review, document review and interview, it was determined the hospital failed to ensure that the staff in the emergency department (ED) followed its policies for: (a) timely management of patients' acute stroke symptoms, and (b) reassessment of patients' elevated blood pressure. This was found in 2 (two) of 10 medical records reviewed (Patient	A1104	482.55(a)(3) EMERGENCY SERVICES POLICIES All patients will be assessed and reassessed as prescribed in Vassar Brothers Medical Center Department of Emergency Medicine Policy "CARE OF THE EMERGENCY DEPARTMENT STROKE PATIENT" All Department of Emergency Medicine providers and RN staff will be re-educated to the standards as prescribed in the policy by June 20, 2016 Evidence of education will be submitted to the Emergency Department Performance Improvement Committee and to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees, then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees.	6/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(Continued from page3)

A1104 Continued From page 3

#1, Patient #3).

Findings include:

Review of the medical record for Patient #1 noted: the patient presented to the ED on January 28, 2016 at 1:49 PM with a complaint of headache since 10:00 AM that morning, left upper extremity tingling, heaviness and facial numbness and left foot numbness. The patient had been sent to the ED by her primary doctor, for a stroke evaluation. The triage was completed at 2:12 PM, twenty-three minutes after arrival and the patient was seen by an ED doctor at 2:25 PM, who noted the patient had blurred vision, "squiggly lines," numbness, tingling and paresthesia (burning or prickling sensation) to the left side of her body. The stroke team was activated at 2:29 PM, forty minutes after the patient's arrival in the ED.

The facility's policy titled "Guidelines for Management of Acute Stroke Patients," last reviewed 10/2014, states, "For acute stroke patients (presenting within 6 hours of onset), activate the Code Stroke system. The stroke team will arrive within 10 minutes of notification for urgent assessment and management." The policy further states urgent assessment and management includes "neurologic screening examination, including an NIHSS." (The National Institutes of Health Stroke Scale).

These policies were not followed as required by its stroke designation status and staff did not activate the Code Stroke system in a timely manner to manage the patient's acute stroke

A1104 Monitoring

50 patient records will be reviewed monthly for 3 months to assess compliance with policy. Initially 2 records daily for month one followed by 12 records weekly for month two and then 50 records monthly for month three by ED Department Leadership Measure of success is >90% compliance. Audits begin July 1, 2016 ending September 3, 2016

The audits will be submitted for review to Emergency Department Performance Improvement Committee with results reported to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees.

These audits will be submitted to Emergency Department Leadership daily during month one, weekly, month two and then monthly for month three, during the audit period.

Those not compliant with protocol will be reviewed by the VBMC ED Medical Audit Committee and the VBMC Multidisciplinary Stroke Committee for review and reported to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees, to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees.

Responsible Parties: Vice President of Medical Affairs or designee, Chief Nursing Officer or designee

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A1104	Continued From page 4 symptoms. The "NIH Stroke scale" form was signed but an assessment was not documented on the form. These findings were shared with the Director, Patient Safety on April 29, 2016 at 3:30 PM. Review of the medical record for Patient #3 noted the following: patient presented to the ED on March 17, 2016 at 1:39 PM with a complaint of "chest, neck and back pain x 1 hour." The patient's pain score was 2 (on a scale of 0 - no pain, to 10 - most severe pain); blood pressure 169/101 (normal adult range 120/80 mmHg). The patient's previous medical history was significant for Hypertension and he had taken Aspirin as an anticoagulant. The patient was sent to the waiting area and documentation at 4:11 PM (approximately 2 hours 30 minutes after arrival in the ED) revealed the patient was "called in the waiting room. No answer." There was no documentation that the patient's elevated blood pressure was reassessed while the patient was waiting in the ED. This is not in compliance with the facility's policy titled "Vital Signs," last revised 08/15, which states, "vital signs are reassessed on all patients when vital signs are not within normal limits." The policy further states vital signs should be repeated "to determine if any change in patient condition has occurred." These findings were shared with the Director, Patient Safety on April 26, 2016 at approximately 2:00 PM.	A1104	Revise the " Emergency Department Triage Policy" and re-educate emergency department providers and RN staff to the requirement that patients with ESI 2 and 3 will be reassessed hourly and documented in the EMR by Emergency Department Medical and Nursing Leadership by June 20, 2016 Monitoring: 70 patient records will be reviewed monthly for 3 months to assess compliance with policy. Initially 2 records daily for month one followed by 17 records per week for month two and then 70 records for month three by ED Department Leadership. Measure of success is >90% compliance. Audits begin July 1, 2016 ending September 3, 2016 These audits will be submitted to Emergency Department Leadership daily during month one, weekly, month two and then monthly for month three, during the audit period. Results including those not compliant with policy requirements along with plans for correction will be reported to the monthly Emergency Department Performance Improvement Committee for review with results reported to the Quality Performance Improvement Committee of the Vassar Brother's Medical Center Board of Trustees then to the Vassar Bothers Medical Center Medical Executive Committee and the Board of Trustees. Responsible Parties: Vice President of Medical Affairs or designee, Chief Nursing Officer or designee	6/27/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 000	INITIAL COMMENTS The deficiencies cited below are a result of a Federal Title 18 Allegation Survey (NY00176890) conducted on 3/2 - 3/7/16 in accordance with 42 CFR part 482 Conditions of Participation (CoPs) for Hospitals. The Condition of Participation for Quality Assessment and Performance Improvement was not met. The plan of correction must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates (X5) and the mechanism(s) established to assure ongoing compliance must be included.	A 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure that Neuro	A 263	482.21 QAPI Corrective Action The Hospital has implemented a hospital wide data driven quality assessment and performance improvement program, the Quality Performance Improvement Committee (QPIC) of the Vassar Brothers Medical Center Board of Trustees. The Hospital has implemented a Neuroscience PI Committee, a subcommittee of the QPIC, focusing on indicators (Exhibit 1a of the Charter Exhibit 1b) related to improved health outcomes and the prevention and reduction of medical errors for patients being treated by the Neuroscience Service (which includes the Neuro Interventional Radiology services). Specifically, the Hospital's AVP Quality, Director of Patient Safety, and AVP of Business Development and Service Lines met on 4.7.2016 and developed the Charter (Exhibit 1b) for the Department's Neuroscience Performance Improvement Committee. This QAPI includes department specific quality indicators for monitoring, and initial program priorities and improvement projects. The Neuroscience QAPI (and associated Charter) has been approved by Vassar Brothers Medical Center VP for Medical Affairs, AVP for Quality and the AVP Service Line Development.	4/7/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING _____ B. WING _____	C 03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

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A 263	Continued From page 1 Interventional Radiology services developed and implemented an effective Quality Assessment and Performance Improvement (QAPI) plan. As a result, the quality of patient care service(s) was not monitored. Findings:	A 263	Continued From page 1 The Neuroscience QAPI is designed to be effective, ongoing, and data-driven. Initial program priorities and improvement projects have been identified and embedded in the Neuroscience Performance Improvement Committee Charter (Exhibit 1b). The Neurosciences QAPI (and associated Charter) has been approved by Vassar Brothers Medical Center VPMA, AVP for Quality, and AVP Service Line development Furthermore, the Charter was approved at the Hospital's monthly VBMC Quality and Performance Improvement Committee of its Board of Trustees at its April 20, 2016 meeting (see attached minutes). Same items will be approved by the Vassar Brothers Board of Trustees at the upcoming meeting on May 26, 2016. Prior to development of the Neurosciences PI, an ad hoc case review committee meeting was held 4/5/2016 (minutes - Exhibit 1c). <u>Responsible Party</u> Vassar Brothers Medical Center Vice-President of Medical Affairs or designee <u>Audit Measure</u> The Neuroscience PI Committee will meet no less than ten times per year, and will review documentation relating to identified quality indicators relating to care provided through the Department. Meeting minutes and quality review documents reviewed or prepared by the Committee are subsequently submitted to the QPIC. Additionally, representatives of the Neuroscience Performance Improvement Committee will make formal annual presentations summarizing committee activities and findings to the QPIC. Please see the 2016 VBMC Quality, Performance Improvement, and Patient Safety Plan (Exhibit 1d). Please see attached the departmental reporting schedule for QPIC (Exhibit 1e) as well as	4/20/2016 5/12/2016

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A 283	See Tags A 283 & A 309) 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions; the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure that data for Neuro-Interventional Radiology Services was collected for Quality Assurance Performance Improvement (QAPI) program in order to assess and evaluate and/or track and trend the information regarding the quality of patient care and to identify areas for improvement.	A 283	Continued From page 2 the case review diagram (Exhibit 1f). 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES Corrective Action In response to the survey finding, the facility has developed a plan for Neuroscience QAPI referenced above, to include indicators to track/trend high risk, high volume, or problem prone areas specific to Neuroscience so that quality and patient safety issues may be promptly identified and addressed. On a monthly basis, the hospital's Quality Systems department will collect outcomes data (within Midas and other systems) to track and trend information regarding the quality of patient care and to identify areas for improvement. These data will be reported to committee members at the Neuroscience PI meeting. Significant identified problems will be added to the Neuroscience quality indicators, so that the Neuroscience PI Committee can monitor future performance to ensure improvements are attained and sustained. Should questions arise regarding Standard of Care (SOC), case review/audit results will be shared with appropriate Medical Staff and Governing Body committees (Exhibit 1h). Neuroscience QAPI reports and the Neuroscience Performance Improvement Committee meeting minutes are maintained by the Hospital's Quality Systems, who will provide them to surveyors upon request, together with other information required for the surveyor to complete the Hospital/CAH Data Base Worksheet (Exhibit 1g).	5/12/2016

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A 283	Continued From page 3 Findings: On 03/03/16, the latest quarterly QAPI reports for Neuro Surgical Interventions were requested several times, but were not provided by the facility. On 03/03/2016, at 11:40, an interview was conducted with Staff B (Interventional Neuro Radiology) and Staff H (Interventional Neuro Radiology). During the interview Staff B stated that Quality Assurance and Performance Improvement studies are conducted and reviewed quarterly. The facility failed to provide evidence of its QAPI activities and that the activities focused on areas that are high risk (severity), high volume (incidence or prevalence), or problem prone. On 03/02/2016-03/07/2016, the facility failed to provide the required information for the Hospital/CAH Data Base Worksheet. As per Staff A (VP Medical Affairs), Neuro Intervention is a relatively new service that is being provided by the facility, but there was no evidence of QAPI monitoring for this service. No QAPI quarterly reports were provided by the Neuroscience Department. These findings were confirmed with the facility's Staff H (Director, Patient Safety).	A 283	Continued From page 3 <u>Responsible Party</u> Vice President of Medical Affairs and Director of Quality Systems. Note: Director, Quality Systems resigned with last day being 3/4/2016. Currently recruiting and role being covered by Corp. AVP Quality. Once Director position is filled, that individual will assume responsibility along with VPMA. <u>Audit Measure</u> Neuroscience PI Committee minutes and quality review documents are submitted to the Quality Performance Improvement Committee of the Vassar Brothers Medical Center Board of Trustees at least 10 times per year, with formal presentations at least annually. Additionally, please see attached the departmental reporting schedule for QPIC (Exhibit 1e)	

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A 309	Continued From page 4 482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained. (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on interview and document review, there is no evidence that the facility has an ongoing formal Quality Assurance and Performance Improvement (QAPI) program aimed at improvement of quality of care and services. Findings: On 03/02/2016, at 12:07, an interview was conducted with Staff A regarding QAPI program. During the interview, the Staff A (Vice President of Medical Affairs) stated that the administration is working on a contract with a consulting firm to provide external QAPI peer review services.	A 309	Continued From page 4 482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES Corrective Action To ensure all patient care areas participate in QAPI activities, the Hospital has conducted an inventory of established and new Hospital services lines to determine if additional service line specific QAPI programs are necessary to monitor the safety or efficacy of care for impacted patients, and to fulfill the obligations under the cited standard. A standardized hospital-wide assessment and performance improvement model, evaluating and responding to the opportunities identified to improve patient safety and quality for patients is in place. See Quality and PI Plan (Exhibit 1d). Meetings/inventory to-date: Director of Patient Safety, AVP of Service Lines, AVP of Quality – Neurosciences 4/7/2016 AVP of Quality, VPMA, Emergency Department MD Directors 4/13/2016 AVP of Quality, VPMA, President, Dept. Chair - Surgery 4/13/2016 AVP of Quality, VPMA, President, Dept. Chair – Cardiology 4/13/2016 AVP of Quality, VPMA, President, Program Director – Trauma 4/13/2016 AVP of Quality, VPMA, President, Dept. Chair – Internal Medicine 4/13/2016 VPMA, President, Dept. Chair – Orthopedics 4/19/2016 VPMA, President, Dept. Chair – Radiology 4/19/2016 Hospital Administration will meet with additional Responsible Department Representatives on or before June 1, 2016	

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	Continued From page 5		Continued From page 5	
A 309	On 03/04/2016, at 15:00, an interview was conducted with Staff R (AVP Business Development and Service Lines who stated that the consulting firm is a part of the facility's QAPI program, but does not have a contract with the firm. Staff R stated that it is a work in progress that has been ongoing for a year. There was no evidence that the facility has a formal QAPI program and clearly designated staff responsible for the QAPI program. There was no evidence of written policies and procedures; and allocation of budgeting resources dedicated to QAPI program.	A 309	*Vassar Brothers Medical Center has a robust Quality Assessment and Performance Improvement program as demonstrated in the attached Quality Dashboards and Reporting Documents.* Service/department quality indicators have been clarified and expanded to identify distinct improvement opportunities. These meetings outlined the oversight expectations of QAPI for their respective areas, as well as the necessary tracking/trending that will be occurring and reported through QAPI committees, with ultimate oversight at the Vassar Brothers Medical Center Board of Trustees. VBMC currently has budgeted resources for a dedicated QAPI program. Specifically, the Hospital's Department of Quality has a line item for staff and administrative support for a QAPI program, and this budget will be reviewed and adjusted, as appropriate, annually for the next three years as the QAPI program is expanded. The Hospital currently is realigning its quality improvement department, to better support a hospital-wide QAPI program which will supplement current quality and performance improvement activities. The Hospital is actively recruiting for a new Director of Quality Systems, who will oversee the entire quality improvement and assessment program, including the hospital-wide QAPI. VBMC is committed to meeting all applicable CMS Hospital Conditions of Participation. For example, in order to assess its compliance, VBMC contracted with Joint Commission Resources to conduct a week-long assessment of performance opportunities. (Conducted 4/26 – 4/29/16)	5/12/2016 4/12/2016 5/3/2016

			Continued From page 6	
		A 309	In addition, VBMC has contracted with Joint Commission Resources (JCR/Michelle McDonald – see bio) to assemble a team that will work onsite and remotely to assist in ongoing PoC monitoring and CoP compliance. This resource includes 4 days onsite with 3 CMS nurse consultants for 2 consecutive weeks, then 3 days onsite with 3 CMS nurse consultants every other week for the remainder of the two months. Following onsite engagement, CMS nurse consultants will assist for the next 6 months in monitoring the implementation of VBMC's PoC to ensure sustainability. Responsible Party Interim Director, Quality Systems or designee Audit Measure Service/department quality indicator data are collected by Hospital Quality Systems, reviewed by each Department, and aggregate data and identified improvement opportunities are reported to the QPIC on a scheduled basis. This information is maintained in the Hospital's quality system databases (through Midas, Crimson, Cerner, etc.) and demonstrates QAPI compliance by each Service/Department. Please see attached the departmental reporting schedule for QPIC (Exhibit 1e)	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.			

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	Continued From page 7		Continued From page 7	
A 405	This STANDARD is not met as evidenced by: Based on an interview and medical record review, the facility failed to ensure that drugs are administered in accordance with Federal and State laws which is a deviation from the accepted standards of practice and carries risks and potential harm to patient's health and well-being. Findings: Review of the medical record for Patient #1 revealed that the nurse withheld an anticoagulant medication for the patient against a physician's order. Two physicians consulted and made a decision to continue with administration of an anticoagulant medication, but the nurse withheld it. On 03/03/2016, at 11:13, during an interview with a Respiratory Care Unit Registered Nurse, she stated that it is acceptable to hold a medication without an MD order using her "nursing judgment." During discussions with Staff #J1, the Director of Quality, on 3/3/16 at 2:30PM, who witnessed the interview with the nurse and who stated that holding medications without physician orders is against the policy, it was verified that the nurse acted against facility policy. This event was not investigated by the facility or reported.	A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS Corrective Action After the issue was identified, nurse managers and assistants discussed safe medication practices with staff at the daily "take 5's" and safety huddles. Nursing staff were reminded of the Hospital's policies requiring that drugs and biologicals must be prepared and administered in accordance with the orders of the physician or other practitioner(s) responsible for the patients care, and applicable law and practice standards. As an ongoing commitment to medication safety, The VBMC policies: PCS: MEDICATION: ADMINISTRATION AND CHARTING BY NURSE and PCS: MEDICATION: ADMINISTRATION AND SAFETY OVERVIEW have been amended to reflect the process by which the RN may hold a medication, notify the physician, and document actions taken in response to concerns. In addition, all Registered Nurses involved in the medication administration process have received education and reviewed the policy regarding safe medication administration practices to include the process by which medications may be held, the physician notification process and documentation thereof. (See attached policy)	4/18/2016 5/16/2016

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A 405	Continued From page 8	A 405	Continued From page 8 Responsible Party Chief Nursing Officer or designee Audit Measure Staff Education Logs will be run at least quarterly and kept by Quality Systems as demonstration of audit compliance. Daily Safety Rounds are being conducted in the Hospital by the Director of Patient Safety. During these rounds, nursing staff will be encouraged to report any identified safety issues, including any issues or questions relating to medication administration. Any reported or observed safety issues will be reported to the CNO (or designee) for action as well as to the Quality Performance Improvement Committee of the Vassar Brothers Medical Center Board of Trustees.	

New York State Department of Health

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S 000	INITIAL COMMENTS State Facility ID: 0181 Operation certificate number: 1302001H Note: The New York official compilation of codes, rules and regulation (10NYCRR) deficiencies below are cited as a result of a Complaint Survey (NY00174747) conducted on 1/6 with follow-up on 1/7/16, in accordance with Article 28 of the New York State Public Health Law. The plan of correction however, must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.	S 000		
S 119	405.2 (a) GOVERNING BODY. The established operator shall be legally responsible for the quality of patient care services, for the conduct and obligations of the hospital as an institution and for ensuring compliance with all Federal, State and local laws. This Regulation is not met as evidenced by: Based on medical record review, document review and staff interview, it was found the facility was not in compliance with PL (Public Health Law) Section 2805-i-a which requires rape kits to be stored in a hospital. This was found in five (5) of five (5) medical records reviewed. Patient #1, #2, #3, #4, #5). Findings include: Review of the medical record for Patient #1 identified; this twenty month old toddler who was	S 119	405.2 (a) GOVERNING BODY. The established operator shall be legally responsible for the quality of patient care services, for the conduct and obligations of the hospital as an institution and for ensuring compliance with all Federal, State and local laws. Corrective Action Rape kits are retained by the hospital and chain of custody defined in Hospital policy DEM 448-006 section 6 revised 9/2015 Hospital policy DEM 448-006 "Sexual Assault" will be modified to define process which will assure full compliance with PL (Public Health Law) Section 2805-i-a, specifically requiring that rape kits be stored in a hospital, eliminating offsite storage, and defining process for retention and disposal of kits by the hospital.	5/9/2016

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S 119	Continued From page 1 taken to the emergency department (ED) on October 6, 2012 at 12:52 PM by her legal guardian (aunt) because vaginal bleeding was observed by the patient's mother, during the toddler's visit with the mother. The physician's assessment was normal except for "+ erythema of labia majora and minora, no blood, hymen is visualized, no lacerations. Excoriations, of the skin, insect bites on ankles and hands." Review of documentation from the facility's contracted provider, revealed this rape kit was still in their possession on October 2015 and was stored offsite with the contractor. Review of the medical record for Patient #2 identified; a thirty-three year old patient presented to the ED on December 4, 2013 at 4:13 AM, with a complaint of "alleged assault" and a physical assessment was conducted. Review of documentation from the facility's contracted provider, revealed this rape kit was still in their possession on October 2015 and was stored offsite with the contractor. Review of the medical record for Patient #3 identified; this eighteen year old patient presented to the ED on December 18, 2012 at 7:30 PM and reported that she "was pretty wasted" and "intoxicated last night" and was alleging she was raped. She was upset and tearful. Documentation at 11:44 PM revealed the patient was waiting for the SANE (Sexual Assault Nurse Examiner) nurse (the contracted provider). Review of documentation from the facility's contracted provider, revealed this rape kit was still in their possession on October 2015 and was stored offsite with the contractor. Similar problem with storage of rape kits was identified for patient # 4 and #5. The rape kits	S 119	Responsible Party Nursing Director, Department of Emergency Medicine Monitoring Monthly review of Security evidence log. Audit results will be reported monthly at the Department of Emergency Medicine Performance Improvement Committee and to the Vassar Brothers Medical Center via meeting minutes presented to the Quality Performance Improvement Sub-Committee of the Board of Trustees.	

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S 119	Continued From page 2 collected for sexual assault victims have been in storage with the contractor. The facility had the rape kits stored by the contractor and this does did not follow Public Health Law 2805-i-a. which requires that the rape kits should only be stored in a hospital. Interview with Staff A, Director of Quality, on January 7, 2015 at 1:00 PM revealed she could not provide any information on the location or the disposition of the rape kits. A review of the facility's Memorandum of Understanding, dated July 31, 2015, between this hospital, Dutchess County Department of Health and Family Services Inc. revealed the memorandum did not specify the rape kits have to be stored in the hospital.	S 119		
S 354	405.5 (b) (4) NURSING SERVICES. Delivery of services. (4) Nursing documentation shall describe the nursing care given and include information and observations of significance so that they contribute to the continuity of patient care. Nursing interventions and patient responses shall be documented. This Regulation is not met as evidenced by: Based on medical record review and document review, the facility failed to ensure that the nursing staff documented what procedures were performed. Specifically, patients who presented to the facility with complaints of sexual assault, underwent examinations by a contracted provider, but there was no documented evidence	S 354	405.5 (b) (4) NURSING SERVICES. Delivery of services. Corrective Action (4) Nursing documentation shall describe the nursing care given and include information and observations of significance so that they contribute to the continuity of patient care. Nursing interventions and patient responses shall be documented. All patients arriving for screening for sexual assault are registered as patients in the emergency department and assessed as defined in Hospital policy DEM 448-006 section 6 revised 9/2015 Hospital policy DEM 448-006 "Sexual Assault" will be modified to define processes which will assure full compliance with 405.5 (b) (4) NURSING SERVICES. Delivery of services.	5/9/2016

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S 354	Continued From page 3 of the nature of the examinations and how the patients tolerated the procedures. This finding was noted in five (5) of five (5) medical records reviewed. (Patients #1, 2, 3, 4 and 5). Findings include: Review of the medical record for Patient #1 identified; a twenty month old toddler who was taken to the emergency department (ED) on October 6, 2012 at 12:52 PM by her legal guardian because the mother observed vaginal bleeding during the toddler's visit with the mother. The physician's assessment was normal except for "+ erythema of labia majora and minora, no blood, hymen is visualized, no lacerations. Excoriations, of the skin, insect bites on ankles and hands." Documentation in the medical record stated that at 5:47 PM, the baby was taken to the designated room with the SAFE (Sexual Assault Forensic Exam) nurse (contracted provider). There was no documentation to indicate whether the sexual assault examination was performed and what portion of the examination was completed. In addition, there was no documentation to indicate the baby's response or reaction during the SAFE examination. Review of the medical record for Patient #2 identified; this thirty-three year old patient presented to the ED on December 4, 2013 at 4:13 AM, with a complaint of "alleged assault." According to the triage note documented upon arrival, the "patient was barely able to speak in triage but was able to nod her head when asked if she was assaulted and raped." Physical assessment was completed. The patient was alert and oriented but agitated and anxious. At 4:25 AM she was distraught, sobbing and unable to give details about what happened.	S 354	Specifically, patients who present to the facility with complaints of sexual assault and undergo examinations by a contracted provider will have the providers documentation entered into the electronic medical record documenting the nature of the examination, findings, and patients tolerance of the examination. Responsible Party Nursing Director, Department of Emergency Medicine Monitoring Hospital policy DEM 448-006 "Sexual Assault" will be modified to define processes which will required the review of 100% of all medical records of patients who present to the facility with complaints of sexual assault and undergo examinations for compliance with 405.5 (b) (4) NURSING SERVICES. Delivery of services. Audit results will be reported monthly at the Department of Emergency Medicine Performance Improvement Committee and to the Vassar Brothers Medical Center via meeting minutes presented to the Quality Performance Improvement Sub-Committee of the Board of Trustees.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING: _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 354	Continued From page 4 At 2:08 PM the patient reported that she wanted to kill herself and she had a history of previous suicidal attempt. She was afraid to report the rape because the perpetrator was in a gang. She was evaluated by a psychiatrist who determined she needed inpatient care. At 9:04 AM the SAFE nurse was "still examining" the patient. The record does not indicate when the examination was completed and how she tolerated the procedure. The patient was transferred to another facility at 5:07 PM that day for inpatient psychiatric care. Review of the medical record for Patient #3 identified; this eighteen year old patient presented to the ED on December 18, 2012 at 7:30 PM and reported that she "was pretty wasted" and "intoxicated last night" and was alleging she was raped. She was upset and tearful. Documentation at 11:44 PM revealed the patient was waiting for the SAFE nurse. The next nursing note entry was at 3:30 AM on December 19, 2012 which revealed that the patient was discharged and discharged instructions were given. There was no documented evidence that the sexual assault examination had been performed and how the patient had tolerated the procedure. In addition there was no documentation to indicate if her mental status had improved or stabilized. Review of the medical record for Patient #4 identified; this twenty-five year old patient presented to the ED at 3:08 AM on December 20, 2013 with the state troopers, to be evaluated after an alleged assault. Documentation at 9:48 AM	S 354		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING: _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 354	Continued From page 5 revealed only male SAFE nurses were available and the patient wanted to be examined by a female provider. Documentation at 11:53 AM revealed the patient was now agreeable to them performing the rape kit. Documentation at 4:34 PM revealed the patient reported suicidal ideations because she wanted to cut herself and a nurse noted that the "patient attempted to strangle herself in the restroom with the emergency call bell. Patient is difficult to speak with, with loss of ability to focus, as well perseverating (repeat or prolong an action, thought, or utterance after the stimulus that prompted it has ceased) throughout interview. Patient was easily agitated and seems to be frightened with sudden changes." The patient was transferred to another acute care facility for admission. There was no documented evidence that the sexual assault examination had been performed and how the patient had tolerated the procedure. Similar problem of failure to document that the sexual assault examination had been performed was noted in Patient #5. These findings were verified by the Director of Quality, on January 6, 2015 at 1:00 PM. The policy titled "Sexual Assault, Allegations of (for inpatients) 5/2015" states, after the SAFE/SANE examination, the primary nurse caring for the patient will perform and document a physical and psychosocial assessment and document in the multidisciplinary progress notes." It was noted that this policy refers to inpatient and the facility does not have a similar policy for patients that present to the ED at the outpatient location, with complaints of sexual assault.	S 354	The hospital has a policy that addresses patients presenting to the ED as an outpatient with complaints of sexual assault. DEM 448-006 "Sexual Assault". It will be modified as previously described to address documentation requirements	5/9/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330023	A. BUILDING: _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VASSAR BROTHERS MEDICAL CENTER	45 READE PLACE POUGHKEEPSIE, NY 12601

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S 401	405.6 (b) (1) QUALITY ASSURANCE PROGRAM. Activities. The activities of the quality assurance committee shall involve all patient care services and shall include, as a minimum: (1) review of the care provided by the medical and nursing staff and by other health care practitioners employed by or associated with the hospital. This Regulation is not met as evidenced by: Based on staff interview, it was determined the facility did not have a quality assurance program that included the review of care that the staff from a contracting agency provided to patients who presented with a complaint of sexual assault. Findings include: On January 6, 2016, the surveyors requested the quality assurance data and analysis for the contractor who provided care to patients who presented to the emergency department with complaints of sexual assault. Interview of the Director of Quality, on January 6, 2016 at 3:00 PM, revealed that the Quality Assurance Committee did not review the care that the contractor provided to its patients.	S 401	405.6 (b) (1) QUALITY ASSURANCE PROGRAM. Activities. The activities of the quality assurance committee shall involve all patient care services and shall include, as a minimum: (1) Review of the care provided by the medical and nursing staff and by other health care practitioners employed by or associated with the hospital. Corrective Action Hospital policy DEM 448-006 "Sexual Assault" will be modified to assure compliance with 405.6 (b) (1) QUALITY ASSURANCE PROGRAM. Activities. Specifically defining the quality assurance processes reviewing the care provided by the medical and nursing staff and by other health care practitioners employed by or associated with the hospital to patients who present with a complaint of sexual assault in the Emergency Department. Responsible Party Nursing Director, Department of Emergency Medicine Monitoring Hospital policy DEM 448-006 "Sexual Assault" will be modified to define processes which will require the review of 100% of all medical records reviewing the care of patients who present to the facility with complaints of sexual assault and undergo examinations by contracted agency staff in accordance with hospital policy. Audit results will be reported monthly at the Department of Emergency Medicine Performance Improvement Committee and to the Vassar Brothers Medical Center via meeting minutes presented to the Quality Performance Improvement Sub-Committee of the Board of	5/9/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 613	405.10 (b) (2)(iii) MEDICAL RECORDS. Content. (2) All records shall document, as appropriate, at least the following: (iii) results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient. This Regulation is not met as evidenced by: Based on medical record review, document review and staff interview, it was determined the facility failed to ensure that all records contained results and findings by all staff involved in the care of the patients. Specifically, an agency contractor evaluated and performed tests on patients that presented to the facility with complaints of sexual assault but the staff did not incorporate the care that the agency contractor provided in the facility's medical records. This finding was noted in five (5) of five (5) medical records reviewed. (Patients #1, 2, 3, 4 and 5). Findings include: Review of the medical records for Patient #1, 2, 3,4 and 5, identified these patients presented to the facility with complaints of sexual assault and were evaluated by the agency contractor (SANE -Sexual Assault Nurse Examiner). The medical records did not include documentation that the SANE examination had been performed. Interview with the Director of Quality verified the findings on January 7, 2015 at 1:00 PM. The facility does not have a policy that specifies which portions of the SAFE nurses' medical records would be incorporated in the facility's medical records.	S 613	405.10 (b) (2) (iii) MEDICAL RECORDS. Content. (2) All records shall document, as appropriate, at least the following: (iii) Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient. Corrective Action Hospital policy DEM 448-006 "Sexual Assault" will be modified assure compliance with 405.10 (b) (2) (iii) MEDICAL RECORDS. Content. Specifically specifying which portion(s) of the contracted provider's (SAFE nurse) medical records will be incorporated in the Hospital's electronic medical record documenting the results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient. Responsible Party Nursing Director, Department of Emergency Medicine Monitoring Hospital policy DEM 448-006 "Sexual Assault" will be modified to define processes which will require the review of 100% of all medical records reviewing the documentation of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient, In accordance with Hospital policy Audit results will be reported monthly at the Department of Emergency Medicine Performance Improvement Committee and to the Vassar Brothers Medical Center via meeting minutes presented to the Quality Performance Improvement Sub-Committee of the Board of Trustees	5/9/2016

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Jacob K. Javits Federal Building, Room 37-130
26 Federal Plaza
New York, New York 10278-0063

NORTHEAST DIVISION OF SURVEY & CERTIFICATION

CENTERS FOR MEDICARE & MEDICAID SERVICES

February 22, 2016

CMS Certification Number: 33-0049

Ms. Denise George
Chief Executive Officer
Northern Dutchess Hospital
6511 Springbrook Avenue
Rhinebeck, NY 12572-5002

Re: Survey ID: 99JD12, Exit Date 09/18/2015
Deemed Status Restored - Termination Rescinded

Dear Ms. George:

The New York State Department of Health conducted a complaint survey on July 15, 2015 resulting in noncompliance with the Medicare Conditions of Participation (CoPs). CMS removed deemed status. A revisit survey conducted on September 18, 2015 determined compliance with the Medicare Conditions of Participation (CoP).

Therefore, Northern Dutchess Hospital is again deemed to meet applicable Medicare requirements based upon accreditation by The Joint Commission. Termination action is also rescinded. The New York State Department of Health will no longer conduct monitoring surveys of your hospital.

We have forwarded a copy of this letter and our findings from this survey to The Joint Commission. The New York State Department of Health has also been sent a copy of this letter.

We appreciate your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions regarding this matter, please contact Ms. Elizabeth Romani via telephone at (212) 616-2479 or via email at Elizabeth.Romani@cms.hhs.gov.

Sincerely,

Lauren D. Reinertsen, MPA, Ph.D., NHA
Certification Branch Manager
Northeast Division of Survey and Certification

Northern Dutchess HOSPITAL

Health Quest affiliate

October 20, 2015

By Federal Express

New York State Department of Health
90 Church Street
15th Floor
New York, NY 10007
Attn: Kathleen A. Gaine, MPA

RE: Title 18 Full Survey Following Complaint
Survey Event ID# KK7Y21 (Life Safety)
Medicare Provider #33-0049
September 14, 2015 through September 18, 2015

Dear Ms. Gaine:

Enclosed herewith please find a completed Plan of Correction on behalf of Northern Dutchess Hospital with regard to the above-referenced Survey. Would you kindly date stamp the copy enclosed and return to the undersigned as proof of receipt.

If you should have any questions, please do not hesitate to contact me. Thank you for your attention.

Very truly yours,

NORTHERN DUTCHESS HOSPITAL

BY: Denise George

Denise George, President

Enc.

6511 Springbrook Avenue
PO Box 5002 • Rhinebeck, NY 12572

Phone: (845) 876-3001 • Fax: (845) 876-7195
www.health-quest.org/ndh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN DUTCHESS HOSPITAL	6511 SPRINGBROOK AVENUE RHINEBECK, NY 12572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The deficiencies below are cited as a result of a Life Safety Survey conducted 09/14/2015 through 09/18/2015. This survey was conducted in conjunction with a Full Survey Following Complaint (Health) survey to determine compliance in accordance with 42 CFR Part 482 Conditions of Participation for hospitals. The Plan of Correction, however, must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debbie Berger | President | 10/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not ensure that exit doors have no impediment to the closing of the doors and have positive latch. Finding: During a tour of the hospital on the afternoon of 9/16/2015, the Exit Door next to the laundry room was found to not have a positive latching mechanism as required by NFPA 101- 2000 edition. The above finding was identified in the presence of the Manager of Facility Operation who acknowledged the finding. NFPA 101 LIFE SAFETY CODE STANDARD	K 018	The exit door cited separates the corridor from the exterior of the building. In accordance with NFPA 101 Section 19.3.6.1, the corridor requirements apply to those walls and doors which separate the corridor from other areas within the building. Therefore, an exterior exit door is not required to be positive latching and no further action is required. The door is secured to prevent unauthorized access via our security control system.	
K 062	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not ensure that the required automatic sprinkler systems are continuously maintained in reliable operating condition. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Finding:	K 062	The sprinkler heads in rooms 2110 and 2112 were cleaned on September 17, 2015.	09/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN DUTCHESS HOSPITAL	6511 SPRINGBROOK AVENUE RHINEBECK, NY 12572

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K 062	Continued From page 2 During a tour of the hospital on the afternoon of 9/17/2015, the sprinkler head in rooms 2112 and 2110 were found to be dirty and dust laden, which prevent their proper functions in the event of fire. The above finding was identified in the presence of the Manager of Facility Operation, who acknowledged the finding. NFPA 101 LIFE SAFETY CODE STANDARD		*Continued from previous page* K 062 Examination and cleaning of sprinkler heads have been added to Environmental Services room cleaning checklists for ongoing compliance. As follow up and to ensure continued compliance, a quarterly review of all sprinkler heads will be performed during scheduled inspections.	
K 145	The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2. This STANDARD is not met as evidenced by: Based on staff interview and document review, it was determined that the hospital's emergency generators are not in compliance with the requirement of NFPA 99. The Hospital's Essential Electrical System is not Type I EES because it is not divided into the critical branch, life safety branch and the equipment branch in accordance with NFPA 99 - 3.4.2.2.2. The hospital performs general anesthesia and has patients who use Life Support Systems (Ventilators) and is required to comply with the provision of Type 1 EES system (Essential Electrical System). Findings include: In an interview with the Director of Facilities on 09/17/15 and review of the directions on the panels of the Essential Electrical System (EES), it was determined that the wiring configuration of	K 145	The wiring configuration of the essential Electrical System in the Facility does not conform to Type 1 EES as per NFPA 99 requirement. An application for a time limited waiver will be applied for by November 30, 2015. The correction will be a compliant type I EES system for the 1929, 1954, and 1986 wings. For the 1929 and 1954 wings we'll add two branches and the associated equipment and then segregate the existing panels into the appropriate branch. *Continued on next page*	11/30/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 145	Continued From page 3 the Essential Electrical System in the facility does not conform with Type I EES and therefore, the EES system in the hospital does not comply with 1999 NFPA 99 3-4.2.2.1. The specific issue involved was the separation of the generator branches into a Life Safety branch, Critical, and Equipment Branches as per the requirement of NFPA 99. The Director of Facilities indicated that the hospital as a whole does not have a code compliant EES Type 1 as per NFPA 99 requirement. The Hospital performs general anesthesia and operates a ventilator dependent unit, and as such, requires a Type I EES. Review of the directions on the panels and switches also revealed that items required to be served by the Equipment Branch of the EES system were not independent or separate from items required to be served by the Life Safety Branch of EES system, and/or from items required to be served the Critical Branch of the EES system. 1999 NFPA 99 3-4.2.1.4, 3-4.2.2, NFPA 70: Article 517 and Article 70	K 145	*Continued from previous page* For the 1986 addition, we only need to add one branch and then segregate the existing panels into the appropriate branch. We estimate it will take us 3 years to do this repair at a cost of $600,000. Our facilities Director has engaged Fellenzer Engineering to work on determining what we have, and to design a new system. The electrical system in the new construction portion of the facility has been surveyed and does conform to Type 1 EES/NFPA requirement.	

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SH000825
01/17/2017

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 14, 2015

Denise George
President and Sr. Vice President of Health Quest
Northern Dutchess Hospital
6511 Springbrook Avenue
Rhinebeck, NY 12571-5002

Re: Title 18 Full Survey Following Complaint
Survey Event ID# KK7Y21 (Life Safety)
Medicare Provider #33-0049
September 14, 2015 through September 18, 2015

Dear Ms. George:

Enclosed is a Statement of Deficiencies (CMS Form 2567) with findings based upon Part 482, Title 42 of the Code of Federal Regulations. The report gives the details of the deficiency(ies) observed during the above referenced survey.

An acceptable Plan of Correction is due back to this office by no later than **October 23, 2015.**

Please prepare a specific Plan of Correction on the original Statement of Deficiencies form enclosed with this letter. The Plan is to be generic for each deficiency, as well as case specific if it refers to an allegation. The Plan is to include specific corrective actions placed in the column labeled "Provider's Plan of Correction," title of the party responsible for each corrective action, and a "Completion Date" for each action plan in the (X5) column. If you require additional space, you may note "See attachment" on the form and attach sheets, which clearly identify, by tag number, the citation being addressed.

If implementation of the Plan of Correction is delayed for any reason, the facility must provide an interim plan until the full corrective action plan is put into effect. Failure to provide any of the foregoing required information constitutes an unacceptable response.

Please ensure that the first page of the Plan of Correction is signed (X6) by a duly authorized representative of your facility. If you have any questions, please call 212-417-5990 or marosodpoc@health.ny.gov. Written correspondence should be sent to the New York State Department of Health, 90 Church Street, 15th floor, New York, NY 10007.

Sincerely,

Kathleen A. Gaine, MPA
Regional Program Director
Metropolitan Area Regional Office
Division of Hospitals and Diagnostic & Treatment Centers

cc: File

edc

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 30, 2015

Denise George
President and Sr. Vice President of Health Quest
Northern Dutchess Hospital
6511 Springbrook Avenue
Rhinebeck, NY 12571-5002

Re: Title 18 Full Survey Following Complaint
Survey Event ID#s KK7Y11 (Health) and KK7Y21 (Life Safety)
Medicare Provider #33-0049
September 14, 2015 through September 18, 2015

Dear Ms. George:

Enclosed is a Statement of Deficiencies (CMS Form 2567) with findings based upon Part 482, Title 42 of the Code of Federal Regulations. The report gives the details of the deficiency(ies) observed during the above referenced survey.

An acceptable Plan of Correction is due back to this office by no later than **October 13, 2015.**

Please prepare a specific Plan of Correction on the original Statement of Deficiencies form enclosed with this letter. The Plan is to be generic for each deficiency, as well as case specific if it refers to an allegation. The Plan is to include specific corrective actions placed in the column labeled "Provider's Plan of Correction," title of the party responsible for each corrective action, and a "Completion Date" for each action plan in the (X5) column. If you require additional space, you may note "See attachment" on the form and attach sheets, which clearly identify, by tag number, the citation being addressed.

If implementation of the Plan of Correction is delayed for any reason, the facility must provide an interim plan until the full corrective action plan is put into effect. Failure to provide any of the foregoing required information constitutes an unacceptable response.

Please ensure that the first page of the Plan of Correction is signed (X6) by a duly authorized representative of your facility. If you have any questions, please call 212-417-5990 or marosodpoc@health.ny.gov. Written correspondence should be sent to the New York State Department of Health, 90 Church Street, 15th floor, New York, NY 10007.

Sincerely,

Kathleen A. Gaine, MPA
Regional Program Director
Metropolitan Area Regional Office
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Executive Deputy Commissioner

September 30, 2015

Denise George
President and Sr. Vice President of Health Quest
Northern Dutchess Hospital
6511 Springbrook Avenue
Rhinebeck, NY 12571-5002

Re: Title 18 Re-visit to Allegation (NY00149237-NS) Survey/ Event ID# 99JD12
Medicare Provider #33-0049
September 14, 2015 through September 18, 2015

Dear Ms. George:

Enclosed is the report of our findings based upon Part 482, Title 42 of the Code of Federal Regulations, with regard to the above referenced survey.

No deficiencies were noted at the time of the survey and no Plan of Correction is needed. However, you are required to have the enclosed report **signed** and **dated** by a duly authorized representative of your facility and return to us by close of business within two (2) business days from the date of this letter. For your convenience you may fax this letter to (212) 417-5914 to meet your deadline, however, the original **signed** and **dated** copy is still required.

If you have any questions, please contact this office] at (212) 417-5990 or e-mail marosodpoc@health.ny.gov. Written correspondence should be sent to the New York State Department of Health, 90 Church Street, 15th floor, New York, NY 10007.

Sincerely,

Kathleen A. Gaine, MPA
Regional Program Director
Metropolitan Area Regional Office
Division of Hospitals and Diagnostic & Treatment Centers

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edc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330049	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN DUTCHESS HOSPITAL	6511 SPRINGBROOK AVENUE RHINEBECK, NY 12572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The deficiencies below are cited as a result of a Full Survey which was conducted on September 14, 15, 16, 17, and 18, 2015, to assess compliance in accordance with 42 CFR PART 482 Conditions of Participation for Hospitals. The plan of correction must relate to the care of all patients and prevent such occurrences in the the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. The following hospital extension clinic was visited: Hyde Park Satellite Health Center 11 Crum Elbow Road Hyde Park, New York 12538	A 000		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on review of document and staff interview, it was determined the facility did not ensure that the medical staff provided care that was consistent with current standards of practice. Specifically, orders for blood transfusions were incomplete and inadequate. This was found in 2 of 4 medical records reviewed for patients who had received transfusion. (Medical Records #4 and #5). Findings include:	A 049		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 049	Continued From page 1 1. A review of MR #4 on September 16, 2015 revealed, this eighty-eight year old patient presented to the facility on August 21, 2015 with a diagnosis of Anemia, Emphysema and a Leaking Heart Valve. The physician wrote an order for transfusion of 2 units of packed red blood cells (PRBC) but did not specify the timeframe that each unit should have been transfused. Each unit of blood was transfused over 2 hours and 55 minutes. 2. A review of MR #5 on September 16, 2015 revealed, this sixty-eight year old patient presented to the facility on August 13, 2015 with diagnoses of Diabetes Mellitus, Total Knee Replacement, Hypertension, Anemia, Spinal Fusion and Mitral and Aortic Stenosis. The physician gave a telephone order to transfuse 2 units of PRBC but did not specify the timeframe for which the units should have been transfused. The first unit was transfused over 3 hours and 55 minutes while the second unit was transfused over 2 hours and 45 minutes These findings were witnessed by the Quality Coordinator on September 15, 2015. Review of the policy titled "Blood Transfusion Guidelines," last revised 5/15, stated PRBC can be transfused over 2 - 3 hours per unit or as ordered by the physician. In addition, this policy also states the "pediatric and elderly patients may require a slower infusion time as per physician"	A 049		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited	A 273		

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A 273	Continued From page 2 to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on observation, document review and interview, it was determined the facility failed to (1) develop an effective program to analyze patient data and develop actions for improvement and (2) failed to ensure quality indicators including patient care data, and other relevant data are reported to the hospital Quality Improvement Organization (QIO). Finding Include: (a) On 9/16/15 at 9:30 AM, a review of the facility Quality Assessment and Performance	A 273		

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A 273	Continued From page 3 Improvement (QAPI) Committee meeting minutes for July 2014 to August 2015 was conducted. The blood transfusion audits dated from July 2014 - June 2015 had not been incorporated into the Quality Assessment and Performance Improvement (QAPI) Committee meeting minutes. The hospital wide blood transfusion audit compliance data dated July 2014 to June 2015 ranged from 91% -98% compliance. During interview on 9/16/15, the Quality Coordinator stated that the hospital goal was 100%. There is no evidence that the hospital developed corrective actions. (b) A review of facility documents revealed a nurse was counseled for an incomplete documentation on a blood transfusion flow sheet. The nurse was counseled by the nurse manager for incomplete documentation and incorrect blood transfusion on 4 occasion, specifically on 7/16/15, 7/20/15, 8/10/15 and 9/10/15. There was no evidence that the counseling or corrective actions were analyzed by the QAPI committee. There was no evidence that the blood transfusions reactions or administration errors were tracked and trended and analyzed by the QAPI committee. Furthermore, a QAPI process was not in place for staff to report blood transfusion reactions or administration errors. The Director of Quality Systems was interviewed on 9/17/15 at 10:30 am. She reported that the Quality Coordinator was responsible for tracking the blood transfusions. The surveyor requested the Blood Transfusion Quality Improvement (QI) audit from the Quality Coordinator. The Director of Quality Systems stated that the QPIC book did not contain the blood transfusion QI.	A 273		

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A 273	Continued From page 4 The Quality Coordinator was interviewed on 9/18/15 at 9:33 am. This interviewee stated that she was responsible for tracking the core measurements for the hospital and ambulatory surgical care and this included immunizations and blood transfusions. She also stated that the blood transfusions are being audited by the unit nurse managers. The Quality Coordinator stated transfusion core measurement were not reported up through Quality Improvement Committee (QPIC) and is not analyzed. (c) Review of the QAPI minutes for the period indicated above, revealed that there was a Pain Control Report which indicated that the hospital tracked and trended "how often was your pain controlled?" The "Pain Controlled" report indicated that from January 2015 to August 2015, the hospital did not meet their established benchmark of 83.03%. The hospital had a pain management control rate of 63.0% to 70% for this period. There is no evidence that the hospital reviewed this data to determine the decrease from 77.8% in June to 63% in July. The report had no evidence that the data was analyzed by the QAPI team and that the hospital developed a plan for improvement. The Patient and Guest Relation Coordinator was interviewed on 9/18/15 at 2:00 pm. This interviewee reported that the hospital did not reach their goal of 83.03% and that there were no analysis of the data. (d) The Hospital "Readmit Report" for 6/1/15 through 8/31/15 indicated that the hospital had 55 patients re-admitted to the hospital within 30 days	A 273		

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A 273	Continued From page 5 after discharge. There is no evidence that this data was reviewed and analyzed to identify trends and develop a plan for improvement. Upon interview on 9/18/15 at 9:35 AM, Quality Coordinator confirmed the findings and stated that this information was done at a department level and was never brought to the QAPI committee. Review of the Hospital's Policy and Procedure "Quality Assessment and Performance Improvement 2015-2016," stated: "Data collected are systematically aggregated and analyzed to transform data into meaningful information for implementation of changes that will improve quality care, treatment and services." The hospital did not adhere to their policy and procedure.	A 273		
A 308	482.21 QAPI GOVERNING BODY, STANDARD TAG ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: Based on review of document and staff interview, it was determined the facility did not ensure that all departments audit and reports are included in the hospital wide Quality Assessment and Performance Improvement (QAPI) program.	A 308		

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A 308	Continued From page 6 Specifically, there was no evidence that blood transfusions audits, pain management audits and readmission reports are reported up through the QAPI Committee. Findings include: See citation at: Tag A 273.	A 308		
A 629	482.28(b), (b)(1) THERAPEUTIC DIETS §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: Based on staff interview and review of document, it was determined that that the Food and Nutrition Department did not ensure that (a) physician prescribed diets in 28 of 28 diets, met the therapeutic nutritional needs of patients, (b) hospital menus were prepared based on standard of practice of menu planning, (c) menus developed for emergency preparedness is complete to meet the needs of the patients. Findings include: (1) A review of hospital menus and nutrient analysis was conducted on 9/15/15 at approximately 1:00 PM, in the presence of the Staff Clinical Dietitian and Corporate Clinical Dietitian. The hospital has a one week cycle menu and a diet formulary consisting of approximately 28	A 629		

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A 629	Continued From page 7	A 629		

different diets available to the physician for ordering of diets. Listed below are the deficits identified in the menus and the nutrient analysis of prescribed diets:

(a) The master menu had no food portions noted on the food items.

(b) There was no through nutritional analysis utilizing the menu by meal and prescribed diet.

(c) Diets listed on the physician diet formulary and patient menu are incomplete. Examples:

- Low Fat Diet- amount of fat not noted.
- High Calorie/High Protein- amount of calorie/protein not noted.
- Low Sodium- amount of sodium not listed.
- Bariatric diet- liquid or solid not specified.
- Vegetarian Diet- no type listed.
- High and Low Fiber- amount not noted.

(d) Patient's on therapeutic diets did not have the portion size next to the food item on their menu nor did the menu document the correct diet order with the amounts restriction.

Due to the absence of nutritional data on the diet formulary, lack of portion size on the menus and a fragmented nutrient analysis; the nutritional adequacy of patient menus and validity of prescribed diets are not met.

(2) A review of the hospital's menu was performed on 9/15/15 at approximately 11:00 AM. Present during this review was the Clinical Staff Dietitian and the Corporate Clinical Dietitian.

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A 629	Continued From page 8 The menu consist of a 1 week cycle menu. The hospital menus did not have portions next to the food item. Due to the absence of food portions it is unknown if these menus are nutritionally adequate as noted in the hospital policy titled, "Menus." (3) Review of the Food Service Department "Emergency Preparedness Manual," identified the menu in the manual was not complete. Examples: a) The menu noted, prepared powder milk, and there was no instructions on how to prepare this milk. b) The menu does not specify what diets are covered by this menu. c) There is no diagram of where to find the menus food items. d) There was no menu for modified texture diets, i.e. Mechanical soft, Pureed and Clear Liquid. e) There was no mention of enteral feedings for patient on tube feedings. These findings were acknowledged by the Food Service Operation Manager.	A 629		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, staff interview and	A 701		

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A 701	Continued From page 9 document review, the hospital did not ensure that the condition of the physical plant and overall hospital environment is maintained in a manner to ensure the safety and well-being of patients. Findings are: During tours of the hospital in the period from 9/15-9/18/201, the following issues were identified in the presence of the Director of Facilities who acknowledged the findings: 1) On 9/15/2015 at 11:25 AM, during a tour of the OR on the third floor of the hospital, the following were identified in the presence of the Director of Facilities. a. The surface of the water fountain outside the OR suite by the staff elevator was found to be dirty, discolored and had a greenish black layer of dirt around the faucet opening and at the drain strainer. b. The scrubbing sinks of the OR suite did not have the proper water temperature. When asked to measure the water temperature from various scrub sinks around the six OR rooms, the temperatures were 65 F, 65 F, 102 F, 83 F, 75 F and 90 Fahrenheit degrees. Per CDC recommendation the hot water Temperature should be between 110 -120 F. c. The floor of the hospital's OR at the expansion joint near ORs 5 and 6 was noted to lack floor tiles and was bumpy and not smooth. This is a tripping hazard and also potential for buildup of	A 701		

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A 701	Continued From page 10 dirt and germs as it may be difficult for the area to be cleaned or disinfected easily. 2) During a tour of the ED on the morning of 9/16/2015, the following were identified in the presence of the Director of Facilities and the Nurse Manager of The ED: a. It was found that the hospital has stored clean supplies in the bathroom near the orthopedic room. The bathroom had a wood cabinet used for storage of clean supplies on its top and inside. The stored supplies included but were not limited to: Clean urine culture kits, boxes of clean gloves, clean cups..etc. b. The soiled utility room did not have a hand-wash sink. c. Flies were observed in the clean supply room of the ED. 3) During a tour of the MRI Suite on the afternoon of 9/16/2015, the following were identified in the presence of the Director of Facilities and the Administrator of the Radiology Department: Many unsafe (ferrous containing items) that are incompatible with the MRI unit were found on the MRI suite outside the MRI room. Examples included but were not limited to: a. The chain and tag holder of the fire extinguisher were from ferrous material and are	A 701		

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A 701	Continued From page 11 not suitable for use in the MRI, unless these parts are replaced with safe materials. b. The crash cart of the unit was not ferrous free. c. The IV Pole on the unit has metal parts that hold its wheels and these parts are not ferrous free. d. The linen hamper on the unit was found to have metal wheels that are not safe for MRI. 4) During a tour of the ICU on the morning of 9/17/2015, the following were identified in the presence of the Director of Facilities and the Director of Nursing: a. The two airborne isolation rooms of the ICU did not have washable ceiling tiles that are required for this type of room as per AIA guidelines and CDC recommendations. b. The curtain in the ICU were observed touching either the hand-wash sinks or garbage containers. c. Oxygen cylinders were observed being stored in each patient room of the ICU and the Medical - Surgical Unit. It should be noted that the Oxygen Cylinders should not be stored in the patient rooms, instead they need to be stored in a clean supply or storage rooms. d. Red Containers were observed being stored in	A 701		

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	330049	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN DUTCHESS HOSPITAL	6511 SPRINGBROOK AVENUE RHINEBECK, NY 12572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	Continued From page 12 the patient bathrooms of the ICU. This finding was brought to the attention of the Director of Nursing who stated that there is not enough space in the patient rooms and they needed the red containers in the room. In the event of a blood transfusion in any room, they will dispose the blood lines in the red containers. Storing the red container in patient bathrooms is potential for the spread of infection. e. The nurses' lounge was being used for storage of personal items, medical equipment and food equipment as follow: Coats and other clothing items; bags, suitcase; medical equipment and IV poles; coffee machines, microwave; boxes of printing papers. This is a potential for the spread of infection and a fire hazard. 5) Flies of different sizes were observed in different location of the hospital. Flies were observed in the clean supply room of the ED; Room 2162 of the Medical Surgical floor on the second floor; in the pantry area of the Ambulatory Surgical Unit and in the Wound Center. When asked, the Manager of the Facility Operations said that they are working with the vendor to take additional measures to address this problem. Review of the facility's Environmental Care Records, showed that there were some complaints and discussion about the spread of the flies since August 2015). 6) During a tour of the Med Surgical unit on the	A 701		

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A 701	Continued From page 13 morning of 9/17/2015, the non-skid Tapes were observed being in disrepair and they were coming off the Parallel Bar machine (a machine used for training of people who have problem with balance and those required training for walking). 7) On the morning of 9/18/2015, during a tour of the Central Sterile, in the presence of the Manager of Facility Operation, the following findings were identified: a. The decontamination room was lacking a hand wash sink for the staff to wash hands. b. There was no hand-wash sink in the decontamination room of the endoscopy suite. 8) During a tour of the hospital extension clinic at Hyde Park, on September 18, 2015 at 11:00 AM, the side walk and handicap parking area was broken and in need of repair. This finding was witnessed by the administrator of the clinic when the observation was identified.	A 701		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of policy and procedures and staff interview, it was determined the facility did not maintain equipment to ensure that patients receive care in a safe manner.	A 724		

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A 724	Continued From page 14 Findings include: During a tour of the off-site location "Hyde Park Satellite Health Center" on September 18, 2015 at 11:00 AM revealed all of the exercise equipment did not have inspection stickers to indicate the due date for inspection of the equipment. Staff interview conducted on September 18, 2015 at 11:00 AM revealed the administrator at the location could not provide any documented evidence of the due dates for inspection of the equipment. The facility's policy titled "Quality Assessment and Performance Improvement," last revised July 22, 2014, stated "employees, professional staff members, and volunteers' report immediately to their manager(s), risk management or other management person any defect, error, medical discrepancy, significant or risks to safety that could result in patient injury, hazardous condition, or risks in environment of care. Based on the findings listed above the facility did not ensure that staff followed this policy.	A 724		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by:	A 749		

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A 749	Continued From page 15 Based on observation, review of document and staff interview, it was determined the facility failed to ensure that patients received care in a clean and sanitary environment. Findings includes: During a tour of the hospital's extension clinic at Hyde Park on September 18, 2015 at 11:05 AM the following observations were identified: The hydrocollator was in need of cleaning. Portions of the heating pads in the hydrocollator had a brown color instead of a white color. This finding was witnessed by the Physical Therapy and Wellness Manager at the time the observations were identified.	A 749		
A 806	482.43(b)(1), (3), (4) DISCHARGE PLANNING NEEDS ASSESSMENT (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.	A 806		

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A 806	Continued From page 16 This STANDARD is not met as evidenced by: Based on document review and staff interview, it was determined the hospital failed to ensure that patients are appropriately evaluated prior to discharge. This was evident in 1 of 5 applicable medical record. (MR#13) Findings include: Review of MR#13, indicated this eighty-six year old patient was brought into the hospital's emergency room by EMS (Emergency Medical Service) on 9/8/15 due to a fall at home. She complained of pain in the lower back. The hospital triage assessment indicated that the patient has an history of falls "within last 3 months." The patient lives alone. On 9/9/15, the Discharge Planner completed an assessment of the patient. There is no documentation that the patient's post discharge care needs were assessed.. There was no documentation whether or not the patient is able to effectively manage all activities of daily living. The discharge planner wrote that prior to the admission the patient had 2 hours of home care each week. There was no documentation of current home care service need or the patient's social support systems and their availability to assist. Upon interview on 9/16/15 at 12:02 PM, Discharge Planner acknowledged the findings and stated that the patient has a daughter who is involved in her care. When asked where the	A 806		

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A 806	Continued From page 17 daughter lives in proximity of the patient, she replied that the daughter lives in New Jersey. The Hospital's "Patient Care Services Policy and Procedure," last reviewed 6/15, stated the Case Coordinator will initiate needed services as appropriate. This policy and procedure has no information requiring the need for an assessment of the patient's post discharge needs.	A 806		
A 886	482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on review of the Organ, Tissue and Eye Procurement Program (OPO) Manual and staff interview, it was determined that the facility failed to ensure that this program was integrated into the Hospital Wide Quality Assessment and Performance Improvement Program (QAPI). Findings include: 1. A review of the hospital's Organ, Tissue and	A 886		

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A 886	Continued From page 18 Eye Procurement (OPO) Program Manual was conducted on 9/15/15 at approximately 2:30 PM. Present during the review of the contract was the Organ Donation Coordinator. The surveyor requested the facility's tracking data and quality assessment program concerning compliance with time notification. The Organ Donation Coordinator informed the surveyor that she did not have a quality assurance program. She only had the reports sent to her by OPO and data on in-service provided to nurses. The facility's current yearly timeliness in organ referral is 71.4%. The report notes that in prior year it was 100%. The tissue donation report notes that the current yearly timeliness in tissue referral is at 88.7%. The year prior it was at 93.8%. The OPO Program does not follow the facility's policy for quality assessment and performance improvement..	A 886		

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{A 000}	INITIAL COMMENTS A revisit survey was conducted on September 14 - 18, 2015 for Allegation # NY00149237 to assess compliance with 42 CFR Part 482, Conditions of Participation for Hospitals. No deficiencies were identified during this survey for the Condition of Participation of Nursing Services. The facility was found to be in substantial compliance with this condition.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	330049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/18/2015**

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K 000	INITIAL COMMENTS The deficiencies below are cited as a result of a Life Safety Survey conducted 09/14/2015 through 09/18/2015. This survey was conducted in conjunction with a Full Survey Following Complaint (Health) survey to determine compliance in accordance with 42 CFR Part 482 Conditions of Participation for hospitals. The Plan of Correction, however, must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not ensure that exit doors have no impediment to the closing of the doors and have positive latch. Finding: During a tour of the hospital on the afternoon of 9/16/2015, the Exit Door next to the laundry room was found to not have a positive latching mechanism as required by NFPA 101- 2000 edition. The above finding was identified in the presence of the Manager of Facility Operation who acknowledged the finding.	K 018		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not ensure that the required automatic sprinkler systems are continuously maintained in reliable operating condition. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Finding:	K 062		

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K 062	Continued From page 2 During a tour of the hospital on the afternoon of 9/17/2015, the sprinkler head in rooms 2112 and 2110 were found to be dirty and dust laden, which prevent their proper functions in the event of fire. The above finding was identified in the presence of the Manager of Facility Operation, who acknowledged the finding.	K 062		
K 145	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2. This STANDARD is not met as evidenced by: Based on staff interview and document review, it was determined that the hospital's emergency generators are not in compliance with the requirement of NFPA 99. The Hospital's Essential Electrical System is not Type I EES because it is not divided into the critical branch, life safety branch and the equipment branch in accordance with NFPA 99 - 3.4.2.2.2. The hospital performs general anesthesia and has patients who use Life Support Systems (Ventilators) and is required to comply with the provision of Type 1 EES system (Essential Electrical System). Findings include: In an interview with the Director of Facilities on 09/17/15 and review of the directions on the panels of the Essential Electrical System (EES), it was determined that the wiring configuration of	K 145		

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K 145	Continued From page 3 the Essential Electrical System in the facility does not conform with Type I EES and therefore, the EES system in the hospital does not comply with 1999 NFPA 99 3-4.2.2.1. The specific issue involved was the separation of the generator branches into a Life Safety branch, Critical, and Equipment Branches as per the requirement of NFPA 99. The Director of Facilities indicated that the hospital as a whole does not have a code compliant EES Type 1 as per NFPA 99 requirement. The Hospital performs general anesthesia and operates a ventilator dependent unit, and as such, requires a Type I EES. Review of the directions on the panels and switches also revealed that items required to be served by the Equipment Branch of the EES system were not independent or separate from items required to be served by the Life Safety Branch of EES system, and/or from items required to be served the Critical Branch of the EES system. 1999 NFPA 99 3-4.2.1.4, 3-4.2.2, NFPA 70: Article 517 and Article 70	K 145		

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A 000	INITIAL COMMENTS The deficiencies below are cited as a result of a Full Survey which was conducted on September 14, 15, 16, 17, and 18, 2015, to assess compliance in accordance with 42 CFR PART 482 Conditions of Participation for Hospitals. The plan of correction must relate to the care of all patients and prevent such occurrences in the the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. The following hospital extension clinic was visited: Hyde Park Satellite Health Center 11 Crum Elbow Road Hyde Park, New York 12538 482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY	A 000	The following report is our plan of corrections in response to the survey findings. The responsible party for the overall plan of correction is the President of Northern Dutchess Hospital, as indicated below.	
A 049	[The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on review of document and staff interview, it was determined the facility did not ensure that the medical staff provided care that was consistent with current standards of practice. Specifically, orders for blood transfusions were incomplete and inadequate. This was found in 2 of 4 medical records reviewed for patients who had received transfusion. (Medical Records #4 and #5). Findings include:	A 049		

Derek Rhodes CNO for — LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Denise George, President — TITLE

10/9/15 — (X6) DATE

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A 049	Continued From page 1 1. A review of MR #4 on September 16, 2015 revealed, this eighty-eight year old patient presented to the facility on August 21, 2015 with a diagnosis of Anemia, Emphysema and a Leaking Heart Valve. The physician wrote an order for transfusion of 2 units of packed red blood cells (PRBC) but did not specify the timeframe that each unit should have been transfused. Each unit of blood was transfused over 2 hours and 55 minutes. 2. A review of MR #5 on September 16, 2015 revealed, this sixty-eight year old patient presented to the facility on August 13, 2015 with diagnoses of Diabetes Mellitus, Total Knee Replacement, Hypertension, Anemia, Spinal Fusion and Mitral and Aortic Stenosis. The physician gave a telephone order to transfuse 2 units of PRBC but did not specify the timeframe for which the units should have been transfused. The first unit was transfused over 3 hours and 55 minutes while the second unit was transfused over 2 hours and 45 minutes These findings were witnessed by the Quality Coordinator on September 15, 2015. Review of the policy titled "Blood Transfusion Guidelines," last revised 5/15, stated PRBC can be transfused over 2 - 3 hours per unit or as ordered by the physician. In addition, this policy also states the "pediatric and elderly patients may require a slower infusion time as per physician"	A 049	482.12(a)(5)Medical Staff The policy "Blood Transfusion Guidelines", last revised 5/2015, has been reviewed. A request was made to the IT department for an EMR revision to add a mandatory dropdown field for specific timeframes when ordering blood product transfusions (excluding FFP). This will be presented for physician approval on 10/19/15 at the Clinical Informatics Council meeting. Then the policy will be revised to remove "usual administration rates" and replaced with "duration of transfusion per provider order". The policy revision will be reviewed for approval by the CNO and the Vice President of Medical Affairs. Education of the practice change will be provided to the Medical Staff and Nursing in anticipation of a "go-live" date of 11/16/2015. Responsible party: Vice President of Medical Affairs	11/16/2015
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited	A 273		

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A 273	Continued From page 2 to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on observation, document review and interview, it was determined the facility failed to (1) develop an effective program to analyze patient data and develop actions for improvement and (2) failed to ensure quality indicators including patient care data, and other relevant data are reported to the hospital Quality Improvement Organization (QIO). Finding Include: (a) On 9/16/15 at 9:30 AM, a review of the facility Quality Assessment and Performance	A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 100% of blood transfusion documentation will continue to be audited until 100% compliance is maintained for a three month period. Continued on next page	10/20/2015

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A 273	Continued From page 3 Improvement (QAPI) Committee meeting minutes for July 2014 to August 2015 was conducted. The blood transfusion audits dated from July 2014 - June 2015 had not been incorporated into the Quality Assessment and Performance Improvement (QAPI) Committee meeting minutes. The hospital wide blood transfusion audit compliance data dated July 2014 to June 2015 ranged from 91% -98% compliance. During interview on 9/16/15, the Quality Coordinator stated that the hospital goal was 100%. There is no evidence that the hospital developed corrective actions. (b) A review of facility documents revealed a nurse was counseled for an incomplete documentation on a blood transfusion flow sheet. The nurse was counseled by the nurse manager for incomplete documentation and incorrect blood transfusion on 4 occasion, specifically on 7/16/15, 7/20/15, 8/10/15 and 9/10/15. There was no evidence that the counseling or corrective actions were analyzed by the QAPI committee. There was no evidence that the blood transfusions reactions or administration errors were tracked and trended and analyzed by the QAPI committee. Furthermore, a QAPI process was not in place for staff to report blood transfusion reactions or administration errors. The Director of Quality Systems was interviewed on 9/17/15 at 10:30 am. She reported that the Quality Coordinator was responsible for tracking the blood transfusions. The surveyor requested the Blood Transfusion Quality Improvement (QI) audit from the Quality Coordinator. The Director of Quality Systems stated that the QPIC book did not contain the blood transfusion QI.	A 273	*Continued from previous page* Blood transfusion audits will be a standing agenda item on the monthly Quality Performance Improvement Committee (QPIC) to report results, analysis, and evolving plan of correction. This will also be reported to the governing board. Responsible party: Director of Quality (b) On the reviewed document, only the entry on 9/10/15 was regarding blood transfusions. From blood transfusion audits, trends of administration errors and their corrective actions will be analyzed and reported at the monthly QPIC as well as presented to the governing board until audit compliance maintains 100% for three months. After Tag A049 above is implemented, the audit will be modified to include adherence to ordered transfusion duration. The lab director will report transfusion reactions and analysis biannually, as scheduled, to QPIC. Responsible party: Director of Quality	10/20/2015

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A 273	Continued From page 4 The Quality Coordinator was interviewed on 9/18/15 at 9:33 am. This interviewee stated that she was responsible for tracking the core measurements for the hospital and ambulatory surgical care and this included immunizations and blood transfusions. She also stated that the blood transfusions are being audited by the unit nurse managers. The Quality Coordinator stated transfusion core measurement were not reported up through Quality Improvement Committee (QPIC) and is not analyzed. (c) Review of the QAPI minutes for the period indicated above, revealed that there was a Pain Control Report which indicated that the hospital tracked and trended "how often was your pain controlled?" The "Pain Controlled" report indicated that from January 2015 to August 2015, the hospital did not meet their established benchmark of 83.03%. The hospital had a pain management control rate of 63.0% to 70% for this period. There is no evidence that the hospital reviewed this data to determine the decrease from 77.8% in June to 63% in July. The report had no evidence that the data was analyzed by the QAPI team and that the hospital developed a plan for improvement. The Patient and Guest Relation Coordinator was interviewed on 9/18/15 at 2:00 pm. This interviewee reported that the hospital did not reach their goal of 83.03% and that there were no analysis of the data. (d) The Hospital "Readmit Report" for 6/1/15 through 8/31/15 indicated that the hospital had 55 patients re-admitted to the hospital within 30 days	A 273	(c) Pain Control is monitored by our Patient Experience committee. Department specific pain scores for each clinical unit will be incorporated into the formal PI program and will be a standing agenda item quarterly at the QPIC during their scheduled reporting. Data will be collected and analyzed for opportunities utilizing the PDCA performance improvement cycle and department managers will be required to document barriers to success and to develop actions planned to effect improvement. Responsible party: Chief Nursing Officer, Director of Quality (d) 30 day readmissions are currently reviewed at the monthly Transition of Care Committee. Analysis will be improved to not only quantify readmissions, but, to qualify the reason for readmission, trend outcomes and determine where improvements are most needed. *Continued on next page*	10/20/2015 11/17/2015

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A 273	Continued From page 5 after discharge. There is no evidence that this data was reviewed and analyzed to identify trends and develop a plan for improvement. Upon interview on 9/18/15 at 9:35 AM, Quality Coordinator confirmed the findings and stated that this information was done at a department level and was never brought to the QAPI committee. Review of the Hospital's Policy and Procedure "Quality Assessment and Performance Improvement 2015-2016," stated: "Data collected are systematically aggregated and analyzed to transform data into meaningful information for implementation of changes that will improve quality care, treatment and services." The hospital did not adhere to their policy and procedure. 482.21 QAPI GOVERNING BODY, STANDARD TAG	A 273	*Continued from previous page* Current categories for readmission analysis will include medication related, discharge planning issues, patient noncompliance, diagnosis related to index diagnosis, diagnosis related to other chronic diagnosis, diagnosis related to new diagnosis not attributed to index admit, medical issue not resolved during index admission, nursing home related issues. Readmission analysis will be incorporated into the standing readmission report at the monthly QPIC and will also be reported to the Board. Responsible party: Director of Quality	
A 308	... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: Based on review of document and staff interview, it was determined the facility did not ensure that all departments audit and reports are included in the hospital wide Quality Assessment and Performance Improvement (QAPI) program.	A 308	The QPIC reporting schedule has been revised to incorporate all departmental PI initiatives, including blood transfusion audits, pain management, and readmission reports.	10/20/2015

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A 308	Continued From page 6 Specifically, there was no evidence that blood transfusions audits, pain management audits and readmission reports are reported up through the QAPI Committee. Findings include: See citation at: Tag A 273. 482.28(b), (b)(1) THERAPEUTIC DIETS §482.28(b) Menus must meet the needs of patients.	A 308		
A 629	(1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: Based on staff interview and review of document, it was determined that that the Food and Nutrition Department did not ensure that (a) physician prescribed diets in 28 of 28 diets, met the therapeutic nutritional needs of patients, (b) hospital menus were prepared based on standard of practice of menu planning, (c) menus developed for emergency preparedness is complete to meet the needs of the patients. Findings include: (1) A review of hospital menus and nutrient analysis was conducted on 9/15/15 at approximately 1:00 PM, in the presence of the Staff Clinical Dietitian and Corporate Clinical Dietitian. The hospital has a one week cycle menu and a diet formulary consisting of approximately 28			

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A 629	Continued From page 7 different diets available to the physician for ordering of diets. Listed below are the deficits identified in the menus and the nutrient analysis of prescribed diets: (a) The master menu had no food portions noted on the food items. (b) There was no through nutritional analysis utilizing the menu by meal and prescribed diet. (c) Diets listed on the physician diet formulary and patient menu are incomplete. Examples: - Low Fat Diet- amount of fat not noted. - High Calorie/High Protein- amount of calorie/protein not noted. - Low Sodium- amount of sodium not listed. - Bariatric diet- liquid or solid not specified. - Vegetarian Diet- no type listed. - High and Low Fiber- amount not noted. (d) Patient's on therapeutic diets did not have the portion size next to the food item on their menu nor did the menu document the correct diet order with the amounts restriction. Due to the absence of nutritional data on the diet formulary, lack of portion size on the menus and a fragmented nutrient analysis; the nutritional adequacy of patient menus and validity of prescribed diets are not met. (2) A review of the hospital's menu was performed on 9/15/15 at approximately 11:00 AM. Present during this review was the Clinical Staff Dietitian and the Corporate Clinical Dietitian.	A 629	(a) The master menu will be reviewed and revised to include food portions. Responsible party: Manager of Food Operations (b) Diets and modifiers will be revised to include nutritional analysis. Responsible party: Clinical Dietician Manager (c) Diet formulary has been revised and will be presented to medical staff for approval. Request will be forwarded to IT for implementation into the EMR and food services database. Education to physicians and food service staff will be provided prior to implementation. Responsible party: Clinical Dietician Manager (d) To ensure that the validity of prescribed diets is met, the nutrition department will review its menu selections. The patient's menu/ tray ticket will be modified to include portion size and diet with restriction amounts. Responsible party: Clinical Dietician Manager/ Manager of Food Operations	01/31/2016 01/31/2016 01/31/2016 01/31/2016

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A 629	Continued From page 8 The menu consist of a 1 week cycle menu. The hospital menus did not have portions next to the food item. Due to the absence of food portions it is unknown if these menus are nutritionally adequate as noted in the hospital policy titled, "Menus." (3) Review of the Food Service Department "Emergency Preparedness Manual," identified the menu in the manual was not complete. Examples: a) The menu noted, prepared powder milk, and there was no instructions on how to prepare this milk. b) The menu does not specify what diets are covered by this menu. c) There is no diagram of where to find the menus food items. d) There was no menu for modified texture diets, i.e. Mechanical soft, Pureed and Clear Liquid. e) There was no mention of enteral feedings for patient on tube feedings. These findings were acknowledged by the Food Service Operation Manager. 482.41(a) MAINTENANCE OF PHYSICAL PLANT	A 629	The master menu will be reviewed and revised to include food portions. Responsible party: Manager of Food Operations	01/31/2016
			(3)The food service department section of the Emergency Preparedness manual will be revised to include the following: instructions on how to reconstitute powdered milk, specific diets that are covered in this manual, a diagram of showing where the kitchen emergency provisions are located, menus for modified texture diets, specifically mechanical soft, pureed, clear liquid, and enteral feedings. Education will be provided to senior management and nursing supervisors. Responsible Party: Manager of Food Operations	11/30/2015
A 701	The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, staff interview and	A 701		

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A 701	Continued From page 9 document review, the hospital did not ensure that the condition of the physical plant and overall hospital environment is maintained in a manner to ensure the safety and well-being of patients. Findings are: During tours of the hospital in the period from 9/15-9/18/201, the following issues were identified in the presence of the Director of Facilities who acknowledged the findings: 1) On 9/15/2015 at 11:25 AM, during a tour of the OR on the third floor of the hospital, the following were identified in the presence of the Director of Facilities. a. The surface of the water fountain outside the OR suite by the staff elevator was found to be dirty, discolored and had a greenish black layer of dirt around the faucet opening and at the drain strainer. b. The scrubbing sinks of the OR suite did not have the proper water temperature. When asked to measure the water temperature from various scrub sinks around the six OR rooms, the temperatures were 65 F, 65 F, 102 F, 83 F, 75 F and 90 Fahrenheit degrees. Per CDC recommendation the hot water Temperature should be between 110 -120 F. c. The floor of the hospital's OR at the expansion joint near ORs 5 and 6 was noted to lack floor tiles and was bumpy and not smooth. This is a tripping hazard and also potential for buildup of	A 701	a. The water fountain has been cleaned and the task added to the daily staff assignments. Weekly monitoring rounds of fountains will be initiated for a period of three months. Results and analysis will be presented at Environment of Care Committee and reported up to QPIC. Responsible party: Manager of Environmental Services. b. The scrubbing sinks were fixed on 9/16/15 to maintain proper temperature. Weekly temperature monitoring will be performed until a goal 95% has been obtained. Audit results will be reported at Environment of Care Committee and reported up to QPIC. Responsible Party: Director of Facilities c. Repair of expansion joint in progress. Responsible Party: Director of Facilities	10/19/2015 10/19/2015 11/10/2015

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A 701	Continued From page 10 dirt and germs as it may be difficult for the area to be cleaned or disinfected easily. 2) During a tour of the ED on the morning of 9/16/2015, the following were identified in the presence of the Director of Facilities and the Nurse Manager of The ED: a. It was found that the hospital has stored clean supplies in the bathroom near the orthopedic room. The bathroom had a wood cabinet used for storage of clean supplies on its top and inside. The stored supplies included but were not limited to: Clean urine culture kits, boxes of clean gloves, clean cups..etc. b. The soiled utility room did not have a hand-wash sink. c. Flies were observed in the clean supply room of the ED. 3) During a tour of the MRI Suite on the afternoon of 9/16/2015, the following were identified in the presence of the Director of Facilities and the Administrator of the Radiology Department: Many unsafe (ferrous containing items) that are incompatible with the MRI unit were found on the MRI suite outside the MRI room. Examples included but were not limited to: a. The chain and tag holder of the fire extinguisher were from ferrous material and are	A 701	a. Supplies kept in the storage area of a rest room have been removed and a designated storage area for urinalysis supplies has been established outside of the rest room. Education has been provided to the Emergency department staff during staff meeting. Responsible party: Director of Emergency Services b. Sink will be installed. Responsible Party: Director of Facilities c. Ongoing monitoring for presence of pests and continued monthly pest control services are in place. In the event of a re-emergence, leadership will be made aware of findings and plan. Garbage dumpster was removed and cleaned. Weekly preventative fly control will be implemented in May 2016. Responsible party: Manager of Environmental Services a. The chain was replaced with nonferrous material.	09/25/2015 11/10/2015 10/01/2015 09/30/2015

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A 701	Continued From page 11 not suitable for use in the MRI, unless these parts are replaced with safe materials. b. The crash cart of the unit was not ferrous free. c. The IV Pole on the unit has metal parts that hold its wheels and these parts are not ferrous free. d. The linen hamper on the unit was found to have metal wheels that are not safe for MRI. 4) During a tour of the ICU on the morning of 9/17/2015, the following were identified in the presence of the Director of Facilities and the Director of Nursing: a. The two airborne isolation rooms of the ICU did not have washable ceiling tiles that are required for this type of room as per AIA guidelines and CDC recommendations. b. The curtain in the ICU were observed touching either the hand-wash sinks or garbage containers. c. Oxygen cylinders were observed being stored in each patient room of the ICU and the Medical - Surgical Unit. It should be noted that the Oxygen Cylinders should not be stored in the patient rooms, instead they need to be stored in a clean supply or storage rooms. d. Red Containers were observed being stored in	A 701	b. Crash cart is chained in place in Zone III. Staff is educated per policy to remove patient from MRI Zone IV in an emergency. All in-house code carts are standardized to include a defibrillator (non-MRI compliant) on top. Risk assessment identified that it is safer to remove patient, then to not have a defibrillator in a code situation. c. Nonferrous IV pole will replace the IV pole in Zone III. d. Nonferrous linen hamper has been purchased to replace ferrous linen cart. Responsible Party: Director of Radiology a. Washable ceiling tiles will be installed. Responsible Party: Director of Facilities b. A stopper on the curtain tracks will be installed to prevent the curtain from touching the sinks and garbage containers. Responsible party: Director of Facilities c. Oxygen cylinders were removed from patient rooms on 9/17/15. Staff will be re-educated on proper storage of medical equipment. Responsible party: Director of ICU d. Red containers will be removed from patient *Continued on next page*	10/09/2015 09/18/2015 10/7/2015 11/10/2015 10/31/2015 11/01/2015 11/01/2015

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A 701	Continued From page 12 the patient bathrooms of the ICU. This finding was brought to the attention of the Director of Nursing who stated that there is not enough space in the patient rooms and they needed the red containers in the room. In the event of a blood transfusion in any room, they will dispose the blood lines in the red containers. Storing the red container in patient bathrooms is potential for the spread of infection. e. The nurses' lounge was being used for storage of personal items, medical equipment and food equipment as follow: Coats and other clothing items; bags, suitcase; medical equipment and IV poles; coffee machines, microwave; boxes of printing papers. This is a potential for the spread of infection and a fire hazard. 5) Flies of different sizes were observed in different location of the hospital. Flies were observed in the clean supply room of the ED; Room 2162 of the Medical Surgical floor on the second floor; in the pantry area of the Ambulatory Surgical Unit and in the Wound Center. When asked, the Manager of the Facility Operations said that they are working with the vendor to take additional measures to address this problem. Review of the facility's Environmental Care Records, showed that there were some complaints and discussion about the spread of the flies since August 2015). 6) During a tour of the Med Surgical unit on the	A 701	*Continued from previous page* Rooms. Staff will be re-educated on proper storage of medical equipment. Responsible party: Director of ICU e. A renovation of the staff lounge will include creating a storage closet with a separate door accessed from the ICU. Medical equipment will also be relocated to the Med Surg storage closet and ICU nurses' station. Responsible parties: Directors of ICU and Facilities. 5) Ongoing monitoring for presence of pests and continued monthly pest control services are in place. In the event of a re-emergence, leadership will be made aware of findings and plan. Garbage dumpster was removed and cleaned. Weekly preventative fly control will be implemented in May 2016. Responsible party: Manager of Environmental Services 6) Nonskid tape on parallel bars will be replaced. Responsible party: Director of Facilities	01/10/2016 10/01/2015 10/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330049	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN DUTCHESS HOSPITAL	6511 SPRINGBROOK AVENUE RHINEBECK, NY 12572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	Continued From page 13 morning of 9/17/2015, the non-skid Tapes were observed being in disrepair and they were coming off the Parallel Bar machine (a machine used for training of people who have problem with balance and those required training for walking). 7) On the morning of 9/18/2015, during a tour of the Central Sterile, in the presence of the Manager of Facility Operation, the following findings were identified: a. The decontamination room was lacking a hand wash sink for the staff to wash hands. b. There was no hand-wash sink in the decontamination room of the endoscopy suite. 8) During a tour of the hospital extension clinic at Hyde Park, on September 18, 2015 at 11:00 AM, the side walk and handicap parking area was broken and in need of repair. This finding was witnessed by the administrator of the clinic when the observation was identified. 482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 701	a. Sink will be installed. Responsible party: Director of Facilities b. Sink will be installed. Responsible party: Director of Facilities 8) Sidewalk will be repaired. Responsible party: Director of Facilities	11/10/2015 11/10/2015 11/30/2015
A 724	Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of policy and procedures and staff interview, it was determined the facility did not maintain equipment to ensure that patients receive care in a safe manner.	A 724		

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A 724	Continued From page 14 Findings include: During a tour of the off-site location "Hyde Park Satellite Health Center" on September 18, 2015 at 11:00 AM revealed all of the exercise equipment did not have inspection stickers to indicate the due date for inspection of the equipment. Staff interview conducted on September 18, 2015 at 11:00 AM revealed the administrator at the location could not provide any documented evidence of the due dates for inspection of the equipment. The facility's policy titled "Quality Assessment and Performance Improvement," last revised July 22, 2014, stated "employees, professional staff members, and volunteers' report immediately to their manager(s), risk management or other management person any defect, error, medical discrepancy, significant or risks to safety that could result in patient injury, hazardous condition, or risks in environment of care. Based on the findings listed above the facility did not ensure that staff followed this policy.	A 724	A review of equipment in the physical therapy facility will be completed by the Department of Bioengineering to determine which equipment requires preventative maintenance as per policy or per manufacturer's instructions. As applicable equipment will be labeled with appropriate PM sticker. Responsible party: Biomedical Coordinator Regarding policy "Quality Assessment and Performance Improvement" the employees of the facility will be re-educated on the importance of reporting any significant risks to patient safety. Responsible party: Director of Physical Medicine	11/01/2015 11/01/2015
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by:	A 749		

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A 749	Continued From page 15 Based on observation, review of document and staff interview, it was determined the facility failed to ensure that patients received care in a clean and sanitary environment. Findings includes: During a tour of the hospital's extension clinic at Hyde Park on September 18, 2015 at 11:05 AM the following observations were identified: The hydrocollator was in need of cleaning. Portions of the heating pads in the hydrocollator had a brown color instead of a white color. This finding was witnessed by the Physical Therapy and Wellness Manager at the time the observations were identified. 482.43(b)(1), (3), (4) DISCHARGE PLANNING NEEDS ASSESSMENT	A 749	A new replacement hydrocollator has been ordered. Cleaning of the new unit and documentation logs will be according to manufacturer's instructions. Responsible party: Director of Physical Medicine	10/31/2015
A 806	(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.	A 806		

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A 806	Continued From page 16 This STANDARD is not met as evidenced by: Based on document review and staff interview, it was determined the hospital failed to ensure that patients are appropriately evaluated prior to discharge. This was evident in 1 of 5 applicable medical record. (MR#13) Findings include: Review of MR#13, indicated this eighty-six year old patient was brought into the hospital's emergency room by EMS (Emergency Medical Service) on 9/8/15 due to a fall at home. She complained of pain in the lower back. The hospital triage assessment indicated that the patient has an history of falls "within last 3 months." The patient lives alone. On 9/9/15, the Discharge Planner completed an assessment of the patient. There is no documentation that the patient's post discharge care needs were assessed.. There was no documentation whether or not the patient is able to effectively manage all activities of daily living. The discharge planner wrote that prior to the admission the patient had 2 hours of home care each week. There was no documentation of current home care service need or the patient's social support systems and their availability to assist. Upon interview on 9/16/15 at 12:02 PM, Discharge Planner acknowledged the findings and stated that the patient has a daughter who is involved in her care. When asked where the	A 806	All discharge planning (case management) staff will be re-educated to the elements required for an appropriate discharge assessment; including capacity for self-care or need to be cared for by others, setting they came from, whether patient will need specialized medical equipment or permanent physical modifications at home, if family or friends are available to help, are community based services available if warranted, post discharge medical appointments, and insurance coverage. An audit of 25 random assessments per month will be done to determine that the appropriate discharge assessment has been completed. This audit will be conducted until a goal of 95% has been obtained. Results of this audit will be reported monthly to QPIC. Responsible party: Director of Case Management	11/01/2015

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A 806	Continued From page 17 daughter lives in proximity of the patient, she replied that the daughter lives in New Jersey. The Hospital's "Patient Care Services Policy and Procedure," last reviewed 6/15, stated the Case Coordinator will initiate needed services as appropriate. This policy and procedure has no information requiring the need for an assessment of the patient's post discharge needs. 482.45(a)(1) OPO AGREEMENT	A 806		
A 886	Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on review of the Organ, Tissue and Eye Procurement Program (OPO) Manual and staff interview, it was determined that the facility failed to ensure that this program was integrated into the Hospital Wide Quality Assessment and Performance Improvement Program (QAPI). Findings include: 1. A review of the hospital's Organ, Tissue and	A 886	The OPO quarterly report card on timely referrals will be integrated into departmental PI for process improvement purposes.	10/20/2015

Continued on next page

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A 886	Continued From page 18 Eye Procurement (OPO) Program Manual was conducted on 9/15/15 at approximately 2:30 PM. Present during the review of the contract was the Organ Donation Coordinator. The surveyor requested the facility's tracking data and quality assessment program concerning compliance with time notification. The Organ Donation Coordinator informed the surveyor that she did not have a quality assurance program. She only had the reports sent to her by OPO and data on in-service provided to nurses. The facility's current yearly timeliness in organ referral is 71.4%. The report notes that in prior year it was 100%. The tissue donation report notes that the current yearly timeliness in tissue referral is at 88.7%. The year prior it was at 93.8%. The OPO Program does not follow the facility's policy for quality assessment and performance improvement..	A 886	*Continued from previous page* Results will be analyzed and evolving plans of correction will be presented, as scheduled, to QPIC which gets reported up to the Board. This will remain a Performance Improvement until sustained improvement in timely reporting has reached a goal of 95%. Responsible Party: Director of ICU	

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A 886	Continued From page 18 Eye Procurement (OPO) Program Manual was conducted on 9/15/15 at approximately 2:30 PM. Present during the review of the contract was the Organ Donation Coordinator. The surveyor requested the facility's tracking data and quality assessment program concerning compliance with time notification. The Organ Donation Coordinator informed the surveyor that she did not have a quality assurance program. She only had the reports sent to her by OPO and data on in-service provided to nurses. The facility's current yearly timeliness in organ referral is 71.4%. The report notes that in prior year it was 100%. The tissue donation report notes that the current yearly timeliness in tissue referral is at 88.7%. The year prior it was at 93.8%. The OPO Program does not follow the facility's policy for quality assessment and performance improvement.	A 886	*Continued from previous page* Results will be analyzed and evolving plans of correction will be presented quarterly on an ongoing basis to QPIC which will then be reported up to the Board on a continuing basis. The goal of this Performance Improvement initiative is 95%. Responsible Party: Director of ICU	

COMPLETENESS EXHIBIT E

FOR-PROFIT

Applicant Name: Sharon Hospital
Financial Worksheet (B)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format.

LINE	Total Entity:	(1) FY 2015 Actual Results	(1a) FY 2016 Actual (est) Results	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON	(11) FY 2020 Projected W/out CON	(12) FY 2020 Projected Incremental	(13) FY 2020 Projected With CON
	Description														
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$143,606,025	$143,045,832	$145,191,519	$12,601,211	$157,792,731	$147,369,392	$39,143,763	$186,513,155	$149,579,933	$43,098,890	$192,678,823	$151,823,632	$44,410,471	$196,234,103
2	Less: Allowances	$90,594,383	$89,942,355	$91,291,490	$7,617,521	$98,909,012	$92,660,863	$23,319,935	$115,980,798	$94,050,776	$25,864,445	$119,915,221	$95,461,537	$26,689,364	$122,150,901
3	Less: Charity Care	$741,722	$536,593	$541,959	$47,037	$588,996	$547,379	$145,393	$692,771	$552,852	$159,295	$712,147	$558,381	$163,334	$721,715
4	Less: Other Deductions	$853,781	$832,193	$840,515	$72,949	$913,463	$848,920	$225,487	$1,074,407	$857,409	$247,048	$1,104,457	$865,983	$253,312	$1,119,295
	Net Patient Service Revenue	**$51,416,139**	**$51,734,691**	**$52,517,555**	**$4,863,704**	**$57,381,259**	**$53,312,231**	**$15,452,947**	**$68,765,178**	**$54,118,896**	**$16,828,102**	**$70,946,998**	**$54,937,731**	**$17,304,461**	**$72,242,192**
5	Medicare	$22,417,977	$22,674,886	$23,018,009	$2,131,721	$25,149,730	$23,366,309	$6,772,899	$30,139,208	$23,719,864	$7,375,618	$31,095,481	$24,078,752	$7,584,402	$31,663,154
6	Medicaid (CT & NY)	$4,630,448	$4,497,479	$4,565,537	$422,819	$4,988,356	$4,634,620	$1,343,379	$5,978,000	$4,704,747	$1,462,926	$6,167,673	$4,775,931	$1,504,338	$6,280,269
7	CHAMPUS & TriCare	$85,803	$86,335	$87,641	$8,117	$95,758	$88,967	$25,788	$114,755	$90,313	$28,083	$118,396	$91,680	$28,878	$120,557
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$27,134,228**	**$27,258,700**	**$27,671,187**	**$2,562,657**	**$30,233,843**	**$28,089,897**	**$8,142,066**	**$36,231,962**	**$28,514,924**	**$8,866,627**	**$37,381,550**	**$28,946,363**	**$9,117,617**	**$38,063,980**
9	Commercial Insurers	$20,061,924	$19,533,993	$19,829,587	$1,836,438	$21,666,025	$20,129,641	$5,834,726	$25,964,367	$20,434,221	$6,353,958	$26,788,179	$20,743,397	$6,533,821	$27,277,218
10	Uninsured	$230,791	$253,870	$257,712	$23,867	$281,579	$261,611	$75,830	$337,441	$265,570	$82,578	$348,148	$269,588	$84,916	$354,504
11	Self Pay	$2,048,841	$2,735,751	$2,777,149	$257,195	$3,034,344	$2,819,172	$817,158	$3,636,330	$2,861,828	$889,877	$3,751,705	$2,905,129	$915,067	$3,820,195
12	Workers Compensation	$925,487	$931,221	$945,312	$87,546	$1,032,859	$959,617	$278,152	$1,237,769	$974,136	$302,905	$1,277,041	$988,875	$311,479	$1,300,355
13	Other	$1,014,868	$1,021,156	$1,036,609	$96,001	$1,132,610	$1,052,294	$305,015	$1,357,309	$1,068,216	$332,159	$1,400,375	$1,084,379	$341,561	$1,425,940
	Total Non-Government	**$24,281,911**	**$24,475,991**	**$24,846,369**	**$2,301,048**	**$27,147,416**	**$25,222,334**	**$7,310,882**	**$32,533,216**	**$25,603,972**	**$7,961,476**	**$33,565,448**	**$25,991,368**	**$8,186,844**	**$34,178,212**
	Net Patient Service Revenuea (Government+Non-Government)	**$51,416,139**	**$51,734,691**	**$52,517,555**	**$4,863,704**	**$57,381,259**	**$53,312,231**	**$15,452,947**	**$68,765,178**	**$54,118,896**	**$16,828,102**	**$70,946,998**	**$54,937,731**	**$17,304,461**	**$72,242,192**
14	Less: Provision for Bad Debts	$1,930,565	$2,583,831	$2,325,448	$215,362	**$2,540,810**	$2,348,702	$680,789	**$3,029,491**	$2,372,189	$737,625	**$3,109,814**	$2,395,911	$754,672	**$3,150,583**
	Net Patient Service Revenue less provision for bad debts	**$49,485,574**	**$49,150,860**	**$50,192,107**	**$4,648,342**	**$54,840,450**	**$50,963,529**	**$14,772,159**	**$65,735,687**	**$51,746,707**	**$16,090,477**	**$67,837,184**	**$52,541,819**	**$16,549,789**	**$69,091,608**
15	Other Operating Revenue	$851,556	$577,554	$577,554	$0	**$577,554**	$583,330	$0	**$583,330**	$589,163	$0	**$589,163**	$595,054	$0	**$595,054**
17	Net Assets Released from Restrictions	$0	$0	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$50,337,130**	**$49,728,414**	**$50,769,661**	**$4,648,342**	**$55,418,004**	**$51,546,858**	**$14,772,159**	**$66,319,017**	**$52,335,869**	**$16,090,477**	**$68,426,347**	**$53,136,874**	**$16,549,789**	**$69,686,663**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$17,318,636	$17,915,581	$18,273,893	$0	$18,273,893	$18,639,370	$898,560	$19,537,930	$19,012,158	$1,149,811	$20,161,969	$19,392,401	$1,172,807	$20,565,208
2	Fringe Benefits	$4,138,300	$3,684,422	$3,758,110	$0	$3,758,110	$3,833,273	$184,793	$4,018,066	$3,909,938	$236,464	$4,146,402	$3,988,137	$241,193	$4,229,330
3	Physicians Fees	$1,806,481	$2,499,784	$2,499,784	$97,274	$2,597,058	$2,499,784	$309,059	$2,808,843	$2,499,784	$336,562	$2,836,346	$2,499,784	$346,089	$2,845,873
4	Supplies and Drugs	$5,438,800	$5,565,783	$5,844,072	$541,225	$6,385,298	$6,136,276	$1,778,645	$7,914,921	$6,443,090	$2,003,459	$8,446,548	$6,765,244	$2,130,938	$8,896,182
5	Depreciation and Amortization	$2,548,585	$1,299,760	$1,338,753	$44,900	$1,383,652	$1,378,915	$24,818	$1,403,734	$1,420,283	$718,411	$2,138,693	$1,462,891	$1,411,382	$2,874,274
6	Provision for Bad Debts-Otherb	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$18,377	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676	$29,676	$0	$29,676
8	Malpractice Insurance Cost	$1,288,699	$896,570	$896,570	$0	$896,570	$896,570	$259,877	$1,156,447	$896,570	$278,786	$1,175,356	$896,570	$282,404	$1,178,974
9	Lease Expense	$246,778	$388,838	$200,244	$0	$200,244	$71,021	$0	$71,021	$71,021	$0	$71,021	$71,021	$0	$71,021
10	Other Operating Expenses	$15,588,586	$17,265,810	$17,438,468	$486,370	$17,924,839	$17,612,853	$1,545,295	$19,158,148	$17,788,981	$1,682,810	$19,471,792	$17,966,871	$1,730,446	$19,697,317
	TOTAL OPERATING EXPENSES	**$48,393,242**	**$49,546,224**	**$50,279,570**	**$1,169,770**	**$51,449,340**	**$51,097,738**	**$5,001,048**	**$56,098,786**	**$52,071,501**	**$6,406,302**	**$58,477,803**	**$53,072,595**	**$7,315,261**	**$60,387,856**
	INCOME/(LOSS) FROM OPERATIONS	**$1,943,888**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
	NON-OPERATING INCOME	**($15,331,206)**	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	Income before provision for income taxes	**($13,387,318)**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
	Provision for income taxesc	**$1,683,460**	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	NET INCOME	**($15,070,778)**	**$182,190**	**$490,091**	**$3,478,573**	**$3,968,664**	**$449,120**	**$9,771,111**	**$10,220,231**	**$264,369**	**$9,684,175**	**$9,948,544**	**$64,278**	**$9,234,528**	**$9,298,807**
C.	**Retained Earnings, beginning of year**		**$21,513,301**	**$21,695,491**	**$0**	**$21,695,491**	$3,478,573	$0	**$3,478,573**	$13,698,804	$0	**$13,698,804**	$23,647,347	**$0**	**$23,647,347**
	Retained Earnings, end of year	**$21,513,301**	**$21,695,491**	**$22,185,582**	**($18,707,010)**	**$3,478,573**	$3,927,693	**$9,771,111**	**$13,698,804**	$13,963,172	**$9,684,175**	**$23,647,347**	$23,711,626	**$9,234,528**	**$32,946,154**
	Principal Payments	$0	$0	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
D.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**5.6%**	**0.4%**	**1.0%**	**74.8%**	**7.2%**	**0.9%**	**66.1%**	**15.4%**	**0.5%**	**60.2%**	**14.5%**	**0.1%**	**55.8%**	**13.3%**
2	Hospital Non Operating Margin	**-43.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-43.1%**	**0.4%**	**1.0%**	**74.8%**	**7.2%**	**0.9%**	**66.1%**	**15.4%**	**0.5%**	**60.2%**	**14.5%**	**0.1%**	**55.8%**	**13.3%**
E.	**FTEs**	**254**	**257**	**257**	**0**	**257**	**257**	**12**	**269**	**257**	**18**	**275**	**257**	**18**	**275**
F.	**VOLUME STATISTICSd**														
1	Inpatient Discharges	2,466	2,411	2,435	363	**2,798**	2,459	1,227	**3,686**	2,484	1,297	**3,781**	2,509	1,326	**3,835**
2	Outpatient Visits	90,592	90,590	91,496	3,813	**95,309**	92,411	10,131	**102,542**	93,335	11,980	**105,315**	94,268	12,626	**106,894**
	TOTAL VOLUME	**93,058**	**93,001**	**93,931**	**4,176**	**98,107**	**94,870**	**11,358**	**106,228**	**95,819**	**13,278**	**109,096**	**96,777**	**13,953**	**110,729**

aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
bProvide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
cProvide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
dProvide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

COMPLETENESS EXHIBIT F

SHARON HOSPITAL HOLDING COMPANY, INC. AND SUBSIDIARY AND AFFILIATES
CONSOLIDATING STATEMENT OF OPERATIONS
For the Year Ended September 30, 2015

Clinics

	Sharon Hospital Holding Co., Inc.	Essent Healthcare of Connecticut, Inc.	Regional Healthcare Associates, LLC	Tri State Women's Services, LLC	Eliminations	Consolidated Sharon Hospital Holding Co., Inc.
Net revenue:						
Net patient revenue	$ -	$ 51,416,139	$ 3,884,807	$ 1,884,308	$ -	$ 57,185,254
Provision for doubtful accounts	-	(1,930,565)	(242,330)	(60,584)	-	(2,233,479)
Net patient revenue, less provision for doubtful accounts	-	49,485,574	3,642,477	1,823,724	-	54,951,775
Electronic health record income	-	442,663	-	-	-	442,663
Other revenue	-	408,893	82,607	300,652	(300,652)	491,500
Total net revenues	-	50,337,130	3,725,084	2,124,376	(300,652)	55,885,938
Operating expenses:						
Salaries and benefits	-	21,456,936	4,572,602	65,164	-	26,094,702
Professional services	-	8,507,102	1,207,651	2,204,776	(300,652)	11,618,877
Supplies	-	5,324,310	235,050	122,923	-	5,682,283
Other operating expenses	-	8,909,766	407,352	163,526		9,480,644
Depreciation and amortization	-	2,548,585	-	-	-	2,548,585
Total operating expenses	-	(A) 46,746,699	(A) 6,422,655	(A) 2,556,389	(A) (300,652)	55,425,091
			# 8,678,392			
Income (loss) before interest, intercompany fees, impairment loss and income tax provision	-	3,590,431	(2,697,571)	(432,013)	-	460,847
Interest (income) expense, net	-	(A) (50,844)	-	-	-	(50,844)
Intercompany fees	-	(B) 3,129,584	(B) (2,697,571)	(B) (432,013)	-	-
Managagement fee from RegionalCare	-	(A) 1,697,387	-	-	-	1,697,387
Impairment loss on long-lived assets	-	15,331,206	-	-	-	15,331,206
Loss before income tax provision	-	(16,516,902)	-	-	-	(16,516,902)
Income tax provision	-	1,683,460	-	-	-	1,683,460
Net loss	$ -	$ (B) (18,200,362)	$ -	$ -	$ -	$ (18,200,362)

See accompanying independent auditor's report.

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SH000878
01/17/2017

COMPLETENESS EXHIBIT G

NON-PROFIT

Applicant: Heath Quest Systems - Hospital
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY15 Actual Results	(1) FY16 (10/15-9/16) Actual Results	(2) FY17 Projected W/out CON	(3) FY17 (3 mo.) Projected Incremental	(4) FY17 Projected With CON	(5) FY18 Projected W/out CON	(6) FY18 Projected Incremental	(7) FY18 Projected With CON	(8) FY19 Projected W/out CON	(9) FY19 Projected Incremental	(10) FY19 Projected With CON	(11) FY20 Projected W/out CON	(12) FY20 Projected Incremental	(13) FY20 Projected With CON
	Description														
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$2,374,832,000	$2,604,438,000	$2,655,559,000	$39,448,183	$2,695,007,183	$2,740,023,000	$186,513,155	$2,926,536,155	$2,899,092,000	$192,678,823	$3,091,770,823	$2,944,688,000	$196,234,103	$3,140,922,103
2	Less: Allowances	$1,464,665,000	$1,610,246,260	$1,564,843,260	$24,727,253	$1,589,570,513	$1,583,734,393	$115,980,798	$1,699,715,191	$1,650,457,357	$119,915,221	$1,770,372,578	$1,643,449,110	$122,150,901	$1,765,600,011
3	Less: Charity Care	$41,274,000	$41,686,740	$42,103,607	$147,249	$42,250,856	$42,524,643	$692,771	$43,217,415	$42,949,890	$712,147	$43,662,037	$43,379,389	$721,715	$44,101,104
4	Less: Other Deductions				$228,366	$228,366		$1,074,407	$1,074,407		$1,104,457	$1,104,457		$1,119,295	$1,119,295
	Net Patient Service Revenue	**$868,893,000**	**$952,505,000**	**$1,048,612,133**	**$14,345,315**	**$1,062,957,448**	**$1,113,763,964**	**$68,765,178**	**$1,182,529,142**	**$1,205,684,753**	**$70,946,998**	**$1,276,631,751**	**$1,257,859,501**	**$72,242,192**	**$1,330,101,693**
5	Medicare	$408,379,710	$447,677,350	$492,847,702	$6,287,433	$499,135,135	$523,469,063	$30,139,208	$553,608,271	$566,671,834	$31,095,481	$597,767,315	$591,193,966	$31,663,154	$622,857,119
6	Medicaid	$165,089,670	$180,975,950	$199,236,305	$1,247,089	$200,483,394	$211,615,153	$5,978,000	$217,593,153	$229,080,103	$6,167,673	$235,247,776	$238,993,305	$6,280,269	$245,273,574
7	CHAMPUS & TriCare	$0	$0	$0	$23,939	$23,939	$0	$114,755	$114,755	$0	$118,396	$118,396	$0	$120,557	$120,557
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$573,469,380**	**$628,653,300**	**$692,084,008**	**$7,558,461**	**$699,642,468**	**$735,084,216**	**$36,231,962**	**$771,316,178**	**$795,751,937**	**$37,381,550**	**$833,133,488**	**$830,187,271**	**$38,063,980**	**$868,251,251**
9	Commercial Insurers	$8,688,930	$9,525,050	$10,486,121	$5,416,506	$15,902,628	$11,137,640	$25,964,367	$37,102,007	$12,056,848	$26,788,179	$38,845,027	$12,578,595	$27,277,218	$39,855,813
10	Uninsured	$0	$0	$0	$70,395	$70,395	$0	$337,441	$337,441	$0	$348,148	$348,148	$0	$354,504	$354,504
11	Self Pay	$17,377,860	$19,050,100	$20,972,243	$758,586	$21,730,829	$22,275,279	$3,636,330	$25,911,609	$24,113,695	$3,751,705	$27,865,400	$25,157,190	$3,820,195	$28,977,385
12	Workers Compensation	$8,688,930	$9,525,050	$10,486,121	$258,215	$10,744,336	$11,137,640	$1,237,769	$12,375,408	$12,056,848	$1,277,041	$13,333,889	$12,578,595	$1,300,355	$13,878,950
13	Other	$260,667,900	$285,751,500	$314,583,640	$283,152	$314,866,792	$334,129,189	$1,357,309	$335,486,498	$361,705,426	$1,400,375	$363,105,801	$377,357,850	$1,425,940	$378,783,790
	Total Non-Government	**$295,423,620**	**$323,851,700**	**$356,528,125**	**$6,786,854**	**$363,314,979**	**$378,679,748**	**$32,533,216**	**$411,212,964**	**$409,932,816**	**$33,565,448**	**$443,498,264**	**$427,672,230**	**$34,178,212**	**$461,850,442**
	Net Patient Service Revenuea (Government+Non-Government)	**$868,893,000**	**$952,505,000**	**$1,048,612,133**	**$14,345,315**	**$1,062,957,447**	**$1,113,763,964**	**$68,765,178**	**$1,182,529,142**	**$1,205,684,753**	**$70,946,998**	**$1,276,631,752**	**$1,257,859,501**	**$72,242,192**	**$1,330,101,693**
14	Less: Provision for Bad Debts	$25,591,000	$27,144,000	$32,544,000	$635,203	**$33,179,203**	$34,432,000	$3,029,491	**$37,461,491**	$36,059,000	$3,109,814	**$39,168,814**	$37,403,000	$3,150,583	**$40,553,583**
	Net Patient Service Revenue less provision for bad debts	**$843,302,000**	**$925,361,000**	**$1,016,068,133**	**$13,710,112**	**$1,029,778,245**	**$1,079,331,964**	**$65,735,687**	**$1,145,067,651**	**$1,169,625,753**	**$67,837,184**	**$1,237,462,937**	**$1,220,456,501**	**$69,091,608**	**$1,289,548,110**
15	Other Operating Revenue	$27,547,000	$30,822,000	$29,243,000	$144,389	**$29,387,389**	$31,326,000	$583,330	**$31,909,330**	$33,485,000	$589,163	**$34,074,163**	$33,749,000	$595,054	**$34,344,054**
17	Net Assets Released from Restrictions					**$0**		$0	**$0**		$0	**$0**		$0	**$0**
	TOTAL OPERATING REVENUE	**$870,849,000**	**$956,183,000**	**$1,045,311,133**	**$13,854,501**	**$1,059,165,633**	**$1,110,657,964**	**$66,319,017**	**$1,176,976,980**	**$1,203,110,753**	**$68,426,347**	**$1,271,537,100**	**$1,254,205,501**	**$69,686,663**	**$1,323,892,164**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$395,322,000	$416,834,000	$441,418,000	$4,568,473	$445,986,473	$462,515,000	$19,537,930	$482,052,930	$484,167,000	$20,161,969	$504,328,969	$506,211,000	$20,565,208	$526,776,208
2	Fringe Benefits	$112,560,000	$119,731,000	$127,910,000	$939,528	$128,849,528	$133,845,000	$4,018,066	$137,863,066	$140,383,000	$4,146,402	$144,529,402	$146,960,000	$4,229,330	$151,189,330
3	Physicians Fees			$60,668,000	$649,265	$61,317,265	$60,735,000	$2,808,843	$63,543,843	$60,806,000	$2,836,346	$63,642,346	$60,818,000	$2,845,873	$63,663,873
4	Supplies and Drugs	$131,573,000	$146,046,000	$163,223,000	$1,596,324	$164,819,324	$177,599,000	$7,914,921	$185,513,921	$196,440,000	$8,446,548	$204,886,548	$204,992,000	$8,896,182	$213,888,182
5	Depreciation and Amortization	$47,934,000	$52,424,000	$61,446,000	$345,913	$61,791,913	$69,031,000	$1,403,734	$70,434,734	$88,874,000	$2,138,693	$91,012,693	$95,504,000	$2,874,274	$98,378,274
6	Provision for Bad Debts-Otherb				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$9,391,000	$9,323,000	$9,004,000	$7,419	$9,011,419	$12,604,000	$29,676	$12,633,676	$23,597,000	$29,676	$23,626,676	$22,994,000	$29,676	$23,023,676
8	Malpractice Insurance Cost				$224,143	$224,143		$1,156,447	$1,156,447		$1,175,356	$1,175,356		$1,178,974	$1,178,974
9	Lease Expense				$50,061	$50,061		$71,021	$71,021		$71,021	$71,021		$71,021	$71,021
10	Other Operating Expenses	$136,650,000	$152,583,000	$111,820,000	$4,481,210	$116,301,210	$116,016,000	$19,158,148	$135,174,148	$122,984,000	$19,471,792	$142,455,792	$124,726,000	$19,697,317	$144,423,317
	TOTAL OPERATING EXPENSES	**$833,430,000**	**$896,941,000**	**$975,489,000**	**$12,862,335**	**$988,351,335**	**$1,032,345,000**	**$56,098,786**	**$1,088,443,786**	**$1,117,251,000**	**$58,477,803**	**$1,175,728,803**	**$1,162,205,000**	**$60,387,856**	**$1,222,592,856**
	INCOME/(LOSS) FROM OPERATIONS	**$37,419,000**	**$59,242,000**	**$69,822,133**	**$992,166**	**$70,814,299**	**$78,312,964**	**$10,220,231**	**$88,533,194**	**$85,859,753**	**$9,948,544**	**$95,808,297**	**$92,000,501**	**$9,298,807**	**$101,299,308**
	NON-OPERATING REVENUE	**($4,648,000)**	**($20,346,000)**	**$12,720,000**	**$0**	**$12,720,000**	**$12,720,000**	**$0**	**$12,720,000**	**$12,720,000**	$0	**$12,720,000**	**$12,720,000**		**$12,720,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$32,771,000**	**$38,896,000**	**$82,542,133**	**$992,166**	**$83,534,299**	**$91,032,964**	**$10,220,231**	**$101,253,194**	**$98,579,753**	**$9,948,544**	**$108,528,297**	**$104,720,501**	**$9,298,807**	**$114,019,308**
	Principal Payments					**$0**			**$0**			**$0**			**$0**
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**4.3%**	**6.3%**	**6.6%**	**7.2%**	**6.6%**	**7.0%**	**15.4%**	**7.4%**	**7.1%**	**14.5%**	**7.5%**	**7.3%**	**13.3%**	**7.6%**
2	Hospital Non Operating Margin	**-0.5%**	**-2.2%**	**1.2%**	**0.0%**	**1.2%**	**1.1%**	**0.0%**	**1.1%**	**1.0%**	**0.0%**	**1.0%**	**1.0%**	**0.0%**	**1.0%**
3	Hospital Total Margin	**3.8%**	**4.2%**	**7.8%**	**7.2%**	**7.8%**	**8.1%**	**15.4%**	**8.5%**	**8.1%**	**14.5%**	**8.5%**	**8.3%**	**13.3%**	**8.5%**
D.	FTEs	**4,739**	**4,762**	4,832	64	**4,896**	4,878	269	**5,147**	4,918	275	**5,193**	4,930	275	**5,205**
E.	**VOLUME STATISTICSc**														
1	Inpatient Discharges	33,674	35,206	36,262	700	**36,962**	37,350	3,686	**41,036**	38,677	3,781	**42,458**	39,085	3,835	**42,920**
2	Outpatient Visits	2,232,267	2,455,494	2,781,929	23,827	**2,805,756**	3,070,814	102,542	**3,173,356**	3,333,985	105,315	**3,439,300**	3,384,166	106,894	**3,491,060**
	TOTAL VOLUME	**2,265,941**	**2,490,700**	**2,818,191**	**24,527**	**2,842,718**	**3,108,164**	**106,228**	**3,214,392**	**3,372,662**	**109,096**	**3,481,758**	**3,423,251**	**110,729**	**3,533,980**

aTotal amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
bProvide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
cProvide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Olejarz, Barbara

From: Schaeffer-Helmecki, Jessica
Sent: Thursday, February 16, 2017 2:54 PM
To: dping@health-quest.org
Cc: User, OHCA; Riggott, Kaila; Fernandes, David; Olejarz, Barbara; Jennifer Groves Fusco
Subject: Sharon Hospital and RHA Completeness Letter
Attachments: 16-32133 2nd Final completeness.docx; 16-32132 Completeness Letter 2 Final.docx

Dear Mr. Ping,

Attached please find second completeness letters for the transfer of ownership of RHA and Sharon Hospital to Vassar. Please confirm receipt of this message.

Thank you and have a good afternoon,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

February 16, 2017 Via Email Only

Mr. David Ping
Health Quest Systems, Inc.
Senior Vice President of Strategic Planning & Business Development
1351 Route 55, Suite 200
LaGrangeville, NY 12540
dping@health-quest.org

RE: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Certificate of Need Completeness Letter

Dear Mr. Ping:

On November 3, 2016, OHCA received the Certificate of Need application from Essent Healthcare of Connecticut, Inc. ("Essent"), a subsidiary of HealthQuest Systems, Inc. ("HealthQuest") and Vassar Health Connecticut ("Vassar") (collectively "the Applicants") seeking authorization to transfer ownership interest in The Sharon Hospital (the "Hospital") to Vassar. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please "reply all" electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to both of the following addresses: OHCA@ct.gov and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 881** and reference "**Docket Number: 16-32132-CON**."

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **April 17, 2017**, otherwise your application will be automatically considered withdrawn.

1. As required by Public Act 15-146 section 30 (to be codified, as amended, as Connecticut General Statute 19a-639a), submit any financial gains realized by each officer, director, board member or senior manager of the hospital and of the purchaser, as a result of the transaction, in the table below. Add rows as necessary. For each such person, list:
   a. The specific person's name;
   b. Such person's position type and whether associated with the hospital, the purchaser or both;
   c. The amount of any expected increase or decrease in such person's salary, inclusive of bonuses;
   d. The amount of any expected severance payments received by such person; and
   e. The value, based on the date of issuance, of any stock or stock options expected to be issued to such person.

TABLE 1
FINANCIAL IMPACT ON CERTAIN HOSPITAL & PURCHASER ASSOCIATES

	Name	With TCHH, HCC or both	Position Type*	Amount of increase/ (decrease) in salary	Severance Payment	Stock Value	Value of other financial gain	Total
1								
2								
3								
4								
5								
6								
7								

* Indicate whether an Officer, Director, Board Member or Senior manager (may select more than one, if applicable).

2. In regard to health care services at Sharon Hospital, complete the following:

   a. Submit a plan demonstrating how health care services will be provided by Sharon Hospital for the first three fiscal years following the transfer of ownership;
   b. Complete the table below (note: it should reflect the information provided in the Hospital services plan, above). List the inpatient and outpatient services currently offered by the Hospital. For each service, indicate (by placing an "X" in the appropriate column) if applicants plan to consolidate, reduce, eliminate or expand services in the three fiscal years following the transfer of ownership; and
   c. Indicate what, if any, new services Sharon Hospital will be adding in the three fiscal years following the transfer of ownership.

TABLE 2
TCHH SERVICE PLAN FOR FIRST THREE FISCAL YEARS

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Inpatient (list existing & planned)								
Outpatient (list existing & planned)								

3. The Applicants state on page 646 of the application that there are currently no tertiary services in Sharon Hospital's primary service area. Please explain:

   a. how the Applicants are defining the term "tertiary services" and
   b. for which such tertiary services Applicants will refer patients from Sharon Hospital's Connecticut primary service area to Vassar Brothers, Northern Dutchess Hospital or Putnam Hospital Center.

4. The Applicants state that they intend to invest in the renovation of medical oncology and infusion space and cite this as one of the largest services for which Sharon-area patients must travel elsewhere. In 2014, Yale-New Haven Hospital terminated its oncology services at Sharon Hospital, citing low patient volumes due to it not being a "full service" site. Yale also cited low volume as an obstacle to retaining the necessary oncologists and offering clinical trials to patients. Would the cancer treatment center be a full-service site offering radiation therapy?

5. The anticipated capital improvements outlined on page 645 to 646 will cost, according to the Applicant's estimates, at least $11.5 million. How does HealthQuest intend to fund the $5.5 million in capital expenditures in excess of the $6 million Working Capital Grant committed by FCH?

6. In projecting the average daily census (ADC) for existing physician service lines on page 650, the Applicants identify "expanding choice" for OB/GYN patients as a driver for the increase in ADC. Please clarify what or how choice(s) will be expanded.

If you have any questions concerning this letter, please feel free to contact Kaila Riggott at (860) 418-7037.

Olejarz, Barbara

From: Ping, David <DPing@Health-quest.org>
Sent: Thursday, February 16, 2017 3:56 PM
To: Schaeffer-Helmecki, Jessica
Cc: User, OHCA; Riggott, Kaila; Fernandes, David; Olejarz, Barbara; Jennifer Groves Fusco
Subject: RE: Sharon Hospital and RHA Completeness Letter

Thank you Jessica. I am in receipt of the message and we will review and get the answers back to you

---

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Thursday, February 16, 2017 2:54 PM
To: Ping, David
Cc: User, OHCA; Riggott, Kaila; Fernandes, David; Olejarz, Barbara; Jennifer Groves Fusco
Subject: Sharon Hospital and RHA Completeness Letter

Dear Mr. Ping,

Attached please find second completeness letters for the transfer of ownership of RHA and Sharon Hospital to Vassar. Please confirm receipt of this message.

Thank you and have a good afternoon,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075 | F: (860) 418-7053 | E: jessica.schaeffer-helmecki@ct.gov

About Health Quest Systems, Inc.

Health Quest Systems, Inc., headquartered in LaGrangeville, New York, is a leading non-profit healthcare system in the Mid-Hudson Valley. The network includes three medical centers: Vassar Brothers Medical Center in Poughkeepsie, Northern Dutchess Hospital in Rhinebeck, and Putnam Hospital Center in Carmel. It also includes Health Quest Medical Practice, Health Quest Urgent Care, and several affiliates, including Hudson Valley Home Care and The Heart Center. Health Quest comprises 597 licensed beds and more than 5,000 employees.

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, February 21, 2017 4:05 PM
To: Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David; User, OHCA
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com); Ping, David
Subject: Sharon Hospital Transfer of Ownership -- Docket No. 16-32132-CON
Attachments: DOCS-#1486920-v1-HEALTH_QUEST_SHARON_CQR2_(HOSPITAL_-_FINAL).pdf; DOCS-#1483721-v1-HEALTH_QUEST_SHARON_CQR_2_(HOSPITAL).docx

All,

Attached are Sharon Hospital's responses to OHCA's February 16th Completeness Questions. Please confirm receipt and let me know if you require anything further.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
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MERITAS LAW FIRMS WORLDWIDE

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Second Completeness Question Responses

1. As required by Public Act 15-146 section 30 (to be codified, as amended, as Connecticut General Statute 19a-639a), submit any financial gains realized by each officer, director, board member or senior manager of the hospital and of the purchaser, as a result of the transaction, in the table below. Add rows as necessary. For each such person, list:
   a. The specific person's name;
   b. Such person's position type and whether associated with the hospital, the purchaser or both;
   c. The amount of any expected increase or decrease in such person's salary, inclusive of bonuses;
   d. The amount of any expected severance payments received by such person; and
   e. The value, based on the date of issuance, of any stock or stock options expected to be issued to such person.

TABLE 1
FINANCIAL IMPACT ON CERTAIN HOSPITAL & PURCHASER ASSOCIATES

	Name	With RCCH (SH), HQ or both	Position Type*	Amount of increase/ (decrease) in salary	Severance Payment	Stock Value	Value of other financial gain	Total
1	Peter Cordeau	RCCH/HQ	CEO	$55,000/yr.	N/A	N/A	$36,750	$91,750
2	Christian Bergeron	RCCH/HQ	CFO	$6,275/yr.	N/A	N/A	$29,059	$35,334
3	Lori Puff	RCCH/HQ	CNO	$25,000/yr.	N/A	N/A	$22,500	$47,500
4								
5								
6								
7								

* Indicate whether an Officer, Director, Board Member or Senior manager (may select more than one, if applicable).

RESPONSE:

In conducting its due diligence relative to the acquisition of Sharon Hospital ("Sharon" or the "Hospital"), Health Quest Systems, Inc. ("Health Quest") identified three (3) senior administrators at the Hospital with significant institutional knowledge and experience that would be needed not only to ensure a seamless transition of operations, but on a continued basis going forward. These individuals include Peter Cordeau, Chief Executive Officer; Christian Bergeron, Chief Financial Officer; and Lori Puff, Chief Nursing Officer (the "Senior Administrators"). In an effort to ensure continuity of leadership the Senior Administrators were offered salary

increases (to align their salaries with those of other Health Quest administrators in comparable positions) and one-time retention bonuses, as detailed in Table 1 above. These salary increases and retention bonuses are the only financial gains realized by any officers, directors, board members, and senior managers of Sharon, RCCH HealthCare and Health Quest as a result of the proposed transaction.

2. In regard to health care services at Sharon Hospital, complete the following:

   a. Submit a plan demonstrating how health care services will be provided by Sharon Hospital for the first three fiscal years following the transfer of ownership;

RESPONSE:

As noted in prior CON submissions, Health Quest is in the process of developing a strategic plan for Sharon to be completed in time to influence the operating and capital budgets of the Hospital for FY 2018 through FY 2022. The strategic planning process, which is participative and involves community members, clinicians and staff, includes the review and analysis of relevant market data regarding service offering. The information gathered will assist Health Quest in determining, among other things, how it should provide services in the future, what services it should provide, and where those services should be located. Note that Health Quest is unable to fully assess services at the Hospital and prepare a detailed, forward-looking plan until it assumes ownership and operation of the facility.

Health Quest does not intend to relocate or eliminate any services currently provided at Sharon Hospital. Rather, it is Health Quest's express intent to expand service offerings and offer more depth of services as discussed in the CON submissions. By way of example Health Quest intends to enhance medical oncology services, including infusions and chemotherapy, and recruit physicians including OB/GYN, general surgeons, cardiologists, and orthopedic surgeons, to name a few. Vassar Health Connecticut, Inc. ("Vassar Connecticut"), the proposed licensee of Sharon Hospital, expects to maintain current services for a period of three (3) years, subject to patient demand and the availability of physicians and other clinical providers and staff.

   b. Complete the table below (note: it should reflect the information provided in the Hospital services plan, above). List the inpatient and outpatient services currently offered by the Hospital. For each service, indicate (by placing an "X" in the appropriate column) if applicants plan to consolidate, reduce, eliminate or expand services in the three fiscal years following the transfer of ownership; and

RESPONSE:

See Table 2 below.

c. Indicate what, if any, new services Sharon Hospital will be adding in the three fiscal years following the transfer of ownership.

RESPONSE:

See Table 2 below.

TABLE 2 – SHARON HOSPITAL SERVICE PLAN FOR FIRST THREE FISCAL YEARS

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Inpatient (list existing & planned)								
Med/Surg (Including Hospice & Pediatrics)	50[1]	50 Hospital Hill Road Sharon, CT 06069	24/7					
ICU	10	50 Hospital Hill Road Sharon, CT 06069	24/7					
Obstetrics	6	50 Hospital Hill Road Sharon, CT 06069	24/7					

[1] Currently, there are 32 staffed Med/Surg beds at Sharon Hospital. Applicants have allocated the 18 unstaffed, licensed beds at Sharon to the Med/Surg service, bringing the Med/Surg bed total to 50, for purposes of this chart only. These beds may be reallocated to existing or new services depending upon need.

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Geripsychiatry	12	50 Hospital Hill Road Sharon, CT 06069	24/7				X[2]	
Rehabilitation	0	N/A	N/A					
Bassinets	16	50 Hospital Hill Road Sharon, CT 06069	24/7					
Outpatient (list existing & planned)								
OB/GYN		120 Park Lane, Suite A202 New Milford, CT 06776	M-F, 9 a.m. – 5 p.m.				X[3]	
		50 Amenia Road Sharon, CT 06069	M-F, 8:30 a.m. – 5 p.m.					
		76 Church Street Canaan, CT 06018	F, 1:30 p.m. – 4:15 p.m.					

[2] Unstaffed Med/Surg beds may be reallocated to geripsychaitric beds to meet demand for senior behavioral health services.
[3] Health Quest intends to add two (2) OBGYN physicians among its Sharon-area sites.

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
OB/GYN contd.		115 Spencer Street Winsted, CT 06098	Thurs., 9 a.m. – 5 p.m.					
Medical Oncology		N/A	N/A					X
Chemotherapy		N/A	N/A					X
Diagnostic Imaging[4]		50 Hospital Hill Road Sharon, CT 06069	24/7					
Magnetic Resonance Imaging (MRI)		50 Hospital Hill Road Sharon, CT 06069	24/7					
Computed Tomography (CT)		50 Hospital Hill Road Sharon, CT 06069	24/7					
Pediatrics		64 Maple Street Kent, CT 06757	M. – F., 8 a.m. – 4:30 p.m.					

[4] Services provided at 50 Hospital Hill Road, 24/7 are both inpatient and outpatient services.

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Primary Care		64 Maple Street Kent, CT 06757	M. – F., 8 a.m. – 4:30 p.m.				X[5]	
Primary Care contd.		29 Hospital Hill Road Sharon, CT 06069	M., W. – F., 8 a.m. – 6 p.m.; Tue. 8 a.m. – 5 p.m.					
Rehabilitation		50 Hospital Hill Road Sharon, CT 06069	M. – F., 8 a.m. – 5 p.m.					
General Surgery/ Orthopedic Surgery		50 Hospital Hill Road Sharon, CT 06069	M. – F., 8 a.m. – 5 p.m.				X[6]	
Emergency Department		50 Hospital Hill Road Sharon, CT 06069	24/7					
Lithotripsy		50 Hospital Hill Road Sharon, CT 06069	24/7					

[5] Health Quest intends to add family practice and cardiology physicians to its primary care locations in and around Sharon.
[6] Health Quest intends to add general surgeons and orthopedic surgeons to its outpatient surgical practice.

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation for o/p services	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Laboratory		50 Hospital Hill Road Sharon, CT 06069	24/7					
Hospitalist		50 Hospital Hill Road Sharon, CT 06069	24/7					
Urology		120 Park Lane, Suite A202 New Milford, CT 06776	M-F, 9 a.m. – 5 p.m.					
		17 Hospital Hill Road Sharon, CT 06069	M-F, 9 a.m. – 5 p.m.					

3. The Applicants state on page 646 of the application that there are currently no tertiary services in Sharon Hospital's primary service area. Please explain:

    a. how the Applicants are defining the term "tertiary services" and

RESPONSE:

Tertiary services are specialized consultative services, typically provided on referral from primary or secondary medical care personnel, by specialists working in a center that has the personnel and facilities for special investigation and treatment.[7] Tertiary care includes highly specialized services such as advanced cardiac services (cardiac catheterization, PAMI, TAVR, open heart surgery), advanced neurosciences services (advanced stroke care), Level 3 NICU, Level 2 Trauma, advanced hepatobilliary surgery, and subspecialty cancer services (e.g., thoracic oncology, head and neck).

    b. for which such tertiary services Applicants will refer patients from Sharon Hospital's Connecticut primary service area to Vassar Brothers, Northern Dutchess Hospital or Putnam Hospital Center.

RESPONSE:

Patients from Sharon Hospital's Connecticut primary service area will be given the option to receive any necessary tertiary services at hospitals located within Connecticut or at Vassar Brothers Medical Center ("VBMC") in New York, assuming a referral to any particular location is clinically indicated. These services include, but are not limited to, those listed in response to Question 2.a. above, as well as high-risk obstetric care, advanced robotic surgery, trauma, high-acuity intensive care, and other tertiary care.

Note that Sharon Hospital patients will always be given a choice in where they receive tertiary care. This includes the many tertiary referral hospitals located within Connecticut in Waterbury, Hartford, Danbury, Bridgeport, and New Haven. Patients will also be given the option to receive services within the Health Quest system at VBMC, where they can benefit from common EMR and better continuity of care. This is consistent with current practice where patients are given a number of options for referral and make the decision based upon factors including where they live and the nature of the services they require. Neither Northern Dutchess Hospital nor Putnam Hospital Center is considered a tertiary referral hospital. Accordingly, patients from the Sharon area would not be given either hospital as an option for any necessary tertiary services.

[7] https://www.hopkinsmedicine.org/patient_care/pay_bill/insurance_footnotes.html

4. The Applicants state that they intend to invest in the renovation of medical oncology and infusion space and cite this as one of the largest services for which Sharon-area patients must travel elsewhere. In 2014, Yale-New Haven Hospital terminated its oncology services at Sharon Hospital, citing low patient volumes due to it not being a "full service" site. Yale also cited low volume as an obstacle to retaining the necessary oncologists and offering clinical trials to patients. Would the cancer treatment center be a full-service site offering radiation therapy?

RESPONSE:

Health Quest will offer medical oncology and subspecialty oncology care, including surgical oncology, breast oncology and chemotherapy, at Sharon Hospital. In looking at volume in the area, Health Quest believes that these services are sustainable, especially when coupled with the recruitment of additional primary care physicians who can refer to the oncology services. As the service grows, Health Quest can rotate physicians to other oncology centers in its System at Northern Dutchess Hospital or VBMC to ensure that their skill sets are maintained and that they are productive. Health Quest will also be providing chemotherapy services locally (something that many patients want), but does not anticipate adding radiation therapy services at this time.

Termination of the YNHH-Smilow location at Sharon Hospital was driven, in large part, by the retirement of both medical oncologists staffing the site (Docket No. 14-31969-CON, p. 14). Recruitment of additional oncologists to practice at Sharon was difficult because of the low volume and part-time nature of the site. This should not be an issue going forward for two reasons: First, the anticipated increase in volume due to the recruitment of additional primary care physicians; and second, physicians recruited into the Health Quest system can split their time between locations in New York and Connecticut, ensuring adequate staffing at Sharon despite any volume considerations that may arise. With respect to radiation therapy, patients will continue to have the option of receiving this service at other locations in Connecticut (e.g. YNHH-Smilow at Torrington) or at Health Quest locations in New York.

5. The anticipated capital improvements outlined on page 645 to 646 will cost, according to the Applicant's estimates, at least $11.5 million. How does HealthQuest intend to fund the $5.5 million in capital expenditures in excess of the $6 million Working Capital Grant committed by FCH?

RESPONSE:

Amounts expended on capital improvements beyond the $6 million Working Capital Grant will be funded with Health Quest's cash reserves.

6. In projecting the average daily census (ADC) for existing physician service lines on page 650, the Applicants identify "expanding choice" for OB/GYN patients as a driver for the increase in ADC. Please clarify what or how choice(s) will be expanded.

RESPONSE:

There are several OB/GYN physicians practicing in the Sharon area currently. However, there are still women who opt to receive OB/GYN care from physicians outside of the service area for reasons of personal preference. Health Quest intends to recruit two (2) new OB/GYN physicians to practice in the service area. Expanding the number of OB/GYNs practicing in and around Sharon will give women more choices for receiving these services within their own community.

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Wednesday, February 22, 2017 8:41 AM
To: Schaeffer-Helmecki, Jessica; Riggott, Kaila; Fernandes, David; User, OHCA
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com); Ping, David
Subject: RE: Sharon Hospital Transfer of Ownership -- Docket No. 16-32132-CON

Thanks, Jessica.

Jennifer Groves Fusco
Principal
Updike, Kelly & Spellacy, P.C.

From: Schaeffer-Helmecki, Jessica
Sent: Wednesday, February 22, 2017 8:20:51 AM
To: Jennifer Groves Fusco; Riggott, Kaila; Fernandes, David; User, OHCA
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com); Ping, David
Subject: RE: Sharon Hospital Transfer of Ownership -- Docket No. 16-32132-CON

Good Morning, Jen—We have received your responses and, at the moment, it appears we are all set but if we need any additional information, we will let you know. Thank you.

Jessica

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, February 21, 2017 4:05 PM
To: Riggott, Kaila <Kaila.Riggott@ct.gov>; Schaeffer-Helmecki, Jessica <Jessica.Schaeffer-Helmecki@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>; User, OHCA <OHCA@ct.gov>
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com) <Peter.Cordeau@sharonhospital.com>; Ping, David

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, February 21, 2017 4:06 PM
To: Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David; User, OHCA
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com); Ping, David
Subject: Regional Healthcare Associates Transfer of Ownership -- Docket No. 16-32133-CON
Attachments: DOCS-#1486919-v1-HEALTH_QUEST_SHARON_CQR2_(RHA_-_FINAL).pdf; DOCS-#1483827-v1-HEALTH_QUESTION_SHARON_CQR2_(RHA).docx

All,

Attached are Regional Healthcare Associates' responses to OHCA's February 16th Completeness Questions. Please confirm receipt and let me know if you require anything further.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
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265 Church Street
New Haven, CT 06510
Office (203) 786.8316
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

TO: Kevin Hansted, Hearing Officer

FROM: Raul Pino MD/MPH, Commissioner

DATE: March 3, 2017

RE: Certificate of Need Application: Docket Number: 16-32132-CON
Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTERS OF:

Certificate of Need Application: Docket Number: 16-32132-CON
Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
Certificate of Need Application: Docket Number: 16-32133-CON
Regional Healthcare and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

ORDER

Pursuant to Conn. Gen. Stat. § 19a-639a(f), the above-referenced dockets are hereby consolidated for purposes of conducting a public hearing. All other proceedings pertaining to the dockets shall remain separate, including the issuance of a decision in each docket.

3/3/17
Date

Kevin T. Hansted
Hearing Officer

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

User, OHCA

From: Schaeffer-Helmecki, Jessica
Sent: Friday, March 03, 2017 1:56 PM
To: Ping, David
Cc: Jennifer Groves Fusco; User, OHCA; Riggott, Kaila; Fernandes, David; Lazarus, Steven; Olejarz, Barbara
Subject: CON Hearing Consolidation Order
Attachments: 32132 and 32133 consolidation order.pdf

Good afternoon (again),

Attached please find an order consolidating the hearings associated with docket numbers 16-32132-CON and 16-32133-CON.

And again, if you have any questions please feel free to contact us. Have a great weekend.

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 3, 2017

Via Email Only

Mr. David Ping
Senior Vice President, Strategic Planning
Health Quest Systems, Inc
1351 Route 55, Suite 200
dping@health-quest.org

RE: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer of Ownership of Sharon Hospital and Sharon Hospital Holding Company from Essent Healthcare of Connecticut to Vassar Health Connecticut, Inc.

Dear Mr. Ping:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of March 2, 2017.

If you have any questions concerning this letter, please feel free to contact me at (860) 509-8075.

Sincerely,

J Schaffer-Helmecki

Jessica Schaeffer-Helmecki
Planning Analyst

CC: Jennifer Groves Fusco, Esq.

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

User, OHCA

From: Schaeffer-Helmecki, Jessica
Sent: Friday, March 03, 2017 1:49 PM
To: Ping, David
Cc: Jennifer Groves Fusco; Riggott, Kaila; Fernandes, David; Lazarus, Steven; User, OHCA
Subject: Notification of CON Applications Deemed Complete
Attachments: 32132-CON Notification of Application Deemed Complete.pdf; 32133-CON Notification of Application Deemed Complete.pdf

Good afternoon,

Attached please find letters deeming complete applications associated with docket numbers 16-32132-CON and 16-32133-CON.

If you have any questions please feel free to contact us.

Thanks,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Tuesday, March 07, 2017 3:17 PM
To: 'jfusco@uks.com'
Cc: 'DPing@Health-quest.org'; Salton, Henry A.; Casagrande, Antony A; Hansted, Kevin; Furniss, Wendy (Wendy.Furniss@ct.gov); Downes, Maura; Stan, Christopher; Kennedy, Jill; Pare, Danielle; 'daniels@chime.org'; Lazarus, Steven; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David; Martone, Kim
Subject: April 5 hearing
Attachments: 32132 32133.pdf

Tracking:

Recipient	Delivery	Read
'jfusco@uks.com'		
'DPing@Health-quest.org'		
Salton, Henry A.	Delivered: 3/7/2017 3:18 PM	
Casagrande, Antony A	Delivered: 3/7/2017 3:18 PM	
Hansted, Kevin	Delivered: 3/7/2017 3:18 PM	
Furniss, Wendy (Wendy.Furniss@ct.gov)		
Downes, Maura	Delivered: 3/7/2017 3:17 PM	Read: 3/7/2017 3:28 PM
Stan, Christopher	Delivered: 3/7/2017 3:18 PM	
Kennedy, Jill	Delivered: 3/7/2017 3:18 PM	
Pare, Danielle	Delivered: 3/7/2017 3:18 PM	
'daniels@chime.org'		
Lazarus, Steven	Delivered: 3/7/2017 3:18 PM	Read: 3/7/2017 3:32 PM
Riggott, Kaila	Delivered: 3/7/2017 3:18 PM	
Schaeffer-Helmecki, Jessica	Delivered: 3/7/2017 3:18 PM	
Fernandes, David	Delivered: 3/7/2017 3:17 PM	Read: 3/7/2017 3:19 PM
Martone, Kim	Delivered: 3/7/2017 3:18 PM	
Furniss, Wendy	Delivered: 3/7/2017 3:18 PM	

3/7/17

Please see attached information regarding the consolidated hearing scheduled for April 5, 2017.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 7, 2017

Jennifer G. Fusco, Esq.
Updike, Kelly & Spellacy, PC
265 Church Street
New Haven, CT 06510

RE: Certificate of Need Application, Docket Number 16-32132-CON and 16-32133-CON
Docket Number: 16-32132-CON
Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc
Docket Number: 16-32133-CON
Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Applicant Hearing Notice

Dear Attorney Fusco:

With the receipt of the completed Certificate of Need ("CON") application information submitted by Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc ("Applicants") and Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. on March 3, 2017 the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Sharon Hospital
Regional Healthcare
Notice of Public Hearing
Docket Number(s) 16-32132-CON and 16-32133-CON

March 7, 2017

Applicant(s):	Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc
Docket Number:	16-32132-CON
Proposal:	Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Applicant(s):	Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
Docket Number:	16-32133-CON
Proposal:	Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date:	April 5, 2017
Time:	4:00 p.m.
Place:	Sharon Town Hall 63 Main Street Sharon, CT 06069

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *Republican American* pursuant to General Statutes § 19a-639a (f).

Sharon Hospital
Regional Healthcare
Notice of Public Hearing
Docket Number(s) 16-32132-CON and 16-32133-CON

March 7, 2017

All Applicants and Intervenors are reminded that The Office of Health Care Access division of the Department of Public Health follows the Rules of Practice under section 19a-9-1, et seq., of the Regulations of Connecticut State Agencies.

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

cc: David Ping, Health Quest Systems, Inc.
Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kennedy, Department of Public Health
Chris Stan, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:JS:DF:bko

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

March 7, 2017

P.O. #54772

Republican-American, Inc.
389 Meadow Street
P.O. Box 2090
Waterbury, CT 06722

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Wednesday, March 8, 2017**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association
KRM:JS:DF:bko

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Republican-American, Inc.
Notice of Public Hearing,
Docket Numbers 16-32132-CON and 16-32133-CON

March 7, 2017

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc
Town:	Sharon
Docket Number:	16-32132-CON
Proposal:	Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Applicant(s):	Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
Town:	Sharon
Docket Number:	16-32133-CON
Proposal:	Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
Date:	April 5, 2017
Time:	4:00 p.m.
Place:	Sharon Town Hall 63 Main Street Sharon, CT 06069

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 31, 2017 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Legals/ Public Notices

LIQUOR PERMIT
NOTICE OF APPLICATION

This is to give notice that I,
NEIL J PERROTTI
245 WESTMONT DR
WATERBURY, CT 06708-2466

have filed an application placarded 03/08/2017 with the Department of Consumer Protection for a
RESTAURANT
WINE & BEER PERMIT
for the sale of alcoholic liquor on the premises at:
544 STRAITS TPKE
WATERTOWN CT 06795-3340

The business will be owned by:
PERROTTI'S PIZZA LLC
Entertainment will consist of: None

Objections must be filed by:
04/18/2017

NEIL J PERROTTI
R-A March 8 & 15, 2017

NOTICE OF PROPERTY
SOLD AT TAX SALE

The Tax Collector of the City of Waterbury, Connecticut, hereby gives Notice that, by these presents and through its agent, a Tax Sale was conducted on January 26, 2017 at 6:00 p.m. against the taxpayer(s) named below for failure to pay real estate taxes due the City of Waterbury. In accordance with CONNECTICUT GENERAL STATUTES, Section 12-157, the tax sale information is listed below:

1. NAME AND ADDRESS OF DELINQUENT TAXPAYER:
Ricardo Joseph
114 Spring Brook Road
Waterbury, Connecticut 06706

ADDRESS:
114 Spring Brook Road,
Waterbury, Connecticut
0550-0341-0004

NAME AND ADDRESS OF PURCHASER:
Luan Krosi
205 Rosengarten Drive
Waterbury, Connecticut 06704

PURCHASE PRICE:
$30,000.00

THE REDEMPTION PERIOD EXPIRES JULY 27, 2017 AT 6:00 P.M. ON THE ABOVE LISTED PROPERTIES. WHERE IT APPLIES, THERE IS A SHORTENED PERIOD AS PERMITTED BY SECTION 12-157(F) OF THE CONNECTICUT GENERAL STATUES.

If the redemption does not take place by the date stated and in the manner provided by law, the delinquent taxpayer, and all other mortgagees, lien holders and other record encumbrancers who have received actual or constructive notice of such sale as provided by law, that their respective titles, mortgages, liens and other encumbrancers in such property shall be extinguished.

William DeMaida-Marshal
56 Center Street
Waterbury, CT 06702
203-757-4748
R-A March 8, 2017

TOWN OF KENT
INLAND WETLANDS COMMISSION
NOTICE OF FINAL ACTIONS

At its regular meeting on February 27, 2017, the Kent Inland Wetlands Commission took the following actions:

Approved: Application #1146-17, John Worthington for Kent Housing for the Elderly, Inc., 16 Swifts Lane, installation of drainage from repaved parking lot, Map 19 Block 12 Lot 4.

Approved: Modification to Application #1071-14, The Marvelwood School, 473 Skiff Mountain Road, Map 7 Block 17 Lot 1, construction of detention pond in regulated area; modification to include increase in size of detention basin.

Dated this 27th day of February, 2017.
Lynn Werner, Chairman
R-A March 8, 2017

NOTICES OF APPROVAL
TOWN OF THOMASTON
PLANNING AND ZONING COMMISSION

The Planning and Zoning Commission of the Town of Thomaston, CT, at a regular meeting held on Wednesday, March 1, 2017, 7:00 pm, Meeting Room #1, 4th Level, Thomaston Town Hall, 158 Main St., Thomaston, CT voted to approve the following applications:

1. Special permit application #2017-01-25-01 of Debra Radosevich for a temporary liquor permit for a single event wine and beer tasting fundraiser at the Thomaston Public Library, 248 Main Street, Assessors Map 40, Block 19, Lot 05 in a General Commercial Zone, subject to conditions.
2. Special permit application #2017-01-27-01 of Michael and Kristen Hart for a legal non-conforming manufacturing / processing use for a machine shop and race shop for automotive parts at 163 Elm Street, Assessors Map 40, Block 14, Lot 10 in an RA-15 Zone, subject to conditions.
3. Special permit application #2017-01-31-01 of Fanol Ramadani, d.b.a Epicure Pizza House for a restaurant liquor permit at 19 Waterbury Road, Assessors Map 55, Block 02, Lot 01 in an M1 Light Manufacturing Zone, subject to conditions.
4. Special permit application #2017-02-01-01 of Ruth Johnson to permit an in-law apartment at 885 Hickory Hill Road, Assessors Map 36, Block 02, Lot 04 in an RA-80A residential zone, subject to conditions.
5. Request for an additional 5-year extension to a previously approved special permit application #2012-02-28-01 for the installation of a running track, gravel parking facilities, tennis courts and drainage improvements to Nystrom's Pond Recreational Area, Turner Road and Hickory Hill Road in an RA-80A residential zone.
6. Site plan application #2017-02-23-01 of Metallon, Inc. for a 4,925 square foot manufacturing building addition and site improvements at 1441 Waterbury Road, Assessor's Map 72 Block 04 Lot 07 in an M1 Light Manufacturing Zone.

Dated at Thomaston, CT
this 8th Day of March, 2017

Ralph Celone, Chairman,
Thomaston Planning
and Zoning Commission
R-A March 8, 2017

NOTICE OF PROPERTY
SOLD AT TAX SALE

The Tax Collector of the City of Waterbury, Connecticut, hereby gives Notice that, by these presents and through its agent, a Tax Sale was conducted on January 26, 2017 at 6:00 p.m. against the taxpayer(s) named below for failure to pay real estate taxes due the City of Waterbury. In accordance with CONNECTICUT GENERAL STATUTES, Section 12-157, the tax sale information is listed below:

1. NAME AND ADDRESS OF DELINQUENT TAXPAYER:
Charles R. Hotchkiss and
Joyce Hotchkiss
11 Cranberry Pond Road
Norwich, Connecticut 06360

ADDRESS:
52 Lockhart Avenue,
Waterbury, Connecticut
0349-0351-0112

NAME AND ADDRESS OF PURCHASER:
Valter Bylyku
195 Rosengarten Drive
Waterbury, Connecticut 06704

PURCHASE PRICE:
$56,000.00

THE REDEMPTION PERIOD EXPIRES JULY 27, 2017 AT 6:00 P.M. ON THE ABOVE LISTED PROPERTIES. WHERE IT APPLIES, THERE IS A SHORTENED PERIOD AS PERMITTED BY SECTION 12-157(F) OF THE CONNECTICUT GENERAL STATUES.

If the redemption does not take place by the date stated and in the manner provided by law, the delinquent taxpayer, and all other mortgagees, lien holders and other record encumbrancers who have received actual or constructive notice of such sale as provided by law, that their respective titles, mortgages, liens and other encumbrancers in such property shall be extinguished.

Donald Cipriano-Marshal
56 Center Street
Waterbury, CT 06702
203-757-4748
R-A March 8, 2017

NOTICE OF PROPERTY
SOLD AT TAX SALE

The Tax Collector of the City of Waterbury, Connecticut, hereby gives Notice that, by these presents and through its agent, a Tax Sale was conducted on January 26, 2017 at 6:00 p.m. against the taxpayer(s) named below for failure to pay real estate taxes due the City of Waterbury. In accordance with CONNECTICUT GENERAL STATUTES, Section 12-157, the tax sale information is listed below:

1. NAME AND ADDRESS OF DELINQUENT TAXPAYER:
Bakari Akil Stepherson
PO Box 370945
Decatur, Georgia 30037

ADDRESS:
19 Poplar Place,
Waterbury, Connecticut
0390-0686-0008

NAME AND ADDRESS OF PURCHASER:
James A. Geddes Jr. and
Gregory Stamlos
70 Lone Oak Avenue
Waterbury, Connecticut 06704

PURCHASE PRICE:
$28,000.00

THE REDEMPTION PERIOD EXPIRES JULY 27, 2017 AT 6:00 P.M. ON THE ABOVE LISTED PROPERTIES. WHERE IT APPLIES, THERE IS A SHORTENED PERIOD AS PERMITTED BY SECTION 12-157(F) OF THE CONNECTICUT GENERAL STATUES.

If the redemption does not take place by the date stated and in the manner provided by law, the delinquent taxpayer, and all other mortgagees, lien holders and other record encumbrancers who have received actual or constructive notice of such sale as provided by law, that their respective titles, mortgages, liens and other encumbrancers in such property shall be extinguished.

Gerald Raimo-Marshal
56 Center Street
Waterbury, CT 06702
203-757-4748
R-A March 8, 2017

NOTICE OF TENTATIVE DECISION OF INTENT TO RENEW A STATE PERMIT
FOR THE FOLLOWING DISCHARGE INTO THE WATERS
OF THE STATE OF CONNECTICUT

TENTATIVE DECISION

The Commissioner of Energy and Environmental Protection ("the Commissioner ") hereby gives notice of a tentative decision to renew a permit based on an application submitted by Allegheny Ludlum, LLC ("the applicant") under section 22a-430 of the Connecticut General Statutes for a permit to discharge into the waters of the state.

In accordance with applicable federal and state law, the Commissioner has made a tentative decision that continuance of the existing system to treat the discharge would protect the waters of the state from pollution and the Commissioner proposes to renew a permit for the discharge to the city of Waterbury Publicly Owned Treatment Works ("POTW").

The proposed permit, if issued by the Commissioner, will require that all wastewater be treated to meet the applicable effluent limitations and periodic monitoring to demonstrate that the discharge will not cause pollution.

APPLICANT'S PROPOSAL

Allegheny Ludlum, LLC proposes to continue discharging up to 43,200 gallons per day of treated industrial wastewaters consisting of spent alkaline cleaners, alkaline cleaning rinses, spent sulfuric acid passivation solutions, passivation rinses, and laboratory wastewaters to the city of Waterbury POTW from its manufacturing of finished specialty steel coils.

The name and mailing address of the permit applicant are: Allegheny Ludlum, LLC, 100 River Road, Brackenridge, PA 15014.

The activity takes place at: 271 Railroad Hill Street, Waterbury.

REGULATORY CONDITIONS

Type of Treatment

DSN 001-1: Equalization, coagulation/flocculation, clarification, final neutralization and sludge dewatering.

Effluent Limitations

This permit contains effluent limitations consistent with a Case-by-Case Determination using the criteria of Best Professional Judgment, Pretreatment Standards for Existing Sources (PSES) under 40 CFR 420 (Title 40 of the Code of Federal Regulations, Part 420), Subparts I and J and Section 22a-430-4(s) of the Regulations of Connecticut State Agencies, and which will protect the waters of the state from pollution when all the conditions of this permit have been met.

In accordance with section 22a-430-4(l) of the Regulations of Connecticut State Agencies, the permit contains effluent limitations for the following types of toxic substances: heavy metals.

COMMISSIONER'S AUTHORITY

The Commissioner is authorized to approve or deny such permits pursuant to section 22a-430 of the Connecticut General Statutes and the Water Discharge Permit Regulations (sections 22a-430-3 and 4 of the Regulations of Connecticut State Agencies).

INFORMATION REQUESTS

The application has been assigned the following numbers by the Department of Energy and Environmental Protection. Please use these numbers when corresponding with this office regarding this application.

APPLICATION NO. 201006673 PERMIT ID NO. SP0001395

Interested persons may obtain copies of the application from Deborah Calderazzo, Allegheny Ludlum, LLC, 100 River Road, Brackenridge, PA 15014, (724) 226-5947.

The application is available for inspection by contacting Stephen Edwards at 860-424-3838, at the Bureau of Materials Management and Compliance Assurance, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106-5127 from 8:30 - 4:30, Monday through Friday.

Any interested person may request in writing that his or her name be put on a mailing list to receive notice of intent to issue or deny any permit to discharge to the surface waters of the state. Such request may be for the entire state or any geographic area of the state and shall clearly state in writing the name and mailing address of the interested person and the area for which notices are requested.

PUBLIC COMMENT

Prior to making a final determination to approve or deny any application, the Commissioner shall consider written comments on the application from interested persons that are received within thirty (30) days of this public notice. Written comments should be directed to Stephen Edwards, Bureau of Materials Management and Compliance Assurance, Department of Energy and Environmental Protection, 79 Elm Street, Hartford, CT 06106-5127. The Commissioner may hold a public hearing prior to approving or denying an application if in the Commissioner's discretion the public interest will be best served thereby, and shall hold a hearing upon receipt of a petition signed by at least twenty-five (25) persons. Notice of any public hearing shall be published at least thirty (30) days prior to the hearing.

Petitions for a hearing should include the application number noted above and also identify a contact person to receive notifications. Petitions may also identify a person who is authorized to engage in discussions regarding the application and, if resolution is reached, withdraw the petition. Original petitions must be mailed or delivered to: DEEP Office of Adjudications, 79 Elm Street, 3rd floor, Hartford, CT 06106-5127. Petitions cannot be sent by fax or email. Additional information can be found at www.ct.gov/deep/adjudications.

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

/s/Oswald Inglese, Jr. Director
Water Permitting and Enforcement Division
Bureau of Materials Management and Compliance Assurance

Dated: 3/7/2017
R-A March 8, 2017

LEGAL NOTICE

Pursuant to Conn. Gen. Stat. §16-234, the Public Utilities Regulatory Authority (PURA) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on March 15, 2017, at 1:00 p.m., concerning Docket No. 16-12-33, Application of Cellco Partnership d/b/a Verizon Wireless for Approval of a Construction Plan to Install Wireless Facilities Within Certain Public Rights-of-Way - Fairfield CT SC12. The PURA may continue the hearing. For information and the Notice of Hearing filed with the Secretary of State's Office, contact: PUBLIC UTILITIES REGULATORY AUTHORITY, JEFFREY R. GAUDIOSI, ESQ., EXECUTIVE SECRETARY. The public may call the Authority's offices, at (860) 827-1553, option 4 (using a touch tone phone), commencing each day from 7:30 a.m., to be advised as to whether this hearing has been cancelled or postponed due to inclement weather. The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation contact us at (860) 418-5910 or deep.accommodations@ct.gov
R-A March 8, 2017

LEGAL NOTICE
CITY OF TORRINGTON
INLAND WETLANDS COMMISSION

Pursuant to Section 12 of the Regulations, the City of Torrington Inland Wetlands Commission gives notice that its agent has approved the following proposed activities:

Bruce Bennett, applicant - Mark & Brigid Merriman, Owner - 26 Pumping Station Rd - construct an in-ground pool and temporary access way within the upland review area

Any person may appeal these decisions to the Torrington Inland Wetlands Commission within 15 days of the notice by submitting such appeal at the Land Use Office, 140 Main Street, Torrington, CT.

Rista Malanca, CZ&WEO

Dated in Torrington, CT
This 6th day of March 2017
RA 3.8.2017

LEGAL NOTICE

The Northwest Hills Council of Governments is seeking proposals from architectural firms to design a new Regional Animal Shelter Facility on land owned by the City of Torrington at 250 Bogue Road in the Town of Harwinton. The deadline for submission of proposals is April 19, 2017. A pre-proposal site meeting is scheduled for March 29, 2017. A detailed description of what is required is available from the NHCOG at rlynn@northwesthillscog.org (860-491-9884).

NHCOG is an Affirmative Action Equal Opportunity Employer.
M/F/V/H/EOE
RA 3/8/2017

Request For Proposal
#04-1702

The State of Connecticut Judicial Branch, on behalf of the Superior Court Operations Division - Jury Administration invites qualified contractors to submit proposals to provide an automated statewide Jury Management System (JMS).

The deadline to submit questions is Wednesday, March 22, 2017 by 4:00 p.m.

Sealed proposals must be received before 2:30 p.m. on Wednesday, April 12, 2017. Immediately thereafter, all proposals will be publicly opened. Late proposals will NOT be accepted.

RESPONDENTS CURRENTLY REGISTERED UNDER THE STATE'S SMALL BUSINESS SET-ASIDE PROGRAM ARE ENCOURAGED TO APPLY.

Proposal package may be obtained at Judicial Materials Management Unit, Purchasing Services at: 90 Washington Street, 4th Floor, Hartford, CT or call (860) 706-5200 to request by mail, or access the web site below.

PLEASE CHECK THE JUDICIAL WEB SITE AT:

www.jud.ct.gov/external/news/busopp/

JUDICIAL BRANCH
MATERIALS MANAGEMENT UNIT
PURCHASING SERVICES
90 WASHINGTON STREET
HARTFORD, CT 06106

An Equal Opportunity/Affirmative Action Employer
RA 3/8/2017

WOLCOTT LEGAL NOTICE

At its regular meeting on March 1, 2017 the Wolcott Planning & Zoning Commission took the following actions:
1. Approved #17-543 Lori Murray - Special Use Permit for preschool/daycare center at 30 Beach Rd. with the conditions that we use the newly revised plan where play area is constructed in front with state approved fence and minimum of 6ft. arborvitaes by front portion of fence.
Details of the above actions are on file in the Planning & Zoning Office at the Wolcott Town Hall. Dated at Wolcott, CT, this 7th day of March 2017
Wolcott Planning & Zoning Commission
Ray Mahoney, Chairman
R-A March 8, 2017

NOTICE OF APPROVAL
TOWN OF THOMASTON
PLANNING AND ZONING COMMISSION

The Planning and Zoning Commission of the Town of Thomaston, CT, at a regular meeting on July 2, 2014 voted to approve special permit application #2014-05-29-01 of Alfred Lemay for farming use consisting of livestock housing, wholesale nursery stock and commercial composting at the south side of Old Smith Road, Assessors Map 05 Block 01 Lot 11 and Assessors Map 05 Block 01 Lot 23 in an RA-80A residential zone.

Dated at Thomaston, CT this 8th Day of March, 2017

Ralph Celone, Chairman,
Thomaston Planning and Zoning Commission
RA 3/8/2017

LEGAL NOTICE

In accordance with the provisions of State law, there being due and unpaid charges for which the undersigned is entitled to satisfy an owner and/or Manager's lien of the goods hereinafter desc ribed and stored at the Life Storage, formerly Uncle Bob's Self Storage location(s) listed below.
And, due notice having been given, to the owner of said property and all parties known to claim an interest therein, and the time specified in such notice for payment of such having expired, the goods will be sold at public auction at the below stated location(s) to the highest bidder or otherwise disposed of on Wednesday, March 22nd, 2017 at 12:30 pm
433 Lakewood Rd., Waterbury, CT 06704.
Phone (203) 756-2000

Space number	Customer Name	Inventory
107C	Henry Santiago	Hsld gds/Furn
132C	Michael J Webber	Hsld gds/Furn
279C	Andre C Council	Hsld gds/Furn
280C	Douglas Gunter	Hsld gds/Furn
643C	Shantee Deyo	Hsld gds/Furn

R-A March 8 & 10, 2017

Office of Health Care Access Public Hearings

Statute Reference: 19a-638
Applicant(s): Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc
Town: Sharon
Docket Number: 16-32132-CON
Proposal: Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Applicant(s): Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
Town: Sharon
Docket Number: 16-32133-CON
Proposal: Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Date: April 5, 2017
Time: 4:00 p.m.
Place: Sharon Town Hall, 63 Main Street, Sharon, CT 06069

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 31, 2017 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.
R-A March 8, 2017

Notice of tax warrant and property tax auction:

Notice of tax warrant and property tax auction: The Tax Collector of the City of Waterbury, Connecticut, hereby gives Notice that a Tax Warrant(s) have been levied on the taxpayer(s) named below for failure to pay real estate taxes and water & sewer use charges due the City of Waterbury, Connecticut and that a Tax Collector's Sale has been scheduled by the Tax Collector, through its agent, Marshal or Constable, 56 Center Street, Waterbury, CT, (203) 757-4748, for the sale of the real properties levied in accordance with Connecticut General Statute §12-157.

TIME AND PLACE OF SALE:
DATE: April 27, 2017
TIME: 6:00 P.M.
PLACE: CITY HALL, 235 GRAND STREET, WATERBURY, CT 06702

The property being sold pursuant to this notice is being sold "as is" and "where is". The Tax Collector or Marshal may adjourn the sale in accordance with the provisions of Conn. Gen. Stat. §12-157. Neither the City nor any of its employees or agents make any representation as to the nature of the status of the property being sold including but not limited to: 1) the physical descriptions of the property; 2) title to the property; 3) its suitability for any particular use; 4) liens or encumbrances against the property that are not subject to extinguishment by virtue of the sale noticed hereby; or 5) any legal requirements or obligations which must be satisfied prior to the development or improvement of the property including, but not limited to, any approvals required pursuant to applicable zoning or land use laws or regulations and the completion of any and all required infrastructure improvements such as the completion of streets, the completion of the installation of public sanitary and storm sewer lines and the completion of the installation of public water lines and all other improvements required to services the development of which the subject property is a part. All bidders are cautioned that they are responsible for performing any and all due diligence with respect to the property and that, if they are successful bidder, they will take title to the property subject to all obligations and exceptions, including, but not limited to those mentioned above, which are not automatically extinguished pursuant to the statutory authority under which the sale notices hereby is being conducted. Qualified bidders at the time of the sale must have a bank or certified check in the amount of Three Thousand and 00/100 ($3,000.00) Dollars made payable to themselves. The balance of the sale price will be due and paid within ten (10) days of the conclusion of the sale, to Marshal or Constable, Trustee by bank or certified check. Additional costs and fees associated with the sale shall be posted and announced the day of the sale. All costs, water & sewer charges, and fees associated with this sale shall be deemed nonrefundable to the purchaser. ADDITIONAL TAXES, INTEREST, FEES AND OTHER CHARGES AUTHORIZED BY LAW ACCRUING AFTER January 31, 2017 SHALL BE ADDED TO THE AMOUNT INDICATED AS DUE AND OWING, AS WELL AS ALL OUTSTANDING WATER AND SEWER CHARGES DUE ON THESE PROPERTIES.
The properties subject to the tax warrant auction, the delinquent taxpayer(s) and the amount of taxes, sewer and water use charges and other charges due are described below:
1. Cap One LLC, 45 Quarry Village Road, Unit 35, Cheshire, CT, 06410
LEGAL DESCRIPTION OF THE PROPERTY UPON WHICH TAXES ARE DUE INCLUDING STREET ADDRESS:
535 Chase Avenue, Waterbury, Connecticut
Original Mylar Map #0102-0975-0047
Wtby. Land Records V.7181 / P.279
AMOUNT OF THE TAX OR TAXES DELINQUENT, INCLUDING INTEREST AND CHARGES ATTRIBUTABLE TO THE PROPERTY AS OF THE LAST DAY OF THE MONTH IMMEDIATELY PRECEDING THE NOTICE AS WELL AS DELINQUENT WATER AND SEWER CHARGES: $6,137.89 (January 31, 2017)
LIST OF MORTGAGEES, LIEN HOLDERS AND OTHER RECORD ENCUMBRANCES OR PARTIES, WHOSE INTEREST IN THE PROPERTY WILL BE AFFECTED BY SUCH SALE, PURSUANT TO CONN. GEN. STAT. §12-157(a): None

2. First Class Industries, LLC
182 Chipper Road, Waterbury, Connecticut
Original Mylar Map #0023-1001-0044
Wtby. Land Records V.7381 / P.122
$9,798.57 (January 31, 2017)
(a): St. Mary's Hospital, Lift Line Partners LLC

3. Manuel Lee Mayo
118 Clinton Street, Waterbury, Connecticut
Original Mylar Map #0146-0874-0054
Wtby. Land Records V.5392 / P.181 and V.5502 / P.180
$10,826.56 (January 31, 2017)
(a): Wells Fargo Bank NA

4. Rosanna Vasquez
123 Cooke Street, Waterbury, Connecticut
Original Mylar Map #0236-0160-0003
Wtby. Land Records V.5985 / P.347 and V.7128 / P.123
$4,085.29 (January 31, 2017)
(a): Deutsche Bank National Trust Company, Capital One Bank (USA) NA, Equable Ascent Financial LLC

5. Miriam Collazo and Luciano Lizardo
215 Cooke Street, Waterbury, Connecticut
Original Mylar Map #0216-0549-0069
Wtby. Land Records V.5931 / P.185
$5,329.71 (January 31, 2017)
(a): Bank of America NA, Waterbury Hospital, Diagnostic Radiology Associates

6. Karen Pierre-Louis
605 Cooke Street, Waterbury, Connecticut
Original Mylar Map #0146-0820-0096
Wtby. Land Records V.6635 / P.152
$5,772.87 (January 31, 2017)
(a): Secretary of Housing and Urban Development, United States Attorney General

7. Orlando Tirado, Jr.
49 East Farm Street, Waterbury, Connecticut
Original Mylar Map #0237-0180-0027
Wtby. Land Records V.7216 / P.16
$3,010.74 (January 31, 2017)
(a): None

8. Global Inv., LLC.
46 Greenview Drive, Waterbury, Connecticut
Original Mylar Map #0497-1116-0032
Wtby. Land Records V.7151 / P.318
$13,485.35 (January 31, 2017)
(a): Pinnacle Financial Services LLC, Farmington Bank

9. Kimberly Ann Gamble-Perugini
279 Moran Street, Waterbury, Connecticut
Original Mylar Map #0147-0886-0112
Wtby. Land Records V.6842 / P.83
$7,660.67 (January 31, 2017)
(a): None

10. Samuel Munoz
107 Orange Street, Waterbury, Connecticut
Original Mylar Map #0276-0169-0014
Wtby. Land Records V.6652 / P.288
$8,896.62 (January 31, 2017)
(a): City of Waterbury Fire Department, City of Waterbury Department of Inspection, City of Waterbury Tax Collector

12. Martin R. LaManna and Francine M. DuVerger
45 Ridge Street, Waterbury, Connecticut
Original Mylar Map #0346-0467-0054
Wtby. Land Records V.1979 / P.81
$6,320.48 (January 31, 2017)
(a): State of Connecticut Department of Revenue Services, State of Connecticut of the Attorney General

13. Rudy Laurie and Margaret Santone
24 Rockhurst Drive, Waterbury, Connecticut
Original Mylar Map #0249-0052-0472
Wtby. Land Records V.6932 / P.274
$9,299.73 (January 31, 2017)
(a): None

14. HSBC Bank USA, National Association
19 Summit Street, Waterbury, Connecticut
Original Mylar Map #0343-0683-0007
Wtby. Land Records V.7415 / P.330
$4,120.44 (January 31, 2017)
(a): CenConn Credit Union Inc., Cavalry SPVI LLC.

15. Mary Lou A. Sciola
150 Waterville Street, Waterbury, Connecticut
Original Mylar Map #0214-0576-0025
Wtby. Land Records V.2098 / P.33
$53,378.61 (January 31, 2017)
(a): Wesson Energy Inc.

16. Thomas Voytek
25 Wightman Place, Waterbury, Connecticut
Original Mylar Map #0482-0332-0013
Wtby. Land Records V.7001 / P.306
$3,290.97 (January 31, 2017)
(a): None

18. Andrew George Williams
106 Wilson Street and adjoining two lots, Waterbury, Connecticut
Original Mylar Map #0291-0621-0097, #0291-0621-0971, 0291-0621-0972
Wtby. Land Records V.7206 / P.187
$7,018.82 (January 31, 2017)
(a): None

R-A March 8, 2017

Notice of tax warrant and property tax auction:

The Tax Collector of the City of Waterbury, Connecticut, hereby gives Notice that a Tax Warrant(s) have been levied on the taxpayer(s) named below for failure to pay real estate taxes and water & sewer use charges due the City of Waterbury, Connecticut and that a Tax Collector's Sale has been scheduled by the Tax Collector, through its agent, Marshal or Constable, 56 Center Street, Waterbury, CT, (203) 757-4748, for the sale of the real properties levied in accordance with Connecticut General Statute §12-157.

TIME AND PLACE OF SALE:
DATE: March 23, 2017
TIME: 6:00 P.M.
PLACE: CITY HALL, 235 GRAND STREET, WATERBURY, CT 06702

The property being sold pursuant to this notice is being sold "as is" and "where is". The Tax Collector or Marshal may adjourn the sale in accordance with the provisions of Conn. Gen. Stat. §12-157. Neither the City nor any of its employees or agents make any representation as to the nature of the status of the property being sold including but not limited to: 1) the physical descriptions of the property; 2) title to the property; 3) its suitability for any particular use; 4) liens or encumbrances against the property that are not subject to extinguishment by virtue of the sale noticed hereby; or 5) any legal requirements or obligations which must be satisfied prior to the development or improvement of the property including, but not limited to, any approvals required pursuant to applicable zoning or land use laws or regulations and the completion of any and all required infrastructure improvements such as the completion of streets, the completion of the installation of public sanitary and storm sewer lines and the completion of the installation of public water lines and all other improvements required to services the development of which the subject property is a part. All bidders are cautioned that they are responsible for performing any and all due diligence with respect to the property and that, if they are successful bidder, they will take title to the property subject to all obligations and exceptions, including, but not limited to those mentioned above, which are not automatically extinguished pursuant to the statutory authority under which the sale notices hereby is being conducted. Qualified bidders at the time of the sale must have a bank or certified check in the amount of Three Thousand and 00/100 ($3,000.00) Dollars made payable to themselves. The balance of the sale price will be due and paid within ten (10) days of the conclusion of the sale, to Marshal or Constable, Trustee by bank or certified check. Additional costs and fees associated with the sale shall be posted and announced the day of the sale. All costs, water & sewer charges, and fees associated with this sale shall be deemed nonrefundable to the purchaser. ADDITIONAL TAXES, INTEREST, FEES AND OTHER CHARGES AUTHORIZED BY LAW ACCRUING AFTER December 31, 2016 SHALL BE ADDED TO THE AMOUNT INDICATED AS DUE AND OWING, AS WELL AS ALL OUTSTANDING WATER AND SEWER CHARGES DUE ON THESE PROPERTIES.
The properties subject to the tax warrant auction, the delinquent taxpayer(s) and the amount of taxes, sewer and water use charges and other charges due are described below:
1. Walford Campbell, 133 Fiske Street, Waterbury, CT, 06710
LEGAL DESCRIPTION OF THE PROPERTY UPON WHICH TAXES ARE DUE INCLUDING STREET ADDRESS:
23 Waterville Street, Waterbury, Connecticut
Original Mylar Map #0234-0059-0164
Wtby. Land Records V.5116 / P.46
AMOUNT OF THE TAX OR TAXES DELINQUENT, INCLUDING INTEREST AND CHARGES ATTRIBUTABLE TO THE PROPERTY AS OF THE LAST DAY OF THE MONTH IMMEDIATELY PRECEDING THE NOTICE AS WELL AS DELINQUENT WATER AND SEWER CHARGES: $4,880.64 (December 31, 2016)
LIST OF MORTGAGEES, LIEN HOLDERS AND OTHER RECORD ENCUMBRANCES OR PARTIES, WHOSE INTEREST IN THE PROPERTY WILL BE AFFECTED BY SUCH SALE, PURSUANT TO CONN. GEN. STAT. §12-157(a): Waterbury CT Teachers FCU, State of Connecticut Department of Revenue Services, State of Connecticut Office of the Attorney General, State of Connecticut Judicial Branch, Office of the Attorney General.

2. U.S. Bank Trust, N.A., as Trustee for LSF8 Master Participation Trust
650 Bunker Hill Avenue, Waterbury, Connecticut
Original Mylar Map #0157-0763-0018
Wtby. Land Records V.7521 / P.170
$18,599.69 (December 31, 2016)
(a): None

3. Katherine Mielicki
35 Deerwood Lane Unit 1, Waterbury, Connecticut
Original Mylar Map #0068-0241-0000-00035-00001
Wtby. Land Records V.4665 / P.212
$3,016.79 (December 31, 2016)
(a): Deerwood Hills Condominium Association Inc., G&W Management Inc., Nationstar Mortgage LLC, Capital One Bank, Law Offices of Howard Lee Schiff

4. Chan Albert- Peoples
137 Downes Street, Unit 1A, Waterbury, Connecticut
Original Mylar Map #0055-0830-0000-00001-0001A
Wtby. Land Records V.6767 / P.102
$2,805.72 (December 31, 2016)
(a): Fort Hill Park Condominium Association Inc., G&W Management Inc., State of Connecticut Department of Social Services, State of Connecticut Office of the Attorney General.

5. Joshua W. Penn
161 East Farm Street (aka 159-161 East Farm Street), Waterbury, Connecticut
Original Mylar Map #0238-0551-0083
Wtby. Land Records V.7076 / P.29
$7,991.45 (December 31, 2016)
(a): None

6. Sheryl A. Barnes
52 Fox Street, Waterbury, Connecticut
Original Mylar Map #0366-0672-0051
Wtby. Land Records V.2997 / P.156 and V.3443 / P.64
$2,723.23 (December 31, 2016)
(a): BMO Harris Bank NA, Ion Bank

10. Paul F. Garfield and Martha C. Garfield
11 Maplewood Street, Waterbury, Connecticut
Original Mylar Map #0095-0922-0007
Wtby. Land Records V.3397 / P.342
$2,386.83 (December 31, 2016)
(a): Beneficial Financial I, Inc., CT Corporation System, Bendett & McHugh, St. Mary's Hospital.

11. Julia Lee Weaver
39 Giles Street, Waterbury, Connecticut
Original Mylar Map #0277-0581-0068
Wtby. Land Records V.1581 / P.211
$2,388.14 (December 31, 2016)
(a): Emma Rinaldi, City of Waterbury Department of Public Health, Webster Bank NA

12. Krystle Rae Gaudiosi
22 Neil Street, Waterbury, Connecticut
Original Mylar Map #0302-0371-0042
Wtby. Land Records V.7282 / P.65
$2,766.30 (December 31, 2016)
(a): None

14. Energy Star, LLC
799 North Main Street, Waterbury, Connecticut
Original Mylar Map #0218-0184-0062
Wtby. Land Records V.6615 / P.145
$2,976.85 (December 31, 2016)
(a): Seven Morand Associates LLC, Daniel I. Konover (Agent)

17. FF98 LLC
10 Pearl Street, Waterbury, Connecticut
Original Mylar Map #0236-0176-0174
Wtby. Land Records V.6722 / P.203
$2,841.38 (December 31, 2016)
(a): City of Waterbury Fire Department

19. Ricardo Garcia, SR.
90 Society Hill Road, Waterbury, Connecticut
Original Mylar Map #0066-0985-0075
Wtby. Land Records V.7018 / P.333
$6,673.60 (December 31, 2016)
(a): Roddy Geddes III, Midland Funding LLC, Portfolio Recovery Associates LLC

21. Gregory E. Williams and Karrgitha E. Williams
53 South View Street, Waterbury, Connecticut
Original Mylar Map #0392-0302-0054
Wtby. Land Records V.7380 / P.259
$2,856.85 (December 31, 2016)
(a): Webster Bank NA, Connecticut Children's Medical Center, Greater Watertown FCU

22. 406 Watertown Avenue LLC
406 and 416 Watertown Avenue, Waterbury, Connecticut
Original Mylar Map #0213-0707-0035 and #0213-0707-0036
Wtby. Land Records V.7175 / P.185 and V.7175 / P.187
$21,278.62 (December 31, 2016)
(a): The Demunda Family LLC, Gloria C. Demunda, LJL Realty LLC

23. Lavish Republic, LLC
32 Winchester Street, Waterbury, Connecticut
Original Mylar Map #0166-0199-0082
Wtby. Land Records V.7251 / P.267 and V.7388 / P.297
$3,537.65 (December 31, 2016)
(a): None

R-A March 8, 2017

User, OHCA

From: Fernandes, David
Sent: Friday, March 17, 2017 8:32 AM
To: Jennifer Groves Fusco
Cc: User, OHCA; Schaeffer-Helmecki, Jessica; Lazarus, Steven; Riggott, Kaila; Roberts, Karen; Foster, Tillman
Subject: Docket # 16-32132 and 16-32133 CON: Request for Prefiled Testimony & Issues
Attachments: 32132, 32133.pdf

Dear Attorney Fusco,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for April 5, 2017 (docket number 16-32132 and 16-32133). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to OHCA@ct.gov by 4:00 p.m. on March 29, 2017. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact Kaila Riggott at Kaila.riggott@ct.gov if you have any questions.

Sincerely,

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 17, 2017

Via Email Only

Jennifer G. Fusco, Esq.
Updike, Kelly & Spellacy, P.C.,
265 Church Street
New Haven, CT 06510

RE: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc. (16-32132-CON)
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.(16-32133-CON)
Request for Prefile Testimony and Issues

Dear Attorney Fusco:

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket numbers on April 5, 2017. The hearing is at 4:00 pm, at Sharon Town Hall, 63 Main Street, Sharon Connecticut, 06069. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA requests that Sharon Hospital, Vasssar Health Connecticut, Inc., Health Quest Sytems, Inc. and Regional Healthcare Associates, LLC ("Applicants in each of the respective dockets") submit prefiled testimony **by 4:00 p.m. on March 29, 2017.**

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA **by 4:00 p.m. on March 29, 2017**.

Please contact Kaila Riggott at (860) 418-7001, if you have any questions concerning this request.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Sincerely,

Kevin T. Hansted
Hearing Officer

Attachment

ISSUES

Office of Health Care Access Docket Nos. 16-32132-CON & 16-32133-CON

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.
&
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.

The Applicants should be prepared to present and discuss supporting evidence on the following issues:

- The clear public need for the proposal;
- Community building and community benefits resulting from the transfer of ownership of Sharon Hospital ("Hospital") to Vassar Health Connecticut, Inc. ("Vassar"); including how these activities and benefits will be determined and prioritized;
- How access to care will be improved in the service area following the transfer of ownership of the Hospital;
- Expansions or additions to services offered, as listed on pages 650 and 883-887 of the application (DN: 16-32132);
- Vassar's plans to develop a Community Health Needs Assessment for the Hospital in 2017 and a subsequent implementation plan;
- The financial feasibility of the proposal; and
- Funding sources, other than those from the Foundation for Community Health, Inc., for capital improvements outlined in the proposal.

Provide a written response on the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the Application completeness process:

1. Provide a list prioritizing critical/immediate (over next 2-3 years) capital and operational improvements, including upgrades or strategic investments for the Hospital.

2. For each response to question one above, provide:

a) the funding source; and
b) the length of time estimated to implement each.

3. Explain how the Hospital currently solicits, conveys to the Hospital Board and addresses community input and concerns. Furthermore, describe how the Hospital will continue to solicit, convey to the Hospital Board and address community input and concerns following the transfer of ownership.

4. Please describe how the Hospital's board make-up currently incorporates representation of local health care consumers and how the Applicant will do so following implementation of the proposal.

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Friday, March 17, 2017 9:39 AM
To: Fernandes, David
Cc: User, OHCA; Schaeffer-Helmecki, Jessica; Lazarus, Steven; Riggott, Kaila; Roberts, Karen; Foster, Tillman
Subject: RE: Docket # 16-32132 and 16-32133 CON: Request for Prefiled Testimony & Issues
Attachments: image001.jpg

Thank you, David. We will have the prefile and responses to you by March 29 as requested.

Jen

_____

From: Fernandes, David [David.Fernandes@ct.gov]
Sent: Friday, March 17, 2017 8:31 AM
To: Jennifer Groves Fusco
Cc: User, OHCA; Schaeffer-Helmecki, Jessica; Lazarus, Steven; Riggott, Kaila; Roberts, Karen; Foster, Tillman
Subject: Docket # 16-32132 and 16-32133 CON: Request for Prefiled Testimony & Issues

Dear Attorney Fusco,

Attached please find a Request for Prefile Testimony and Issues related to the hearing scheduled for April 5, 2017 (docket number 16-32132 and 16-32133). Submit responses as an e-mail attachment, in both Word and .pdf format, and reply to OHCA@ct.gov<mailto:OHCA@ct.gov> by 4:00 p.m. on March 29, 2017. Additionally, confirm receipt of this e-mail with me as soon as possible.

Please feel free to contact Kaila Riggott at Kaila.riggott@ct.gov<mailto:Kaila.riggott@ct.gov> if you have any questions.

Sincerely,

David Fernandes
Planning Analyst (CCT)
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, Hartford, Connecticut 06134
P: (860) 418-7032|F: (860) 418-7053|E: David.Fernandes@ct.gov

[http://www.ct.gov/insidedph/lib/insidedph/communications/DPH-Color.gif]

_____

The Community Association to Save Sharon Hospital
P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

FAX Sheet

Date: March 23, 2017

To: Ms Yvonne T. Addo, MBA
Deputy Commissioner
Office of Health Care Access

Fax Number: 860- 418-7053

From: Community Association to Save Sharon Hospital

Subject: Attached Letter Requesting Intervenor Status at April 5, 2017 Hearing Concerning the Sale of Sharon Hospital

Please Note: For speed of communication, could you please contact me at my email address above, fax or phone. Thank you.
Victor Germack

The Community Association to Save Sharon Hospital

P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

March 23, 2017

Ms. Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Certificate of Need: Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

Dear Deputy Commissioner Addo:

This letter requests intervenor status at the April 5th public hearing concerning the above referenced Certificate of Need.

By way of background, I testified as an intervenor as vice-president of the Community Association to Save Sharon Hospital, Inc. (CASSH) at the original CON public hearing in Sharon, CT concerning the sale of Sharon Hospital to Essent Healthcare some 15 years ago. The Community Association to Save Sharon Hospital represented well over 100 people in the greater Sharon community, and today many of us, from our original group, still feel very strongly about the need for a well financed, resourced, quality hospital, and we continue to advocate for it.

In the 2001-2002, CASSH raised over $125,000 and retained a well-known health care attorney to represent us. We opposed the sale to Essent, and submitted suggestions to then Attorney General Blumenthal that imposed several financial restrictions on the buyer. We knew that as a financial private equity buyer, Essent would sell Sharon Hospital to another financial buyer, and then it would be sold to another as this is equity groups' financial model. History has demonstrated this: there have been three corporate owners over the past 15 years. During that period, Sharon Hospital's services, its quality, and the number of patients served have declined.

Review of the CON and discussions with the Sharon Hospital management, the Foundation for Community Health, and Health Quest reveals several issues of concern, such as:

1. Health Quest has an aggressive plan to attract patients, increase patient referrals and rapidly increase revenue and profitability in a very short time period – a plan that requires probing into its implementation;

2. The decreased and limited participation, governance role and share given to The Foundation for Community Health as outlined in its agreement with Health Quest. The Foundation will contribute the majority of the transaction purchase price ($3millon out of the $5million purchase price, and an additional $6million in capital commitments) – with little other input. The Foundation received $16 million when Sharon Hospital was sold, and its total funds are now $25million – any diminution of its corpus negatively impacts its continued successful funding of healthcare projects throughout our extended community;

3. The staying power and long-term commitment of Health Quest to Sharon Hospital must be questioned and ascertained since this is probably our last chance to get Sharon Hospital operating successfully.

Thank you for your consideration.

Sincerely,

Victor Germack
Vice President

cc: Attorney General George Jepsen
Assistant Attorney General Gary W. Hawes
Representative Brian Ohler
Charlene LaVoie, Esq.
Jennifer Groves Fusco, Esq.
(Updike, Kelly & Spellacy, P.C.)

Olejarz, Barbara

From: Lazarus, Steven
Sent: Friday, March 24, 2017 2:20 PM
To: Olejarz, Barbara; Martone, Kim; Hansted, Kevin; Schaeffer-Helmecki, Jessica; Fernandes, David; Foster, Tillman; Roberts, Karen; Riggott, Kaila
Subject: FW: Sharon Hospital -- Docket Nos. 16-31132-CON & 16-32133-CON
Attachments: DOCS-#1520171-v1-HEALTHQUEST_SHARON_OBJECTION_CASSH.PDF

Barbara,

Please add to the record.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Friday, March 24, 2017 2:13 PM
To: Lazarus, Steven
Cc: victorger@pipeline.com
Subject: Sharon Hospital -- Docket Nos. 16-31132-CON & 16-32133-CON

Steve,

Attached please find an Objection to CASSH's Request for Status, filed on behalf of the Applicants in both of the above-referenced dockets.

Thanks,
Jen

Jennifer Groves Fusco, Esq.

Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: TRANSFER OF OWNERSHIP OF SHARON HOSPITAL TO VASSAR HEALTH CONNECTICUT, INC.	)	DOCKET NO. 16-32132-CON & DOCKET NO. 16-32133-CON
IN RE: TRANSFER OF OWNERSHIP OF REGIONAL HEALTHCARE ASSOCIATES, LLC TO A SUBSIDIARY OF VASSAR HEALTH CONNECTICUT, INC.	)	MARCH 24, 2017

OBJECTION TO REQUEST OF
THE COMMUNITY ASSOCIATION TO SAVE SHARON HOSPITAL
FOR INTERVENOR STATUS

Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital ("Essent"), Sharon Hospital Holding Company ("SHHC"), Health Quest Systems, Inc. ("Health Quest"), Vassar Health Connecticut, Inc. ("Vassar Connecticut"), and Regional Healthcare Associates, LLC ("RHA") (collectively "Applicants"), Applicants in the above-referenced CON proceedings under Docket Nos. 16-32132-CON and 16-32133-CON, hereby object to The Community Association To Save Sharon Hospital's ("CASSH") request for intervenor status, dated March 23, 2017 (the "Request"). CASSH has not established that it has a present interest affected by these proceedings that would justify its request to participate (Regulations of Connecticut State Agencies ("RCSA"), §19a-9-27(b)(2)). Nor has CASSH established that its participation in these proceedings will add evidence or arguments on relevant issues that would not otherwise be available to OHCA (RCSA, §§19a-9-27(b)(4)) or that its participation is in the interest of justice and will not impair the orderly conduct of the proceedings (Conn. Gen. Stat. §4-177a(b)).

CASSH's "concerns" relative to the proposed sale of Sharon Hospital to Vassar Connecticut, and its belief that OHCA should "probe" or further question Health Quest on various issues related to its Application, are not sufficient to support its status as an intervenor. CASSH's participation as an intervenor should therefore not be allowed. Rather, the organization's members should be limited to informal participant status, the same as other interested members of the public.

In support of the Objection, Applicants offer the following:

- Per the Request, CASSH was formed more than 15 years ago for the specific purpose of opposing and/or suggesting restrictions relative to the for-profit conversion of Sharon Hospital under Sections 19a-486 et seq. of the Connecticut General Statutes. Although the organization claims to still "feel strongly about the need for a well-financed, resourced and quality hospital," CASSH has not demonstrated through the Request that it has an interest in these proceedings beyond those interests held by the general public (RCSA § 19a-9-27(b)(2)). Nor has CASSH established that it has organizational standing to intervene and participate in a CON proceeding regarding the subsequent sale of Sharon to a tax-exempt entity and its conversion back to a not-for-profit hospital.
- CASSH has not, in its Request, described the manner in which it proposes to participate in the public hearing, as required by Section 19a-9-27(b)(3) of the Regulations of Connecticut State Agencies.
- CASH has not, in its Request, described the manner in which such participation will furnish assistance to the agency in resolving the issues before it, as required by Section 19a-9-27(b)(4) of the Regulations of Connecticut State Agencies. Instead, CASSH simply lists three areas into which it believes OHCA should inquire further of Applicants.

These topics include volume and financial projections for the Hospital; the Foundation for Community Health, Inc.'s ("FCH") participation with the new Sharon Hospital; and Health Quest's commitment to the Sharon community. These are all matters that have been discussed at length in Applicants' submission, will be detailed further in written testimony and hearing presentations, and that OHCA can inquire about without CASSH's formal participation in these proceedings.

- CASSH has not, in its Request, adequately summarized the evidence it intends to offer at the public hearing, as required by Section 19a-9-27(b)(5) of the Regulations of Connecticut State Agencies. Again, CASSH simply raises topics for further inquiry by OHCA at the public hearing.
- Representatives of the Applicants have spoken with Victor Germack and other members of CASSH on several occasions over the course of the last month. These included an in-person meeting at Sharon Hospital on March 6th that lasted nearly three hours at which Mr. Germack and others were allowed to ask questions and a two-hour Community Forum held on March 16th at Sharon Town Hall. We also understand that representatives of CASSH met separately with FCH to address their concerns.
- Based on these conversations, Applicants are aware of no specific evidence that CASSH members can or will present other than their own opinions relative to the volume and financial projections contained within the CON submissions. To the best of Applicants' knowledge, no member of CASSH has unique knowledge with respect to the operation and financing of an acute-care hospital such that the organization's participation will be of assistance to OHCA in adjudicating Applicants' request.

- Moreover, the statements made by CASSH in its Request relative to the issuance of grant funding by FCH are misleading and have been addressed both in CON submissions and at the recent public forum where CASSH representatives were in attendance. Allowing this type of participation by an organization that has limited knowledge of the terms of a privately negotiated transaction will impair the orderly conduct of the CON proceedings.

In light of the foregoing, Applicants respectfully request that CASSH's Request for intervenor status be denied and that its members be given informal participant status instead. If CASSH is allowed to participate as an intervenor, Applicants request that its participation be limited to written filings on relevant issues and that CASSH not be given the opportunity to cross-examine Applicants.

Respectfully Submitted,

ESSENT HEALTHCARE OF CONNECTICUT, INC; SHARON HOSPITAL HOLDING COMPANY; REGIONAL HEALTHCARE ASSOCIATES, LLC; HEALTH QUEST SYSTEMS, INC.; VASSAR HEALTH CONNECTICUT, INC.

By: Jennifer G. Fusco

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 24th day of March, 2017 to the following parties:

Victor Germack
The Community Association
To Save Sharon Hospital
P.O. Box 612
Salisbury, CT 06068
victorger@pipeline.com

Jennifer G. Fusco
JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTERS OF:

Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc. (16-32132-CON)
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.(16-32133-CON)

RULING ON A PETITION FILED BY THE COMMUNITY ASSOCIATION TO SAVE SHARON HOSPITAL TO BE DESIGNATED AS AN INTERVENOR

By petition dated March 23, 2017, The Community Association to Save Sharon Hospital ("Petitioner") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the above-referenced Certificate of Need ("CON") applications.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioner is hereby designated as an Intervenor with limited rights at the hearing scheduled for April 5, 2017 at Sharon Town Hall, 63 Main Street, Sharon, Connecticut. As an Intervenor with limited rights, the Petitioner may participate as indicated below.

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CONs filed under Docket Numbers 16-32132-CON and 16-32133-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an Intervenor with limited rights, the Petitioner may be cross-examined by the Applicant but the Petitioner may not cross-examine the Applicant.

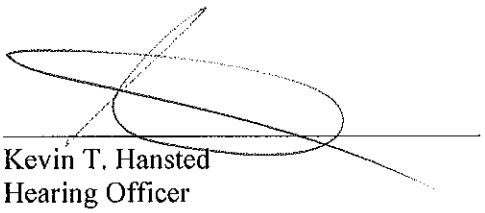
OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

The Petitioner shall maintain compliance with Section 2-44A of the Connecticut Practice Book.

DPH
Connecticut Department of Public Health

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

3/24/17
Date



Kevin T. Hansted
Hearing Officer

Olejarz, Barbara

From: Lazarus, Steven
Sent: Friday, March 24, 2017 2:58 PM
To: victorger@pipeline.com
Cc: Jennifer Groves Fusco (jfusco@uks.com); Olejarz, Barbara; Riggott, Kaila
Subject: re: Docket Numbers: 16-32132 and 16-32133 _Ruling on Petition for Status by CASSH
Attachments: 16-32132 and 16-32133 Ruling on Petition for Status by CASSH.pdf

Good Afternoon Mr. Germack,

Please see the attached ruling by the Office of Health Care Access in the above referenced matter. Please feel free to contact me if you have any questions.

Thank you,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Olejarz, Barbara

From: Lazarus, Steven
Sent: Tuesday, March 28, 2017 8:56 AM
To: Olejarz, Barbara
Cc: Greer, Leslie; Martone, Kim; Riggott, Kaila; Hansted, Kevin; Fernandes, David; Schaeffer-Helmecki, Jessica
Subject: FW: Legislative Letters of Support
Attachments: Sharon Hospital Letter of Support.pdf; Letter to Yvonne Ado DPH CON Sharon Hospital Nov 2016.pdf

Barbara,

Please see the email below and the attachments regarding DN: 16-32132.

Thanks,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Monday, March 27, 2017 4:39 PM
To: Lazarus, Steven
Cc: Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com)
Subject: Legislative Letters of Support

Hi, Steve.

I'm not sure if these letters of support were sent to OHCA directly, so I am forwarding copies for the record in Docket Nos. 16-32132-CON. The letters are from former State Rep. Roberta Willis, State Sen. Craig Miner and State Rep. Brian Ohler.

Time permitting, Rep. Ohler may attend the hearing on April 5th. Is it still OHCA's practice to allow legislators to give their remarks at the beginning of the hearing?

Thanks,
Jen

Jennifer Groves Fusco, Esq.
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State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

March 27, 2017

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue
MS #13HCA
Hartford, CT 06134-0308

Dear Deputy Commissioner Addo:

We write in enthusiastic support of Sharon Hospital's request for a Certificate of Need (CON). Upon obtaining a CON, Sharon Hospital will be able to complete the process of transitioning to a non-profit hospital and join a group of other non-profit hospitals and healthcare professionals known as Health Quest.

By joining Health Quest, Sharon Hospital will be afforded the opportunity to expand and improve upon the outstanding healthcare services they currently provide to residents of Northwestern Connecticut. Sharon Hospital is a small rural facility, so an association with Health Quest would ensure they remain competitive with other healthcare facilities throughout the state.

It is our belief that granting a CON to Sharon Hospital is in the best interest of so many residents of Connecticut, and it is our hope that you will give favorable consideration to this worthwhile request in your evaluation process.

Sincerely,

Craig Miner
State Senator, 30th District

Brian Ohler
State Representative, 64th District

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ROBERTA B. WILLIS
SIXTY-FOURTH DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 1802
HARTFORD, CT 06106-1591
HOME: (860) 435-0621
CAPITOL: (860) 240-8585
TOLL FREE: (800) 842-8267
FAX: (860) 240-8833
E-MAIL: Roberta.Willis@cga.ct.gov

CHAIRMAN
HIGHER EDUCATION & EMPLOYMENT ADVANCEMENT COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE

November 7, 2016

Yvonne T. Addo, MBA, Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #13HCA
Hartford, CT 06134-0308

Re: Certificate of Need – Sharon Hospital

Dear Ms. Addo:

I write to you today in enthusiastic support of Sharon Hospital's application for a Certificate of Need that is required for its affiliation with Health Quest. The citizens of Northwest Connecticut are eager to see their small rural hospital to once again become a community not for profit full service acute care health center.

Sharon Hospital's patients will continue to have access to the services they presently receive, and in addition, a greater network of professional providers. There will the added opportunity for expanded services when it joins Health Quest, a family of nonprofit hospitals and healthcare professionals.

Health Quest is a natural fit for Sharon. It is the nearest tertiary care facility to Sharon. With the proposal for Charlotte Hungerford and Hartford Health Care, Sharon becomes one of the few hospitals in Connecticut that does not have an affiliation in the area, which puts a small rural hospital at a tremendous disadvantage and places its future in harm's way. To survive in the present healthcare landscape, the state's smallest hospital requires a sustainable framework.

Thank you for considering the Certificate of Need application being submitted by Sharon Hospital. I think I can say with confidence, the community is hopeful that this application is approved as expeditiously as possible. I have been on the Advisory Board of the hospital since it was acquired by Essent Healthcare, so please do not hesitate to ask any questions you might have on this proposal.

Sincerely,

Roberta Willis
State Representative

The Community Association to Save Sharon Hospital
P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

FAX SHEET

Date: March 27, 2017

To: Ms. Yvonne T. Addo, MBA
Deputy Commissioner
Office of Health Care Access

Fax Number: 860-418-7053

From: The Community Association to Save Sharon Hospital

Subject: Copy of Letter to Assistant Attorney General Gary W. Hawes

Please Note: For speed of communications, could you please contact me at my email address above, fax or phone. Thank you. Victor Germack

The Community Association to Save Sharon Hospital

P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

March 27, 2017

Mr. Gary W. Hawes
Assistant Attorney General
State of Connecticut
55 Elm Street
Hartford, CT. 06106

Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Certificate of Need: Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Assistant Attorney General Gary W. Hawes
Office of the Attorney General
State of Connecticut
55 Elm Street
Hartford, CT. 06106

Dear Assistant Attorney General Hawes:

Thank you for your March 24th. email regarding the Sharon Hospital sale to Health Quest, and the role of The Foundation for Community Health ("the Foundation") in providing the majority of the purchase price as well as providing significant capital funds. Since time is short and I was told you wouldn't be back till Thursday of this week, I thought I would send you this letter for your consideration.

While you state that the Hospital Conversion Act does not apply to the sale of for-profit hospitals, we want to bring several facts to your attention. As citizens of Connecticut we expect the Attorney General to represent the public interest which is embodied in The Foundation for Community Health since they are providing the majority of the financing

for this purchase; not to do so would be an abrogation of your constitutional duties as Attorney General.

We are writing you in the expectation, that your office would review and then mandate, in the public interest, certain specific changes in the existing Foundation's Grant Agreement, dated September 13, 2016, between the Foundation, Health Quest, and Berkshire Taconic Community Foundation, Inc. (the "Agreement") which will remedy certain shortcomings in the Agreement. We have outlined specific recommendations for changes which we hope you and the Office of Healthcare Access will adopt.

We feel that the Agreement, as it is currently written, is not a 'good deal' for the community, is 'one-sided', and is not fair for those who have contributed to the Foundation. It is unfair and prejudicial to the public interest, to the interests of the Foundation contributors and to those individuals in the Community who initially contributed to Sharon Hospital, prior to its initial conversion in 2002.

The Foundation has currently $25 million in assets which includes the Essent Healthcare purchase price, existing endowment funds at the time of sale in 2002, and funds raised and interest earned since then. The Grant Agreement requires that the Foundation restrict $9 million of its funds, or 36%, of its total funds. This will dramatically negatively impact the Foundation's future annual grant making ability to the Community which it has successfully implemented over the past 15 years. The $9 million also represents over 56% of the $16 sale amount that the Foundation received from the sale of Sharon Hospital to Essent Healthcare in 2002. In fairness to the many contributors to Sharon Hospital, pre 2002, and to the Foundation, post 2002, we urge the Attorney General and the Office of Healthcare Access to mandate the changes that we have recommended below, and to make this a fairer and more equitable structure and agreement and protect the public interest.

1. **Coverage by the Attorney General:**
   Since the Foundation is a public charity within the meaning of Code 501(c) (3), it comes under the jurisdiction and review of the Attorney General of Connecticut.

2. **Purchase Price:**
   Under the Grant Agreement, the Foundation is committing $9 million (which become restricted funds) in grants to Health Quest. 60% of the Sharon Hospital acquisition purchase price - $3 million out of the $5 million total purchase price will be committed by the Foundation and another $6 million in Investment up to 4 years is being committed to Health Quest.

   Since the Foundation is not the buyer of Sharon Hospital and is only helping Health Quest finance the acquisition, why then does it have to put in 60% of the purchase price? By any manner of comparison, Health Quest, as the owner of Sharon Hospital, does not have enough financial stake and financial commitment in this planned purchase. Additionally since the Foundation does not get a carried ownership interest, or have a real governance role at Sharon Hospital or gets its investment back if the Hospital is sold to a third party after the first five years of

ownership, then the Foundation's agreement to fund the $3 million is not prudent or fair.

We suggest that a purchase investment of only $1 or 2 million by the Foundation would be appropriate – given the limited stated representation that the Foundation will have on the Sharon Hospital Board of Trustees (just an advisory board), the Health Quest Board of Trustees (just one seat) and its lack of an ownership, carried interest or no governance role as it is currently stated in the Agreement. These issues are spelled out in greater detail below.

3. **Working Capital Grant:**
These grants totaling $6 million "...are dedicated for actual direct cost outlays associated with Health Quest's strategic investments at New Sharon Hospital including, without limitation, investments in direct physician and provider costs, investments in strategic equipment, facility upgrades, investments in ambulatory networks, investments in information technology infrastructure, and other strategic programmatic investments (collectively, "Investments")". We don't believe that paying for direct physician and provider costs are strategic investments – what they are is normal operating costs. Health Quest should be providing enough working capital to support Sharon Hospital's ongoing operations, including physician costs.

We would suggest that the Grant Agreement language pertaining to the Working Capital Grant should be changed to remove any references to investments in, or paying for direct physician and provider costs.

4. **Return of Grant Amount:**
If Sharon Hospital is sold to a third party after the first five years of ownership by Health Quest, then the Foundation does not get its asset purchase grant and, or its capital grant returned.
This is unfair to the public interest and to the Foundation. We would suggest that it should be changed so that if Sharon Hospital is sold to a third party during the first 15 years of ownership by Health Quest, then the Foundation should get its asset purchase grant, and working capital grant, less all Capital Campaign Funds raised to date by the Foundation, returned to it.

5. **There Is No Binding Commitment by Health Quest to Continue to Financially Support Sharon Hospital for a Specified Period of Time and, or For a Specific Amount:**
As the financial and operating numbers in the CON show, Sharon Hospital has been in decline for a long period of time – over the past several years, the Hospital has been cutting staff and services, losing quality doctors by attrition and poor management by three corporate owners, leading to a decline in the number of both in-and outpatients. This has caused many former patients and potential patients to seek health care elsewhere. To see the effect of this, all you have to do is read the local newspapers, speak to the doctors, and speak to the former patients who have given up on Sharon Hospital. In a small, local Community, such as ours, news travels mainly by word of mouth and referrals.

The business plan and financial projections as set forth in the CON by Health Quest for Sharon Hospital are too aggressive and are unrealistic. The CON show Sharon Hospital returning to profitability in two short years – earning $5.2 million – by 2018, and discharges increasing by 53% between 2016 and 2018. It projects adding incremental operating revenue of $17.5 million in the first two years (2017 and 2018) with an associated operating profit margin of 45.1% on this revenue base. The CON financial projections show an operating profit margin for Sharon Hospital in 2018 of 6.9% on its projected total revenue of $74.9 million. The projected operating profit margin is higher that any hospital has ever achieved in Connecticut in recent years. Using OHCA's 2015 financial results for Connecticut (the latest year that OHCA has made this information publicly available), the hospital with the best operating profit margin in Connecticut is Yale-New Haven which reached 4.5% for 2015. The Sharon Hospital CON projections are just not believable, and we don't believe they are attainable. Further it casts doubt on the reasonableness of Health Quest's action plans for Sharon Hospital.

What is missing in the CON is a lack of the detailed explanations and the level of support on how Health Quest will implement the Sharon Hospital turnaround and make their projected results happen. It will take years for Sharon Hospital to reach a significant level of profitability and then only, with solid management, leadership and underlying financial support from Health Quest.

Since it took such a long time for Sharon Hospital to decline, it will also take a long period of time, for the word to travel that Sharon Hospital is a quality health resource once again. This takes time, staying power and money.

In its CON, Health Quest states that, "Vassar Connecticut expects to maintain current services for a period of three years, subject to patient demand and the availability of physicians and other clinical providers and staff" – what exactly does this guarantee to our Community?

There are no contractual minimum levels of financial support that are set forth by Health Quest in the Agreement, or in the CON. Nor is Health Quest bound to support Sharon Hospital for any minimum period of time. The Foundation is committing $9 million to Sharon Hospital which may never be recovered, if the Hospital fails under Health Quest ownership. What this means, is that the Foundation will have $9 million less to spend on worthy health-related Community projects throughout our area. Additionally, there is no contractual guarantee contained in the Agreement, that Health Quest won't come back to the Foundation and ask for more financial support.

We would suggest that Health Quest commit to financially and operationally support Sharon Hospital for a minimum period of 10 years, and commit that they will not ask the Foundation for any additional financial support.

6. **Governance – Sharon Board of Trustees:**
The Grant Agreement provides that the Foundation can have up to 12 representatives (80% of the total) serve on the Sharon Board of Trustees (which is basically a local advisory group) which will be composed of 15 members. There are three groups of Trustees with different terms, but in no event is there a contractual right for the Foundation to have its representatives serve as trustees after the sixth year.
This is unfair and we would suggest that it should be changed so that after the sixth year, there will continue to be a majority of the trustees who will be selected by the Foundation and who will serve on the Sharon Hospital Board of Trustees as long as Sharon Hospital is owned by Health Quest.

7. **Governance – Health Quest Board of Trustees:**
The Grant Agreement states that, "The Chair of the Board of Trustees of New Sharon Hospital shall serve ex-officio on the Health Quest Board of Trustees." There is not enough board representation by the Foundation on the Health Quest Board of Trustees given the Agreement's current requirement that the Foundation invest $9 million into New Sharon Hospital.

   We would suggest that at least three members of the New Sharon Hospital Board of Trustees be named to the current 18 members Health Quest Board of Trustees, and that they be full voting members as long as Sharon Hospital is owned by Health Quest.

8. **Annual Information Reporting to the Community to be Required:**
To serve and inform the Community on its progress in improving Sharon Hospital, the Grant Agreement should be modified to require that the Sharon Hospital Board of Trustees will issue an written annual report to the Community, no later than March 1 of the following year, on the state of Sharon Hospital as it pertains to the services offered, the quality of health, physician recruitment, hospital services added, patients serviced and discharged – inpatients and outpatients, the financial results, and whatever other critical information the Sharon Hospital Board feels it needs to present to the Community.

9. **A Monitor Should Be Added:**
We would suggest that a monitor be appointed by either the Attorney General or OHCA for the first five years, following the purchase of Sharon Hospital by Health Quest, to insure that the terms of the Agreement are followed and there is an equitable accounting of the funds given by the Foundation to Health Quest under the terms of the Agreement.

By way of background, I am the President of RateFinancials Inc. which was started in 2002. Our company rates the financial reporting, accounting and governance practices of corporations, including health care companies and hospitals – and as such, we are considered financial experts. I am the President of Heritage Capital Corp. – a middle market investment banking company which was started in 1977. I am also the Treasurer and on the Board of The Osborne Association – a non-profit social services agency which

works in over 20 prisons in New York State, providing a full range of services including behavioral, court advocacy, job placement, addiction treatment, etc.

The members of The Community Association to Save Sharon Hospital all live in the area served by Sharon Hospital and have organizational standing as we are all impacted and affected by the medical services offered by Sharon Hospital. If Sharon Hospital ceases to exist, we would all be directly adversely affected so therefore we have a meaningful stake in the outcome of the public hearings and what is decided. We also intend to submit written testimony prior to the public hearing.

We ask that the Attorney General act in these proceedings and adopt our suggestions for the various changes we have made.

Thank you for your consideration.

Sincerely,

Victor Germack
Vice President

cc: The Honorable Attorney General George Jepsen
The Honorable Senator Richard Blumenthal
Deputy Commissioner Ms. Yvonne T. Addo
Representative Brian Ohler
Charlene LaVoie, Esq.
Jennifer Groves Fusco, Esq.

User, OHCA

From: victorger@pipeline.com
Sent: Wednesday, March 29, 2017 12:47 PM
To: User, OHCA
Cc: Jennifer Groves Fusco; Hawes, Gary W.; Charlene LaVoie
Subject: Testimony Submitted By CASSH for April 5, 2017 Public Hearing
Attachments: 3-29-17 Testimony Submitted From CASSH.docx

To: Ms.Yvonne T. Addo, Deputy Commissioner, Office of Health Care Access and Mr. Kevin T. Hansted, Hearing Officer

Testimony Submitted by The Community Association to Save Sharon Hospital for the April 5, 2017 Public Hearing

The Community Association to Save Sharon Hospital

P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

March 29, 2017

Ms. Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capital Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Certificate of Need: Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Testimony Submitted by The Community Foundation to Save Sharon Hospital

For the Public Hearing to be held by the Department of Public Health Office of Health Care Access on April 5, 2017 at Sharon Town Hall, Sharon, CT.

Some sixteen years ago, I testified as the Vice President of The Association to Save Sharon Hospital (CASSH) at the original CON public hearing in Sharon, CT. before Attorney General Blumenthal and the Office of Health Care Access concerning the sale of Sharon Hospital to Essent Healthcare. Since then, Sharon Hospital has had three corporate owners, its services have deteriorated, patient volume has declined, and it is unprofitable. My testimony today seems even more important than it was sixteen years ago as Sharon Hospital today only has one more chance for it to become a viable entity.

In general, we support non-profit hospitals as a better alternative than the for-profit model. On a preliminary basis, subject to our reservations, we support the planned sale of Sharon Hospital to Health Quest provided certain additional information, not provided in the CON, is furnished, and certain written assurances are obtained from Health Quest about the extent and amount of their financial commitment to Sharon Hospital.

In addition, we seek certain specific changes to the existing Foundation's Grant Agreement, dated September 13, 2016, between the Foundation, Health Quest, and Berkshire Taconic Community Foundation, Inc. (The "Agreement") which will remedy certain shortcomings in the Agreement. We have outlined specific recommendations below that we hope the Office of Healthcare Access will adopt. We have also written to the Attorney General asking him to represent the public interest which is embodied in The Foundation for Community Health since they are providing the majority of the financing for this purchase; and not to do so would be an abrogation of the Attorney General's constitutional duties

We have asked the Attorney General to review and then mandate, in the public interest, certain specific changes in the existing Foundation's Grant Agreement, which will remedy certain shortcomings in the Agreement. We have outlined below specific recommendations for changes which we hope that the Office of Health Care Access and the Attorney General will adopt.

We feel that the Agreement, as it is currently written, is not a 'good deal' for the community, is 'one-sided', and is not fair for those who have contributed to the Foundation. It is unfair and prejudicial to the public interest, to the interests of the Foundation contributors and to those individuals in the Community who initially contributed to Sharon Hospital, prior to its initial conversion in 2002 and subsequently from 2002 to the present. Those who contributed to the Foundation between 2002 and the present were contributing in the expectation and knowledge that their contributions would be going to the stated purpose of helping fund worthwhile health care projects in our Community, not that their funds would be committed to buy Sharon Hospital.

1. **There Is No Binding Commitment by Health Quest to Continue to Financially Support Sharon Hospital for a Specified Period of Time and, or For a Specific Amount:**
   As the financial and operating numbers in the CON show, Sharon Hospital has been in decline for a long period of time – over the past several years, the Hospital has been cutting staff and services, losing quality doctors by attrition and poor management by three corporate owners, leading to a decline in the number of both in-and outpatients. This has caused many former patients and potential patients to seek health care elsewhere. We met with Sharon Hospital's management on March 6, 2017 to get additional insight into their operation. They said that they only had 6 inpatients that week in the Hospital, and in the prior week, they had only admitted one new inpatient. They said that the emergency room is the main driver of inpatients and that a real cultural change is necessary for the EMS groups that bring patients to the Hospital and transfer them out. They feel that they lose some 500 patients annually who get transferred-out because Sharon Hospital lacks the specialists and the services. They also mentioned the negative impact of the Connecticut 6% hospital provider tax which cost them some $3.1 million last year. This wasn't a surprise to us, as all you have to do is read the local newspapers, speak to the doctors, and speak to the former

patients who have given up on Sharon Hospital. In a small, local Community, such as ours, news travels mainly by word of mouth and referrals.
Since it took such a long time for Sharon Hospital to decline, it will also take a long period of time, for the word to travel that Sharon Hospital is a quality health resource once again for former patients to return and new ones to approach the Hospital. This takes time, staying power and money

The business plan and financial projections as set forth in the CON by Health Quest for Sharon Hospital are too aggressive and are just not believable. We took the financial worksheets that were submitted in the CON for Sharon Hospital and Regional Healthcare Associates and consolidated them into a separate worksheet, Exhibit 1 which is attached. The reason for the consolidation is that for financial reporting purposes, both entities are combined. Exhibit 1 shows Sharon Hospital returning to profitability in two short years – earning $5.2 million – by 2018. In the CON, in a response to a question by OHCA, Sharon Hospital showed in its Incremental Growth Projections, discharges increasing by 53% between 2016 actual and 2018. Exhibit 1 projects adding incremental operating revenue of $17.5 million in the first two years (2017 and 2018) with an associated operating profit margin of 45.1% on this incremental revenue base. This is a very high unjustified margin. The CON financial projections show an operating profit margin for Sharon Hospital in 2018 of 6.9% on its projected total revenue of $74.9 million. The projected operating profit margin is higher that any hospital has ever achieved in Connecticut in recent years. Using OHCA's 2015 financial results for Connecticut listed on their website (FY 2015 Hospital Health System – Statement of Operations Data - the latest year that OHCA has made this information publicly available), the hospital with the best operating profit margin in Connecticut is Yale-New Haven which reached 4.5% for 2015. In fact, of the 17 hospital systems listed and reported in the OHCA data, just 10 systems showed profitable profit margins, and most did not exceed a 1% operating profit margin. There is no reason to believe that in just two short years Sharon Hospital can turn around and outperform every other hospital in Connecticut. The Sharon Hospital CON projections are just not believable and these projections cast serious doubt on the soundness of Health Quest's overall business plan for the New Sharon Hospital. <u>We would like to see realistic business and operating projections</u>.

What is missing in the CON is a lack of the detailed explanations and the level of support on how Health Quest will implement the Sharon Hospital turnaround and make their projected results happen. It will take years for Sharon Hospital to reach a significant level of profitability and then only, with solid management, leadership and underlying financial support from Health Quest.

There are no contractual minimum levels of financial support that are set forth by Health Quest in the Agreement, or in the CON. Nor is Health Quest bound to support Sharon Hospital for any minimum period of time. The Foundation is committing $9 million to Sharon Hospital which may never be recovered, if the Hospital fails under Health Quest ownership. What this means, in the meantime, is that the Foundation will have $9 million less to spend on worthy health-related

Community projects throughout our area. Additionally, there is no contractual guarantee contained in the Agreement, that Health Quest won't come back to the Foundation and ask for more financial support.

We would therefore ask that Health Quest commit to financially and operationally supporting Sharon Hospital for a minimum period of 10 years, and commit that they will not ask the Foundation for any additional financial support

2. **Detailed CON Review and Requests for Information and Clarification**
We have noted in our review of the CON, a number of inadequate or incomplete responses to the questions raised by the OHCA staff. Some of these are:

   A. In its CON, Health Quest states that, "Vassar Connecticut expects to maintain current services for a period of three years, subject to patient demand and the availability of physicians and other clinical providers and staff" – what exactly does this guarantee to our Community? Health Quest should make a long-term commitment to provide essential medical at New Sharon Hospital for a minimum period of 10 years. This should be a minimum requirement.
   B. How much working capital is needed to finance the operation of Sharon hospital until 'real' profitability is achieved. We don't know now as we have a business plan/financial projection that is not believable, and no cash flow projection has been submitted. Please furnish the working capital requirements over time.
   C. In a response to a question asked by OHCA, to "explain the 143% increase in inpatient discharges or outpatient visits to cover financial incremental expenses between FY 2018 and FY 2019 as stated on page 44 of the application. How did the Applicants arrive at this increase in incremental inpatient and outpatient utilization?" The answer does not appear to be responsive, and is somewhat confusing. It doesn't explain the increase in utilization and, furthermore, using the specific discharge rate of $10,000 per discharge, and $300 for each outpatient visit, generates revenue of $4,254,90 in 2019 – way in excess of the total estimated incremental costs of $2,125,000. Would Health Quest please explain this?
   D. How does Health Quest's charity or indigent care policy differ from that provided by Sharon Hospital – and on a going forward basis, and using Health Quest's charity care policy at New Sharon Hospital, how many patients will be covered and to what degree, compared to Sharon Hospital's existing policy? Will Sharon Hospital's charity care patients be better off or worse off under Health Quest's charity care program, and by how much?
   E. The CON states that capital improvements will cost, at least $11.5 million. We believe that this may be materially understated. At the March 16, 2017 Public Forum, Mr. Friedberg, President of Health Quest, said that they will put capital into retrofit some areas but physical plant is not likely to need expansion. Upon information and belief, we understand that Sharon Hospital paid for an energy efficiency and savings program/energy audit that Trane conducted, approximately two years ago. It showed that Sharon Hospital is still burning grade 6 fuel oil (which is not permitted in New York – and is terribly dirty

stuff) – and they must convert the system and make a fuel change over to burning cleaner fuel which is absolutely essential. We read in the Con, that the Hospital is planning to spend some $1.5 million and take an old oil tank out of the ground and make a partial change in their energy generation system. The main boilers will still be over 50 years old. We understand that the energy study showed that a complete change and energy upgrade would cost approximately $5 million, but would generate savings of approximately $400,000 plus in annual utility savings. Sharon Hospital's private equity owner did not want to spend for this program or incur additional debt. Does Health Quest intend to invest to upgrade the energy generation and improve the Hospital's energy efficiency?

F. Health Quest says that "Sharon Hospital is projecting to add a total of eighteen (18) full time positions through FY 2020, all of which are non-physician positions". It also says it will add "48 additional full time employees through FY 2020". How many full time physicians will be added to Sharon Hospital and when? Will they be primary care or what will be their specialty – can this be broken out? Will these physicians be working solely at Sharon Hospital, or will they be dividing their time at other Health Quest hospitals? Will Health Quest provide a staffing spreadsheet by timing, specialty and location - spelling out the above information?

G. In Sch. 4.16 Tax Returns, it says that Regional Healthcare Associates LLC has not filed its federal or state income tax returns or paid any corresponding income taxes for the last 2 fiscal years ending 9/30/14 and 9/30/15. We were told at our March 6 meeting with Sharon Hospital management that this was a clerical issue., and that they are treated as a partnership for Federal and State income tax. As full disclosure, we still would like to see the returns and understand why they weren't timely filed. When will these returns be filed?

3. **The Foundation for Community Health Involvement in the Purchase of Sharon Hospital and Suggested Changes in the Structure, Governance and Oversight**

The Foundation has currently $25 million in assets which includes the Essent Healthcare purchase price, existing endowment funds at the time of sale in 2002, and funds raised and interest earned since then. The Grant Agreement requires that the Foundation restrict $9 million of its funds, or 36%, of its total funds. This will dramatically negatively impact the Foundation's future annual grant making ability to the Community which it has successfully implemented over the past 15 years. The $9 million also represents over 56% of the $16 sale amount that the Foundation received from the sale of Sharon Hospital to Essent Healthcare in 2002. In fairness to the many contributors to Sharon Hospital, pre 2002, and to the Foundation, post 2002, we urge the Attorney General and the Office of Healthcare Access to mandate the changes that we have recommended below, and to make this a fairer and more equitable structure and agreement and protect the public interest.

A. Coverage by the Attorney General:
Since the Foundation is a public charity within the meaning of Code 501(c) (3), it comes under the jurisdiction and review of the Attorney General of Connecticut.

B. Purchase Price:
Under the Grant Agreement, the Foundation is committing $9 million (which become restricted funds) in grants to Health Quest. 60% of the Sharon Hospital acquisition purchase price - $3 million out of the $5 million total purchase price will be committed by the Foundation and another $6 million in Investment up to 4 years is being committed to Health Quest.

Since the Foundation is not the buyer of Sharon Hospital and is only helping Health Quest finance the acquisition, why then does it have to put in 60% of the purchase price? By any manner of comparison, Health Quest, as the owner of Sharon Hospital, does not have enough financial stake and financial commitment in this planned purchase. Additionally since the Foundation does not get a carried ownership interest, or have a real governance role at Sharon Hospital or gets its investment back if the Hospital is sold to a third party after the first five years of ownership, then the Foundation's agreement to fund the $3 million is not prudent or fair.

We suggest that a purchase investment of only $1 or 2 million by the Foundation would be appropriate – given the limited stated representation that the Foundation will have on the Sharon Hospital Board of Trustees (just an advisory board), the Health Quest Board of Trustees (just one seat) and its lack of an ownership, carried interest or no governance role as it is currently stated in the Agreement. These issues are spelled out in greater detail below.

C. Working Capital Grant:
These grants totaling $6 million "…are dedicated for actual direct cost outlays associated with Health Quest's strategic investments at New Sharon Hospital including, without limitation, investments in direct physician and provider costs, investments in strategic equipment, facility upgrades, investments in ambulatory networks, investments in information technology infrastructure, and other strategic programmatic investments (collectively, "Investments")". We don't believe that paying for direct physician and provider costs are strategic investments – what they are is normal operating costs. Health Quest should be providing enough working capital to support Sharon Hospital's ongoing operations, including physician costs.

We would suggest that the Grant Agreement language pertaining to the Working Capital Grant should be changed to remove any references to investments in, or paying for direct physician and provider costs.

D. Return of Grant Amount:
If Sharon Hospital is sold to a third party after the first five years of ownership by Health Quest, then the Foundation does not get its asset purchase grant and, or its capital grant returned.
This is unfair to the public interest and to the Foundation. We would suggest that it should be changed so that if Sharon Hospital is sold to a third party during the first 15 years of ownership by Health Quest, then the Foundation should get its asset purchase grant, and working capital grant, less all Capital Campaign Funds raised to date by the Foundation, returned to it.

E. Governance – Sharon Board of Trustees:
The Grant Agreement provides that the Foundation can have up to 12 representatives (80% of the total) serve on the Sharon Board of Trustees (which is basically a local advisory group) which will be composed of 15 members. There are three groups of Trustees with different terms, but in no event is there a contractual right for the Foundation to have its representatives serve as trustees after the sixth year.
This is unfair and we would suggest that it should be changed so that after the sixth year, there will continue to be a majority of the trustees who will be selected by the Foundation and who will serve on the Sharon Hospital Board of Trustees as long as Sharon Hospital is owned by Health Quest, and part of its system.

F. Governance – Health Quest Board of Trustees:
The Grant Agreement states that, "The Chair of the Board of Trustees of New Sharon Hospital shall serve ex-officio on the Health Quest Board of Trustees." There is not enough board representation by the Foundation on the Health Quest Board of Trustees given the Agreement's current requirement that the Foundation invest $9 million into New Sharon Hospital.

We would suggest that at least three members of the New Sharon Hospital Board of Trustees be named to the current 18 members Health Quest Board of Trustees, and that they be full voting members as long as Sharon Hospital is owned by Health Quest.

G. Annual Information Reporting to the Community to be Required:
To serve and inform the Community on its progress in improving Sharon Hospital, the Grant Agreement should be modified to require that the Sharon Hospital Board of Trustees will issue a written annual report to the Community, no later than March 1 of the following year, on the state of Sharon Hospital as it pertains to the services offered, the quality of health, physician recruitment, hospital services added, patients serviced and discharged – inpatients and outpatients, the financial results, and whatever other critical information the Sharon Hospital Board feels it needs to present to the Community.

H. A Monitor Should Be Added:
We would suggest that a monitor be appointed by either the Attorney General or OHCA for the first five years, following the purchase of Sharon Hospital by Health

Quest, to insure that the terms of the Agreement are followed and there is an equitable accounting of the funds given by the Foundation to Health Quest under the terms of the Agreement, and that the medical services that were committed to by Health Quest in the CON are supplied to New Sharon Hospital.

By way of background, I am the President of RateFinancials Inc. which was started in 2002. Our company rates the financial reporting, accounting and governance practices of corporations, including health care companies and hospitals – and as such, we are considered financial experts. I am the President of Heritage Capital Corp. – a middle market investment banking company which was started in 1977. I am also the Treasurer and on the Board of The Osborne Association – a non-profit social services agency which works in over 20 prisons in New York State, providing a full range of services including behavioral, court advocacy, job placement, addiction treatment, etc.

The members of The Community Association to Save Sharon Hospital all live in the area served by Sharon Hospital and have organizational standing as we are all impacted and affected by the medical services offered by Sharon Hospital. If Sharon Hospital ceases to exist, we would all be directly adversely affected so therefore we have a meaningful stake in the outcome of the public hearings and what is decided.

We would also ask that the Attorney General also act in these proceedings, since the interests of the public are involved due to the involvement of the Foundation for Community Health and adopt our suggestions for the various changes we have requested.

Thank you for your consideration.

Sincerely,

Victor Germack
Vice President

cc: The Honorable Attorney General George Jepsen
The Honorable Senator Richard Blumenthal
The Honorable Senator Chris Murphy
Deputy Commissioner Ms. Yvonne T. Addo
Assistant Attorney General Gary W. Hawes
Representative Brian Ohler
Charlene LaVoie, Esq.
Jennifer Groves Fusco, Esq.

EXHIBIT 1

Combined Sharon Hospital & Regional Healthcare Associates (in $ millions) *

Pro Forma Operating Results

	FY 2015 Act. Results	FY 2016 Act. Results Estimated	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON	FY 2020 Projected W/out CON	FY 2020 Projected Incremental	FY 2020 Projected With CON
Operating Revenue	$54.00	$50.10	$56.80	$5.20	$62.00	$57.30	$17.50	$74.90	$58.20	$20.00	$78.00	$59.00	$21.00	$80.00
Operating Expenses	54.8	55.7	59.2	2.4	61.6	60.1	9.6	69.7	61.2	11.40%	72.6	62.3	12.9	75.2
Operating Income	-0.8	-5.6	-2.4	2.8	0.4	-2.8	7.9	5.2	-3.0	8.6	5.4	-3.3	8.1	4.8
Net Income	-17.7	-5.6	-2.4	2.8	0.4	-2.8	7.9	5.2	-3.0	8.6	5.4	-3.3	8.1	4.8
Operating Margin - %	-1.48%	-11.17%	-4.22%	53.84%	0.65%	-4.88%	45.14%	6.94%	-5.15%	43.00%	6.92%	-5.59%	38.57%	6.00%
Total Margin - %	-32.77%	-11.17%	-4.22%	53.84%	0.65%	-4.88%	45.14%	6.94%	-5.15%	43.00%	6.92%	-5.59%	38.57%	6.00%

* All financial information is taken from the financial worksheets submitted as part of the CON by Sharon Hospital and Regional Healthcare Associates

Worksheet Prepared by Victor Germack - 3/11/17

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 29, 2017

The Honorable Craig Miner
State Senator, 30th District
State of Connecticut
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Dear Senator Miner:

On March 27, 2017, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the transfer of ownership of The Sharon Hospital to Vassar Health Connecticut, Inc.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Yvonne T. Addo, MBA
Deputy Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 29, 2017

The Honorable Brian Ohler
Representative, 64th District
State of Connecticut
State Capitol
Hartford, CT 06106-1591

Re: Certificate of Need Application: Docket Number: 16-32132-CON
Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

Dear Representative Ohler:

On March 27, 2017, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the transfer of ownership of The Sharon Hospital to Vassar Health Connecticut, Inc.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application docket. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Yvonne T. Addo, MBA
Deputy Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Wednesday, March 29, 2017 3:46 PM
To: User, OHCA; Lazarus, Steven; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David; Roberts, Karen; Foster, Tillman
Cc: Ping, David; victorger@pipeline.com
Subject: Transfer of Ownership of Sharon Hospital and RHA -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: DOCS-#1523614-v1-HEALTH_QUEST_SHARON_HEARING_COVER_LETTER.PDF; DOCS-#1523593-v1-HEALTH_QUESTION_SHARON_APPEARANCE_(SHARON_HOSPITAL).PDF; DOCS-#1523595-v1-HEALTH_QUEST_SHARON_APPEARANCE_(RHA).PDF; DOCS-#1524034-v1-HEALTH_QUEST_SHARON_HOSPITAL_PREFILE_(FINAL).PDF; DOCS-#1506861-v1-HEALTH_QUEST_SHARON_CORDEAU_PREFILE_(FINAL).docx; DOCS-#1506913-v1-HEALTH_QUEST_SHARON_BROWDER_PREFILE_(FINAL).docx; DOCS-#1507137-v1-HEALTH_QUEST_SHARON_FRIEDBERG_PREFILE_(FINAL).docx; DOCS-#1507681-v2-HEALTH_QUEST_SHARON_HEATON_PREFILE_(FINAL).docx; DOCS-#1523604-v1-HEALTHQUEST_SHARON_RHA_PREFILE_(FINAL).PDF; DOCS-#1507695-v1-HEALTH_QUEST_RHA_CORDEAU_TESTIMONY_(FINAL).docx; DOCS-#1507731-v1-HEALTH_QUEST_RHA_LOOMIS_PREFILE_(FINAL).docx; DOCS-#1523878-v1-HEALTH_QUEST_SHARON-RHA_HEARING_ISSUES_(FINAL).PDF; DOCS-#1522798-v1-HEALTH_QUEST_SHARON-RHA_HEARING_ISSUES_(FINAL).docx

All:

Attached please find the following in connection with the April 5, 2017 consolidated hearing on the above-referenced dockets:

- Cover Letter (Docket Nos. 16-32132-CON & 16-32133-CON);
- Appearances of UKS on behalf of all Applicants (Docket Nos. 16-32132-CON & 16032133-CON);
- PDF of Prefiled Testimony in Docket No. 16-32132-CON;
- Word versions of individual Prefiled Testimony in Docket No. 16-32132-CON (Cordeau, Browder, Friedberg & Heaton);
- PDF of Prefiled Testimony in Docket No. 16-32133-CON;
- Word versions of individual Prefiled Testimony in Docket No. 16-32133-CON (Cordeau & Loomis);
- PDF of Hearing Issues (Docket Nos. 16-32132-CON 7 16-32133-CON); and
- Word version of Hearing issues (Docket Nos. 16-32132-CON & 16-32133-CON).

Please confirm receipt of this email and attachments at your earliest convenience. Let me know if you require any additional information.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316

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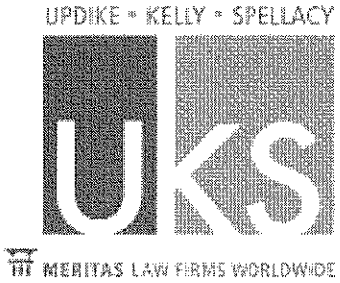


Jennifer Groves Fusco
(t) 203.786.8316
(f) 203.772.2037
jfusco@uks.com

March 29, 2017

VIA ELECTRONIC MAIL

Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc. Docket No. 16-32132-CON & Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Dear Deputy Commissioner Addo:

This office represents Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, Sharon Hospital Holding Company, Regional Healthcare Associates, LLC, Health Quest Systems, Inc., and Vassar Health Connecticut, Inc. in connection with the above-referenced dockets. Enclosed please find the following for your review and consideration:

- Notice of Appearance of Updike, Kelly & Spellacy, P.C. (Docket Nos. 16-32132-CON & 16-32133-CON);
- Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA, Chief Executive Officer, Sharon Hospital (Docket No. 16-32132-CON);
- Prefiled Testimony of Michael W. Browder, Executive Vice President & Chief Financial Officer, RCCH HealthCare Partners (Docket No. 16-32132-CON);
- Prefiled Testimony of Robert Friedberg, President & Chief Executive Officer, Health Quest Systems, Inc. (Docket No. 16-32132-CON);
- Prefiled Testimony of Nancy Heaton, Chief Executive Officer, Foundation for Community Health, Inc. (Docket No. 16-32132-CON);
- Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA, Chief Executive Officer, Sharon Hospital (Docket No. 16-32133-CON);
- Prefiled Testimony of Glenn Loomis, MD, MSHM, FAAFP, Chief Medical Operations Officer, Health Quest Systems, Inc. & President, Health Quest Medical Practice (Docket No. 16-32133-CON); and
- Responses to Hearing Issues (Docket Nos. 16-32132-CON & 16-32133-CON).

These documents are being submitted in connection with the consolidated public hearing on Docket Nos. 16-32132-CON and 16-32133-CON scheduled for April 5, 2017 at 4:00 p.m. Messrs. Cordeau, Browder and Friedberg, Ms. Heaton and Dr. Loomis will be present at the hearing to adopt their prefiled testimony under oath and for cross-examination.

Should you require anything further, please feel free to call me at (203) 786-8316.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: David Ping *(w/enc)*
Michael W. Browder *(w/enc)*
Victor Germack *(w/enc)*

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: TRANSFER OF OWNERSHIP OF REGIONAL HEALTHCARE ASSOCIATES, LLC TO A SUBSIDIARY OF VASSAR HEALTH CONNECTICUT, INC.	)	DOCKET NO. 16-32133-CON
	)	MARCH 29, 2017

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Regional Healthcare Associates, LLC, Health Quest Systems, Inc., and Vassar Health Connecticut, Inc. (collectively the "Applicants"). The Firm will appear and represent the Applicants at the public hearing on this matter, scheduled for April 5, 2017.

Respectfully Submitted,

REGIONAL HEALTHCARE ASSOCIATES, LLC;
HEALTH QUEST SYSTEMS, INC.; &
VASSAR HEALTH CONNECTICUT, INC.

By: _____

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037
jfusco@uks.com

CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 29th day of March, 2017 to the following parties:

Victor Germack
The Community Association
To Save Sharon Hospital
P.O. Box 612
Salisbury, CT 06068
victorger@pipeline.com

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.
Docket No. 16-32132-CON

Transfer of Ownership of Regional Healthcare Associates, LLC
to a Subsidiary of Vassar Health Connecticut, Inc.
Docket No. 16-32133-CON

RESPONSES TO HEARING ISSUES

Per OHCA's request, below are written response to Hearing Issues dated March 17, 2017:

1. Provide a list prioritizing critical/immediate (over next 2-3 years) capital and operational improvements, including upgrades or strategic investments for the Hospital.

RESPONSE:

Below is a table listing all projects that Health Quest Systems, Inc. ("Health Quest") intends to undertake during the first two to three years following its acquisition of Sharon Hospital ("Sharon" or the "Hospital"). It should be noted that Health Quest, as it is not yet the owner of Sharon Hospital, has not completed a detailed strategic or capital plan for the Hospital. Moreover, Health Quest has not yet received input from the Sharon community about the needs for Sharon Hospital. Health Quest's final plan may well be amended once it has had the opportunity to better assess the capital needs and service needs of the Hospital. The final plan will be based on this detailed analysis and understanding of the capital and service requirements. The below table includes a description of the proposed project, its approximate capital cost, the funding source, and the estimated commencement/completion date. In addition, please note the following:

- When Health Quest is listed as a funding source this refers to the company's cash reserves and income from operations;
- When the Foundation for Community Health, Inc. ("FCH") is listed as a funding source this means until the Working Capital Grant funds are exhausted, after which projects will be fully funded by Health Quest;
- Health Quest has had various reviews undertaken and has further refined the costs of its proposed capital projects as follows:
    - The Cerner EMR upgrade, which was estimated at $3 to $3.5 million, will cost approximately $5 million;
    - The replacement and upgrade of boilers and underground storage tanks is estimated to be $600,000, which is less than was projected in initial CON submissions;
    - The renovation of space at the Hospital for the addition of beds to the Geropsychiatric Unit is estimated to cost $2 million, as opposed to the $1.5 million initially projected; and
    - Renovation of space for Medical Oncology/Infusion and other clinical services has been estimated at $1.5 million.

Anticipated Capital Improvements & Strategic Investments, FY 2017 – FY 2019

Project List	Description	Funding Source	Time to Complete
Conversion to Cerner Electronic Health Record ($5,000,000)	This project will replace the existing EMR at Sharon Hospital and RHA/TriState Offices	Health Quest and Foundation for Community Health	9 months, starting in July 2017, ending in April 2018
Life Safety and Regulatory Upgrades ($600,000)	This project will involve the removal and replacement/upgrade the boilers and underground fuel tanks	Health Quest and Foundation for Community Health	6 months, starting in July 2017, ending in December, 2017
Expansion of the Geropsychiatric Unit ($2,000,000)	This renovation project will increase the number of beds in the Geropsychiatry unit to accommodate additional demand for these services locally, as well as to make this a destination service for Health Quest patients	Health Quest and Foundation for Community Health	12 months, starting in January 2018, ending in December 2018
Renovation for Medical offices, including Oncology and Infusion ($1,500,000)	This will provide office space for additional physicians to be recruited to the area, including primary care, oncology, endocrinology and cardiology. It will also involve renovation of space for the addition of an infusion center for providing chemotherapy for oncology patients. Chemo infusion is not currently offered at Sharon Hospital	Health Quest and Foundation for Community Health	9 months, starting in October of 2017, ending in June 2018
Purchase of DaVinci Robot ($2,500,000)	Health Quest will purchase and install a DaVinci Robot, which is used for a variety of surgical procedures, reducing blood loss and decreasing recovery time. This is a new service for Sharon Hospital.	Health Quest and Foundation for Community Health	3 months, starting in January 2019, ending in April of 2019

Project List	Description	Funding Source	Time to Complete
ICU Renovation/Monitor Upgrades ($1,500,000)	Health Quest will renovate and install telemedicine equipment in the ICU, allowing Sharon to keep more patients in the Hospital by providing direct access to intensivists and specialists at VBMC.	Health Quest and Foundation for Community Health	4-6 months, starting in January/March 2019, ending in June 2019
Installing Wireless Telemetry on Medical/Surgical Unit ($1,000,000)	Health Quest will make all medical/surgical beds at the Hospital telemetry capable, improving patient care and safety.	Health Quest and Foundation for Community Health	3 months, starting in April 2019, ending in June 2019

Health Quest has also identified more than $1 million in cost savings opportunities available to Sharon Hospital once it becomes part of the Health Quest System. These savings are largely made possible due to the proximity of Sharon Hospital and Health Quest, which allows greater synergies than the relationship with its existing owner RCCH. These cost savings are in addition to those that may be achieved as a result of shared corporate services such as legal, compliance, human resources, IT, planning, and finance across Health Quest. In addition, Health Quest is evaluating whether it can save on Sharon's current medical malpractice expenses, which total $1.1 million annually.

Anticipated Annual Cost Savings

Area	Description	Annual Cost Savings
Pharmacy	Reduce Drug Costs	$31,500
Medical/Surgical	Reduce Supply Costs	$91,000
Purchased Services	Reduce Contract Costs	$227,000
Locum Tenens	Cost to staff with temporary nurses and physicians	$120,000
Coding	Discontinue use of third party coders	$150,000
Marketing	Use internal resources	$200,000
Equipment Maintenance	Discontinue use of outside services	$200,000

2. For each response to question one above, provide:
    a. The funding source; and
    b. The length of time estimated to implement each.

RESPONSE:

See Responses to Question 1 above.

3. Explain how the Hospital currently solicits, conveys to the Hospital Board and addresses community input and concerns. Furthermore, describe how the Hospital will continue to solicit, convey to the Hospital Board and address community input and concerns following the transfer of ownership.

RESPONSE:

Below are descriptions of the processes in place at the existing Sharon Hospital, and that will be put into place at the new Sharon Hospital, to solicit, convey to the Hospital Board and address community input and concerns.

Existing Sharon Hospital

Under current for-profit ownership, Sharon Hospital has both a Local Governing Board and an Advisory Board of Trustees ("Local Advisory Board"). The Local Governing Board derives its authority from the Essent Healthcare of Connecticut, Inc. corporate board and deals with issues relating to day-to-day operations at the Hospital. Authority has been delegated to the Local Governing Board to oversee matters including, but not limited to, physician credentialing, evaluation of performance of local management, and monitoring of clinical quality efforts. The Local Advisory Board was established pursuant to the Attorney General Order authorizing the conversion of Sharon to ensure a level of community involvement with the for-profit Hospital. It is comprised of elected public officials from the Sharon area, members of the Sharon Hospital Medical Staff, community members, and representatives of RCCH (formerly Essent Healthcare, Inc.).

There are numerous ways in which current Hospital administration solicits input and concerns from the local community. As Peter Cordeau, the CEO of Sharon Hospital, mentioned in his testimony he has an "open door" policy and is continually meeting with members of the community to discuss issues related to Sharon. Mr. Cordeau and other senior administrators have offices located off of the main lobby of the Hospital and are likely more accessible than any other hospital administrators in Connecticut. Sharon community members are encouraged to call or simply walk in and request a meeting if they have concerns to be addressed, including patient-care complaints.

In addition, Hospital administrators hold community forums and one-on-one meetings at local business establishments, newspapers and even at individual community members' homes. The forums are open to the public and Mr. Cordeau and his colleagues use these

meetings as an opportunity to solicit input and respond to any and all questions posed to them. Mr. Cordeau also has monthly meetings with community physicians, who relay any concerns that they hear from their patients. In addition, the Hospital conducts outreach on social media to both solicit input and keep the community apprised of matters related to Sharon.

Lastly, the Hospital solicits input from the Local Advisory Board, which was established to be the eyes and ears of the Sharon community in the absence of a non-profit hospital board. It is comprised of local community members including the Sharon First Selectman, the Hospital CEO, and residents from Sharon and surrounding towns.

Any and all comments or concerns raised by the community through any of these channels are shared among local Hospital administrators, RCCH corporate representatives, and members of the Local Governing Board (most of whom are community members), as necessary to inform decisions and resolve issues.

New Sharon Hospital

Health Quest will restore Sharon Hospital governance to a non-profit board. As mentioned in other submissions, the new Sharon board will be comprised, initially, of 12 members nominated by the FCH. As discussed below, these individuals represent a cross-section of the Sharon community from which the Hospital expects to solicit input and hear and address community concerns. Mr. Cordeau and his colleagues will also continue their "open door" policy under Health Quest ownership, with an understanding that input from local consumers is critical to meeting community needs and ensuring the future success of Sharon Hospital.

Specific to addressing community health needs, Health Quest will use the same process at Sharon that it uses at each of its other hospitals. Each Health Quest hospital has a Community Needs Committee consisting of hospital board members, physicians, staff, and members of the community. For instance, representatives from the Dutchess and Putnam Counties of Health are on the Northern Dutchess Hospital ("NDH"), Vassar Brothers Medical Center ("VBMC") and Putnam Hospital Center ("PHC") committees, respectively. Because issues of the aging are important in the NDH service area, there is representation from local NGOs on aging. At PHC, as the sole mental health provider in the county, there is representation from local mental health agencies.

Each of the hospital Community Needs Committees is responsible for identifying issues related to community need that the hospital and Health Quest should address in their respective service areas. These committees each develop a three year community service plan for their areas, which is reviewed for progress at each meeting and updated annually. Every three years Health Quest conducts a Community Needs Assessment. They have done this in conjunction with the Dutchess County Department of Health for NDH and VBMC and with the Putnam County Department of Health for PHC. As part of this process, Health Quest also conducts community forums on community health needs. They provide financial support for the County to conduct the survey and then use the results of the survey in the development of a Community Service Plan. Health Quest also conducts an annual symposium in conjunction with the County Health Departments regarding community health.

Health Quest just completed its Community Needs Assessment in 2016, and has developed its Community Service Year Plans for 2017, 2018 and 2019 based on this assessment. A copy of Health Quest's most-recent Community Service Plan is attached as Exhibit A. This plan, along with links to the assessments for Dutchess and Putnam Counties, may be found on Health Quest's website. They also distribute hard copies of the plan throughout Health Quest's service area. The Community Needs Committees give regular reports to their respective hospital boards.

In Sharon, Health Quest proposes to work with FCH and the local health departments to prepare its Community Needs Assessment. Health Quest would use as a starting point the Community Needs Assessment that FCH completed a few years ago. Health Quest would also work with these agencies to get advice on the membership of the Sharon Hospital Community Needs Committee. Health Quest would then develop a Community Service Plan for the area that incorporates the information from the assessment, from interviews and/or community forums that Health Quest would have. The Community Service Plan would be for 2018 and 2019, to put Sharon on the same cycle as the other Health Quest hospitals. In 2019, Health Quest would undertake a new Community Needs Assessment, just as they will do for the other System hospitals that year, which will become the basis for their next Community Service Plan, covering 2020-2022.

4. Please describe how the Hospital's board make-up currently incorporates representation of local health care consumers and how the Applicant will do so following implementation of the proposal.

RESPONSE:

The Hospital's Local Governing Board has nine (9) voting members, including seven (7) who reside in the local community and are representative of local healthcare consumers. The current Board Chair, Howard Fuhr, and member Dr. Robert Schnurr live in Sharon. Members Rusty Chandler and Dr. Jeremy Roth live in the surrounding towns of Salisbury and Cornwall, respectively. Member Dr. Donald Soucier lives outside of the service area, but he has served as the Chief of Cardiology at Sharon Hospital for 15 years. Patricia Chamberlain, Superintendent of Region 1 Public Schools and a Sharon resident is also a member, as is Waterbury Republican-American reporter and Kent resident Ruth Epstein. The Sharon Hospital CEO, Peter Cordeau, is a member and resides in Goshen. The only out-of-state voting member of the Board is Robert Jay, a representative of RCCH.

As previously mentioned, Health Quest will establish a local non-profit board once it acquires Sharon Hospital. This board will have responsibility for quality, physician credentialing and identifying community needs. The board will be populated by individuals who live in the service area. Health Quest relied heavily on FCH to identify 12 nominees for the newly constituted Sharon Hospital board. FCH hired an outside consultant and developed criteria for board member identification. FCH identified individuals from all parts of the Sharon service area, including Connecticut and New York, so that the board would have geographic diversity. FCH proposed nominees who could contribute their time and talents to develop a high functioning board for Sharon Hospital. After interviews and further

vetting of the potential board members, the nominations were presented to the Health Quest board for approval. The terms for the board members were staggered to allow for an orderly transition to new board members over time.

The new board will have a nominating committee, which will identify potential future board members from within the Sharon Hospital service area. These potential members will be interviewed and vetted and presented to the Health Quest board for approval. This is the exact process used to populate the boards of the other hospitals within the Health Quest system, which ensures adequate input from local healthcare consumers.

Note also that the Connecticut Office of Attorney General has relieved Health Quest of its obligation to continue the Local Advisory Board established by the for-profit Sharon Hospital because the new non-profit board will properly represent the community's needs.

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Nancy Heaton
Chief Executive Officer, Foundation for Community Health, Inc.

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Nancy Heaton and I am the Chief Executive Officer of the Foundation for Community Health, Inc. ("FCH"). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest Systems, Inc. ("Health Quest"). FCH is the successor entity to the Sharon Area Community Health Foundation ("SACHF"), which established in connection with the for-profit conversion of Sharon in 2002. With the anticipated return of Sharon to a non-profit hospital, FCH will be providing grant funds to assist with both the purchase of and strategic investment in the Hospital by Health Quest. FCH will also be given the opportunity to nominate a significant percentage of the initial Sharon Hospital Board under Health Quest ownership. FCH looks forward to this new partnership and ability to collaborate with our community hospital in ways that were not possible when Sharon was a for-profit facility. For these reasons, we urge OHCA to approve Applicants' request for a CON to transfer ownership of Sharon Hospital to Health Quest.

Background on Foundation for Community Health

FCH (originally formed as SACHF) is the "conversion foundation" approved by the Office of the Attorney General under Sections 19a-486 et seq. of the Connecticut General Statutes to receive the net proceeds of the sale of Sharon Hospital to Essent Healthcare of Connecticut, Inc. in 2002. FCH was also the recipient of all restricted and non-restricted funds

and income and legacies left in wills and from trusts that were originally designated to go to the former non-profit Hospital. FCH is a public charity within the meaning of the Code and, more specifically, a "supporting organization" that derives its tax-exempt status from the support it provides to other organizations in conducting charitable activities. In the case of FCH, our supported organizations include Berkshire Taconic Community Foundation, Community Foundation of the Hudson Valley, and Northwest Connecticut Community Foundation.

FCH's mission is to maintain and improve the physical and mental health of the residents of the area historically served by Sharon Hospital. We have been a leader and catalyst for the development of innovative and effective rural health delivery systems that focus on prevention, access and community-level collaboration. FCH accomplishes its mission through activities that include, but are not limited to, collaboration and advocacy, issuing grants, evaluating existing healthcare services, making program-related investments, and conducting research. Our grant of funds to Health Quest for the acquisition of Sharon and ongoing strategic investments in the Hospital is consistent with our mission and the purposes of our supported organizations, which include enhancing community health in the Sharon Hospital catchment area.

Decision to Partner with Health Quest – Asset Purchase & Working Capital Grants

The Foundation for Community Health, through its board and senior leadership, has determined that the greatest impact we can have on healthcare in the Sharon community is to assist Health Quest in returning Sharon to a non-profit hospital and community asset. We have conducted our due diligence, including visiting other Health Quest System hospitals and having extensive discussions with Health Quest management about their plans for Sharon. Based on this diligence and Health Quest's pledge of capital and resources, FCH is confident in Health Quest's ability to revitalize Sharon Hospital and certain of its long-term commitment to the

Sharon community. I can assure you, FCH would not be providing such a substantial grant to Health Quest if this was not the case.

As OHCA is aware, FCH has agreed to provide Health Quest with $9 million in grants in connection with the acquisition, operation and improvement of Sharon Hospital. This includes a $3 million Asset Purchase Grant, which will be used to fund a portion of the purchase price. It also includes a $6 million Working Capital Grant that will be used to fund "Investments" in Sharon. These include such items as direct physician and provider costs, equipment acquisitions, facility upgrades, investments in ambulatory networks, IT infrastructure upgrades, and other strategic programmatic investments. All Investments must directly benefit Sharon Hospital. We are aware of some of the investments that Health Quest has planned already, including EMR upgrades and service line expansions (e.g. oncology) that we believe will greatly enhance the quality and accessibility of healthcare services in the Sharon area.

FCH's funding under the Working Capital Grant covers a percentage of actual investments made by Health Quest at Sharon. It was important to our Board that Health Quest cover a percentage of each investment reimbursed by FCH in order to ensure the company's ongoing commitment to our Hospital and the community. Moreover, Health Quest is reimbursed on an annual basis for investments and FCH's obligation to fund investments through the Working Capital Grant ceases if all monies are not spent in Health Quest's first four years of operation. We believe this process will serve as incentive for Health Quest to move forward with needed capital investments as expeditiously as possible.

In addition, the question has been asked whether the grant of $9 million to Health Quest will impair FCH's ability to make other necessary grants to promote community health. First note that after disbursement of $9 million in grants to Health Quest, FCH will still have

approximately $16 million with which to continue its charitable mission in and around Sharon. Moreover, under the terms of the Grant Agreement between Health Quest and FCH, Health Quest has agreed to assist FHC in maintaining its existing level of community activities for the next ten years, either through direct funding or the assumption of community services and programs that would otherwise be funded by FCH. Lastly, the Grant Agreement contemplates a capital campaign whereby the funds provided by FCH to Health Quest for purposes of restoring Sharon Hospital to a non-profit community asset and enhancing care may be replenished through charitable giving.

Furthermore, we would like to point out certain safeguards in the Grant Agreement regarding the funding arrangement between FCH and Health Quest. Specifically, there are provisions that require the return of grant funds to FCH if Health Quest sells or closes the Hospital within the first five years or the Hospital loses its tax exemption. While we do not expect this to be the case, we want to assure OHCA that our investment is protected. In addition, the Grant Agreement requires Health Quest to maintain services at Sharon Hospital in accordance with any Order issued by this agency.

FCH's Right to Nominate Sharon Hospital Board Members

As part of the Grant Agreement with Health Quest, FCH has been given the right to nominate 12 of 15 members of the initial non-profit Sharon Hospital board. These nominees will serve staggered terms, giving FCH nominees a majority stake in the Sharon board for at least six years. We have already completed an extensive process, with the help of a consultant, which included identifying, vetting, interviewing and recommending our board nominees to Health Quest.

Our goal was to assemble a diverse group of community constituents. We were looking for individual with a stake in Sharon Hospital – those who reside in the service area and whose families obtain their healthcare services at Sharon. The nominees represent different interests within the Sharon community, come from all corners of the Sharon service area (including Connecticut and New York), and have varied professional backgrounds. There are nominees with expertise in healthcare and marketing, small business owners, and individuals who serve on other non-profit boards. We have also included nominees that represent the interest of the average healthcare consumer in the Sharon area.

After the terms of the FCH-nominated board members have expired, the Sharon board itself will be responsible for nominating replacements, subject to Health Quest board approval. In our experience, this is similar to the process in place for most non-profit boards. It is our understanding that Health Quest is committed to having local representation and perspective on the Hospital's board and we are confident that they will appoint members of the community to serve for many years beyond the tenure of FCH's initial appointees.

Conclusion

Speaking for myself and members of the FCH board, we are pleased to see the Hospital returned to non-profit status. This provides FCH with opportunities to collaborate on issue related to community health that simply were not possible with a for-profit Sharon Hospital. FCH has identified significant health needs in our community and we look forward to partnering with Health Quest to address these needs going forward.

Thank you again for this opportunity to speak in support of the CON Application for approval to transfer ownership of Sharon Hospital to Health Quest. I am available to answer any questions you have about FCH or our involvement with this transaction.

The foregoing is my sworn testimony.

Nancy Heaton
Executive Director
Foundation for Community Health

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer, Sharon Hospital

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Peter Cordeau and I am the Chief Executive Officer of Sharon Hospital ("Sharon" or the "Hospital"). With me today is Mike Browder, Executive Vice President and Chief Financial Officer of RCCH HealthCare Partners ("RCCH"), Robert Friedberg, President and Chief Executive Officer of Health Quest Systems, Inc. ("Health Quest") and Nancy Heaton, Chief Executive Officer of the Foundation for Community Health, Inc. ("FCH").

Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon to Vassar Health Connecticut, Inc. ("Vassar Connecticut"). With this transaction Sharon will become part of Health Quest, a non-profit regional healthcare system based out of Eastern New York that includes tertiary and community hospitals, a physician practice with several hundred providers, and various other healthcare facilities. As our CON submissions and hearing testimony have shown, the sale of Sharon Hospital to Vassar Connecticut represents the best option for restoring and revitalizing a hospital that the Sharon community has relied on to serve its healthcare needs for more than a century. For the many reasons articulated throughout this process, we at Sharon Hospital urge OHCA to approve our request for a CON to transfer ownership of the Hospital to the Health Quest system.

Background

Sharon Hospital is a 78-bed acute-care hospital located in the Northwest corner of Connecticut. We are one of the smallest and most remote hospitals in the state, located nearly 30

miles from the next closest acute-care general hospital. Sharon provides a full complement of hospital services to the community, subject to the limitations on certain specialty services that will be discussed here today and that have had a significant impact on our ability to drive volume and revenue at the Hospital.

We are somewhat unique among Connecticut hospitals in that a significant percentage of Sharon's patients originate from outside of the state. In FY 2016, for example, 42% of our inpatient discharges were of New York residents. Our primary and secondary service areas extend well into Eastern New York, overlapping with those of Health Quest's other system hospitals and providers. Sharon is also an aging community with approximately 40% of the Hospital's service area population projected to be over the age of 55 by FY 2021. Moreover, as OHCA is well aware, Sharon became the first for-profit acute-care hospital in Connecticut when it was purchased by Essent Healthcare, Inc. ("Essent"), RCCH's predecessor, in 2002.

I have served as CEO of Sharon Hospital since November of 2015, first in an interim capacity and since March of 2016, on a permanent basis. Before that I served as Sharon's Chief Nursing and Chief Operating Officer. In each of these roles I have interfaced with Hospital administration and staff, as well as members of the Sharon community. In my short time at Sharon I have come to understand just how much the Hospital is valued both by those who work here and those who live in and around Sharon. I can also see clearly the significant financial and operational issues the Hospital is facing and the impact that these issues have had on our ability to provide access to the highest quality healthcare services. And perhaps more so than others who are not in the Hospital every day, I understand that these issues are systemic and will not be resolved without the sale of Sharon to Health Quest.

Decision to Sell Sharon Hospital

As you will hear from my colleagues at RCCH and Health Quest, it was a perfect storm that led us to this place where we are requesting permission to sell Sharon to Vassar Connecticut and restore the Hospital to non-profit status. As Mike Browder will testify, Essent has delivered on its promises to make the capital and other investments and commitments necessary to turnaround and sustain a Hospital that was on the verge of closing in the early 2000s. Essent invested in infrastructure and services, including complete overhauls of the Labor and Delivery Unit and Emergency Department, and brought prosperity to the Hospital that lasted through its first decade of ownership.

Recently, however, the Hospital's bottom line was hit hard by factors largely outside of our control, including cuts in Medicaid reimbursement, a provider tax levied by the Connecticut General Assembly that negatively impacted Sharon, increased cost of delivering physician services with limited provider availability (e.g. call-coverage costs), and an inability to recruit and retain the physicians necessary to maintain certain medical specialty services (e.g. oncology) within the community. With the increased tax burdens, lower reimbursement, and outmigration of patients in need of specialty services that are either unavailable or available in limited capacity within the Sharon community, the Hospital has seen a consistent decrease in its financial performance.

You will also hear from Mr. Browder that while RCCH did all it could to make the Hospital viable, the company understood when it was time to pursue other strategic options to meet the healthcare needs of the Sharon community. RCCH made the responsible decision to sell the Hospital and, through extensive due diligence, determined that Health Quest was the best fit for Sharon on multiple levels. Mr. Friedberg will discuss the synergies among Health Quest

and Sharon and the System's plans for the Hospital in greater detail. I can tell you from what I have seen over the last several months, Health Quest's mission and vision fit squarely with the mission and vision of Sharon Hospital. Health Quest understands Sharon's problems and has a plan and the resources necessary to address those problems for the benefit of our community.

Involvement of the Sharon Community

It is apparent to anyone who has worked at Sharon for any length of time how much this Hospital means to the community. We have heard from families who have had generations born at Sharon and who have a vested interest in ensuring that this Hospital survives. We have taken the time to listen to community members' concerns about the proposed sale of Sharon Hospital, both in one-on-one meetings and at a Community Forum held on March 16th in this same room. There were approximately 40 members of the Sharon community in attendance and they spent nearly two hours asking questions of Messrs. Browder and Friedberg about the transaction and the Hospital's future. We did our collective best to explain why the sale of Sharon is necessary, Health Quest's plans for the Hospital and why this change will be beneficial. It was a spirited discussion that focused largely on Health Quest's commitment to Sharon and how it will work to expand and enhance service availability in our community. We also touched on the uncertainty around Federal healthcare reform and the role that digital healthcare technology will play in the provision of services in rural areas such as Sharon. We hope that the forum helped assuage any concerns on the part of the community about the impact of the sale of Sharon Hospital on the accessibility, quality and cost-effectiveness of services.

In addition to the community forum, our CON submissions are publically available, including copies that we provided to the Sharon Town Hall and The Hotchkiss Library of Sharon. And my door is always open to anyone in the community who wants to discuss this

transaction of other matters related to Sharon Hospital. This will continue to be the case going forward under Health Quest leadership.

Lastly, we have had numerous Town Hall meetings with Hospital staff to discuss the proposed transaction with Health Quest and respond to any questions or concerns that they have. Thus far the feedback that we have gotten from Hospital staff about this sale has been universally positive.

I personally am extremely excited to complete this transaction and see Sharon Hospital move forward under Health Quest leadership. Just as RCCH concluded that Health Quest was the best fit for Sharon, I believe the same based on my dealings with the company thus far and the commitment they have already shown to this community and our Hospital. Change is always difficult, but in a case like Sharon it is absolutely necessary. I believe that Health Quest has the resources and wherewithal to make Sharon Hospital thrive once again, and that change will be a positive one for all involved.

Thank you again for your time. I would now like to introduce my colleagues Mike Browder and Robert Friedberg who will tell you a little more about the impetus for this transaction and Health Quest's plans for Sharon Hospital. Nancy Heaton will also speak briefly about FCH's role with the new non-profit Hospital.

The foregoing is my sworn testimony.

Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer
Sharon Hospital

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Robert Friedberg
President & Chief Executive Officer,
Health Quest Systems, Inc.

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Robert Friedberg and I am the President and Chief Executive Officer of Health Quest Systems, Inc. ("Health Quest"). Thank you for this opportunity to speak in support of the CON Application for the transfer of ownership of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest, to be operated as a non-profit, charitable entity. My testimony today will focus on Health Quest's decision to acquire Sharon Hospital and why we believe it is a perfect fit for both the community and our broader system. I will also discuss what Health Quest has planned for capital improvements at Sharon Hospital and how we intend to enhance the availability of services in the primary and secondary services areas of the Hospital through focused physician recruitment and other initiatives. Lastly, I will touch on our new partnership with the Foundation for Community Health ("FCH") and why we believe their continued funding and involvement with Sharon Hospital governance going forward will be of great benefit to the Sharon community. Health Quest's acquisition of Sharon Hospital presents tremendous opportunities both for the Hospital and our existing providers to improve access to, and the provision of, healthcare services in and around Northwestern Connecticut. We at Health Quest therefore urge you to approve our CON request.

Background on Health Quest

Health Quest is a leading non-profit healthcare system based in Lagrangeville, New York, currently serving the Mid-Hudson Valley. The system includes three medical centers: Vassar Brothers Medical Center ("VBMC") in Poughkeepsie; Northern Dutchess Hospital ("NDH") in Rhinebeck; and Putnam Hospital Center in Carmel. We also operate Health Quest Medical Practice ("HQMP"), a network of nearly 300 physicians and providers, encompassing more than 25 specialties, practicing at our hospitals and at more than 20 offices located throughout the Mid-Hudson Valley. Health Quest also operates urgent care centers, a home care agency and The Thompson House, a skilled nursing facility, all located in New York.

Health Quest is a non-profit, tax-exempt organization that provides care to all patients regardless of ability to pay. In FY 2016, Health Quest provided more than $40 million in free and reduced-cost care. In addition, Health Quest reinvested substantially in its hospitals, facilities and providers. In the last three years alone, Health Quest has committed more than $750 million to improve VBMC, NDH, PHC, and HQMP. Hospitals operated by non-profit entities are considered community assets. Thus, they are governed by, and management is accountable to, boards of trustees that represent the interests of the local community. This will be the case with Sharon Hospital once it is acquired by Health Quest.

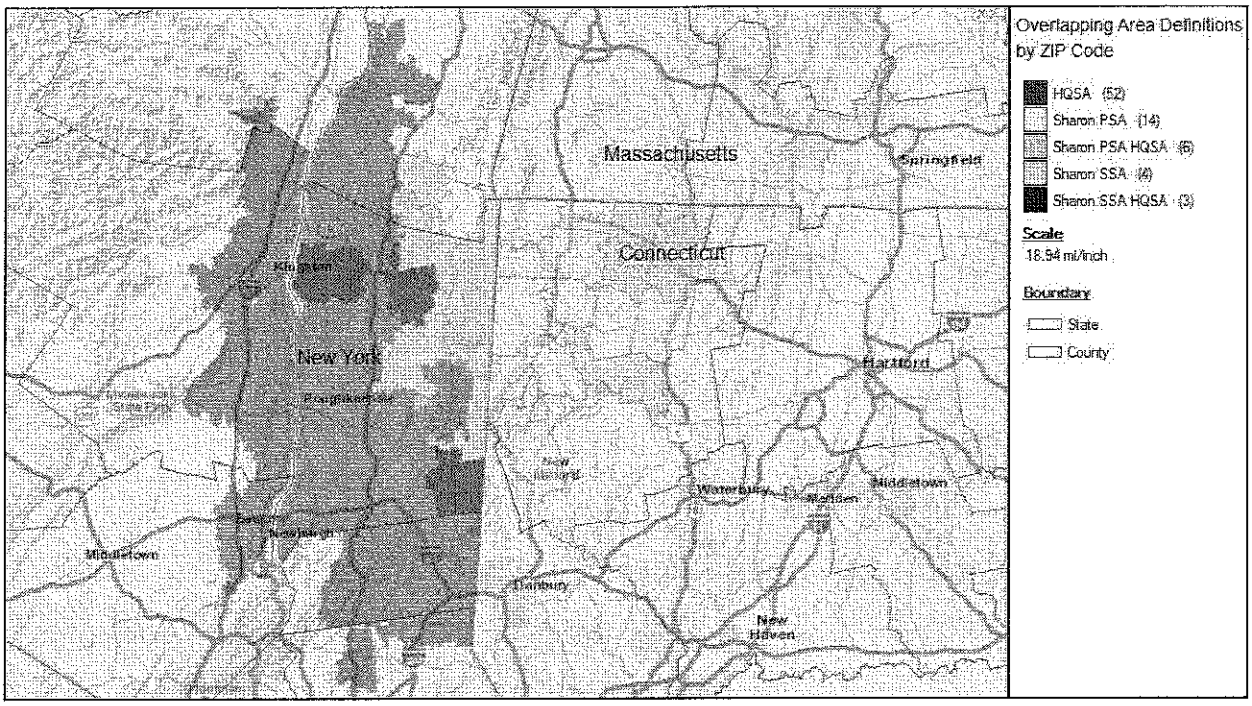
Health Quest's Mission is to deliver exceptional healthcare to the communities we serve. Our Vision is to be the region's leading healthcare organization recognized nationally for quality, safety, service and compassion. We have implemented this Mission and Vision through, among other things, striving for top-decile performance in quality and patient and employee satisfaction. As a measure of our success, Health Quest Medical Practice currently boasts an 80% physician

satisfaction rating. Among our existing facilities, NDH is leading the way for our hospitals with a patient satisfaction level that is nearly top-decile.

Health Quest's Mission and Vision will be extended to Northwest Connecticut and the surrounding community served for over a century by Sharon Hospital. Health Quest is driven by a core set of values that include Respect, Excellence, Accountability, Compassion, and Honor. Each of these values will apply equally to Health Quest's ownership and operation of Sharon Hospital going forward.

Decision to Acquire Sharon Hospital

Health Quest has had an interest in Sharon Hospital historically and, in fact, considered acquiring the hospital in the early 2000s before the former non-profit owners opted to sell to Essent, a for-profit entity. Our interest is based on common philosophies among our organizations, as well as great synergies that exist in terms of geography and services. As detailed in our CON submissions, Health Quest is a natural fit for Sharon Hospital (and vice versa) because of its geographic location and proximity to our other providers such as VBMC and NDH, and many of the HQMP offices. Given this geographic proximity there is necessarily overlap in the service areas of Sharon Hospital and the Health Quest providers. As the map below shows there is substantial overlap both in primary and secondary service areas extending far into New York:



In FY 2016 alone, more than 2,300 patients residing in the New York primary and secondary service areas of Sharon Hospital were discharged from Health Quest hospitals. Many more patients residing in these areas use HQMP for their physician services.

These synergies present opportunities for both organizations. Referral patterns show that patients from the Sharon Hospital primary and secondary service areas can and do obtain services at tertiary care centers such as VBMC with some regularity. These patients will now have the ability to obtain tertiary services at VBMC, if they so choose and it is clinically indicated, in a more coordinated manner inclusive of a common EMR and other Health Quest System practices. On the other hand, patients from the overlapping services areas who use Health Quest hospitals in New York can choose to obtain their services (subject to any clinical counter-indications) at Sharon Hospital and remain within Health Quest. In fact, both NDH and VBMC are experiencing capacity issues and we look forward to serving some of the patients at

Sharon Hospital. It is because of these types of synergies that the acquisition of Sharon Hospital makes tremendous sense for Health Quest.

Benefits to Sharon Hospital & the Sharon Community of Health Quest Ownership

Health Quest is committed to returning Sharon Hospital to the growth and prosperity it has experienced within the recent past. This will be achieved by, among other things, capital investments in infrastructure; leveraging local resources to recruit primary care and specialty physicians to practice in Sharon; and partnering with FCH to give the local community a say in Sharon Hospital and ensure that community healthcare needs are being met.

Capital Expenditures

Health Quest understands that its investment in Sharon Hospital does not end with its purchase of the Hospital. Sharon Hospital has significant and immediate capital needs and Health Quest is committed to completing many improvements within its first several years of ownership. For example, one of the largest and most costly capital expenditures involves upgrade and modernization of the EMR for Sharon Hospital and associated physician practices. Health Quest will replace the existing EMR system with Cerner, thereby linking Sharon Hospital to all existing Health Quest providers via a common digital platform. This project is expected to cost approximately $5 million. Health Quest is also planning the addition of geropsychiatric beds, expanding the existing Senior Behavioral Health Unit, a service for which there is limited capacity and tremendous demand. Along with the addition of these beds Health Quest will renovate space for clinical services including, but not limited to, medical oncology and infusion. These projects are expected to cost $3.5 million combined.

Health Quest also intends to renovate Sharon Hospital's Intensive Care Unit ("ICU"), including the addition of telemedicine equipment. This will allow Sharon Hospital to keep more

patients local by providing remote access to intensivists and other specialists, rather than transferring patients to other facilities. The ICU project is expected to cost approximately $1.5 million. In addition, Health Quest will make all of the Hospital's medical/surgical beds telemetry capable in order to enhance patient care and safety. This project will cost over $1 million. Moreover, Health Quest is considering the purchase of a da Vinci Robot so that additional general, gynecological and urological surgeries can be performed using this new technology. This equipment would cost approximately $2.5 million.

It should be noted that all of this is in addition to the normal course of business infrastructure maintenance and upgrades that are coming due in the near future. For example, there are boilers and an oil tank that need to be replaced and necessary HVAC upgrades, which will cost approximately $600,000. Health Quest will also undertake to "refresh" the aging infrastructure at Sharon Hospital to make it a more modern and appealing healthcare destination.

Health Quest fully understands the need to undertake these capital expenditures in order to meet its performance objectives at Sharon Hospital and improve the quality and accessibility of care. We are committed to moving forward and spending the necessary capital to ensure that Sharon Hospital has the appropriate physicians, equipment and facilities to best meet the needs of the Sharon community. As mentioned in the CON, a portion of this investment will be funded by a conditional grant from FCH. However, a vast majority will be funded by Health Quest through its cash reserves. Health Quest has a proven record of investing the necessary capital in its hospitals and facilities to maintain and expand the care available in the communities we serve. We intend to make significant investments in Sharon Hospital over the short and long-term to accomplish the same objectives, as previously noted.

Physician Recruitment

As Mike Browder mentioned in his testimony, one of the biggest hurdles RCCH faced in operating Sharon Hospital was its inability to recruit specialty physicians to practice in Sharon, primarily because of the lack of patient demand and other RCCH physicians to provide back-up and coverage. RCCH operated Sharon Hospital as a standalone hospital and, as such, had no local network of physicians to call upon. The sale of Sharon Hospital to Vassar Connecticut (Health Quest) will solve this issue. As my colleague Dr. Glenn Loomis will testify in the companion hearing on the transfer of Regional Healthcare Associates to a Connecticut Medical Foundation affiliated with Health Quest, the full resources of Health Quest will be available to the Connecticut Medical Foundation to assist with recruitment of physicians. Health Quest has a dedicated team of in-house physician recruiters whose only role is to identify physician recruits and employ them within the Health Quest System. We use a physician-led approach to practice and offer attractive compensation and benefits. We provide the security of a large group practice, which is attractive to younger physicians who want to be mentored and who do not want the responsibility for providing a specialty physician service to fall on their shoulders alone.[1]

HQMP has been extremely successful in its recent physician recruitment efforts. In FY 2016 alone we recruited 47 physicians to practice in the Mid-Hudson Valley region of New York, including 13 primary care physicians and 34 specialists. We expect to recruit at least another 40 physicians in FY 2017. Several of HQMP's offices are located in rural areas and medically underserved communities. We have been successful recruiting physicians to these

[1] Health Quest will also be implementing a Graduate Medical Education program system-wide beginning in FY 2019. Initial specialties will include family medicine and surgery. We expect to have 250 residents among our system hospitals by FY 2024. This program will serve as a pipeline for new physicians who want to continue practicing with the Health Quest system post-residency.

locations, which we believe speaks well of our ability to recruit physicians to practice in the Sharon primary and secondary service areas. Moreover, whereas previously a physician might not have wanted to relocate to Sharon for a part-time practice we can now repurpose our own physician to share time between practice locations in New York and Connecticut.

Our plans for Sharon Hospital are simple in this regard. Our first priority is to recruit and repurpose physicians (primary and specialty) in order to establish services that are not presently available in the Sharon community. This includes, notably, oncology services, which have not been available since Yale-New Haven closed its Smilow location in Sharon in 2015. We will also enhance other services where we know that patients are leaving the service area due to backlogs or limited physician availability or choice, for example cardiology, orthopedics, general surgery, and OB/GYN. As far as cardiology is concerned, Health Quest has three physicians committed to provide services in Sharon. With respect to orthopedics, Sharon physicians perform a small fraction (4%) of the approximately 650 total joint and spine surgeries for service area residents annually. We expect to recruit physicians who will be able to address the demand for these services directly in the community. General surgery is another area where Sharon Hospital is losing 80-90% of service area cases. Health Quest intends to help recapture this volume as well. We will also recruit to enhance patient choice for providers such as OB/GYNs where we know, for example, that some women are self-selecting providers outside of the community.

We also expect that the expansion of specialty services in the Sharon community will instill renewed confidence in Sharon Hospital on the part of local EMS providers. These providers will be more comfortable transporting patients to Sharon if they know there are specialty physicians available to provide needed care, whereas now they might select an alternate

hospital in order to avoid a second transport if the patient needs services that are not currently available.

Moreover, Health Quest intends to expand digital platforms that will allow for consultation by specialists outside of the community. We believe that this type of accessibility is an important aspect of how rural healthcare will be delivered in years to come.

Enhancing access and choice for physician services should also drive volume and revenue growth, as was the case historically. And, as Mr. Browder mentioned, the fixed costs associated with repurposed physicians are already being borne by Health Quest. In addition, HQMP physicians are able to cover call at Sharon at a lower cost than the locum tenens cost of coverage that Sharon Hospital contracts for presently. These cost savings, which are available by virtue of Sharon's membership in Health Quest, will contribute favorably towards the Hospital's financial improvement.

Foundation for Community Health

I would also like to speak briefly about the partnership that Health Quest has undertaken with the Foundation for Community Health ("FCH"). FCH is the successor organization to the Sharon Area Community Health Foundation, which was established to receive the proceeds of the sale of Sharon Hospital's assets to Essent in 2002. FCH is providing Health Quest with a $3 million conditional Asset Purchase Grant, towards the purchase of Sharon Hospital. Subsequently, FCH will provide an additional $6 million conditional Working Capital Grant to fund strategic investments in Sharon Hospital including direct physician and provider costs, investment in equipment, facility upgrades, ambulatory networks, IT infrastructure, and other strategic programmatic investments.

Our partnership with FCH is possible through the return of Sharon Hospital to a non-profit, charitable and tax-exempt organization. This will allow FCH to reinvest funds that were originally intended for Sharon Hospital but never achieved due to the Hospital's for-profit tax status. Now, as a tax-exempt organization, the funds can be directly provided in order to enhance the quality and accessibility of healthcare services for the community. We look forward to working with FCH in a meaningful way to benefit the health of Sharon area residents.

As part of our arrangement with the foundation, FCH is entitled to nominate 12 members (80%) of the initial Sharon Hospital Board under Vassar Connecticut ownership. These nominees will serve staggered terms and a number of the nominees will remain on the Board for a full six years. As their Chief Executive Officer Nancy Heaton will tell you in her remarks this afternoon, FCH has already conducted its due diligence and provided Health Quest with an exceptional group of nominees who we are interviewing and expect to appoint to the new Hospital Board in the near future. These nominees are from diverse personal and professional backgrounds and represent all corners of the Sharon Hospital service area, including both Connecticut and New York.

Once the terms of these FCH-nominated Board members expire new members will be nominated by the Sharon Hospital Board in the normal course and approved by Health Quest. Health Quest is absolutely committed to having local representation on Sharon Hospital Board going forward. We understand from operating other hospitals that local representation is critical to understanding and addressing the needs and concerns of the communities we serve.

In addition, as a tax-exempt hospital, we will be required to develop and implement a Community Health Needs Assessment ("CHNA") for the Sharon service area and to update that assessment periodically as required by law. The CHNA process for Health Quest hospitals is a

collaborative one involving clinicians, local boards of health, community members, and others who provide valuable input on community health priorities. We expect to be able to utilize FCH as a resource in this regard.

Projected Enhancement of Sharon Hospital

We understand that our volume and financial projections show significant growth in Sharon Hospital during Health Quest's first three years of operation. However we believe these projections are consistent with what has been achieved at Sharon Hospital historically and attainable given Health Quest's resources (human resources, financial resources, operational expertise and resources) and business plan. As Mr. Browder testified, Sharon Hospital/Regional Healthcare Associates achieved a 7% margin (income before interest and income taxes) as recently as FY 2011. We are projecting a consolidated (Sharon Hospital/Regional Healthcare Associates) margin of 6% by FY 2020. This is consistent with, and in many instances less than, the operating margins achieved by other Connecticut hospitals in FYs 2015 and 2016. Attached as Exhibit A is a comparison and summary of hospital operating margin data, compiled using audited financial statements and other information collected by OHCA. This data shows that each year there were seven (7) Connecticut hospitals with higher operating margins than what is projected for Sharon Hospital, including two (2) hospitals with operating margins in excess of 10%. It should also be noted that Health Quest hospitals have historically exceeded the average operating margins of hospitals in New York. For example, VBMC had an operating margin in excess of 6% last year, where the New York state average is just over 1%.

The projected growth at Sharon Hospital and RHA reflects Health Quest's commitment to invest, grow and expand services and access in and around Sharon. Expectations for Sharon's future are high, but are by no means out of line with what is occurring across Connecticut

hospitals today. There is tremendous upside capacity at Sharon Hospital. With the local resources of Health Quest and our ability to recruit and repurpose physicians and grow specialty services, our projections are entirely achievable. There are patients who are leaving the service area because ether specialty services are not available or are not to their liking. We can and will bring these patients back by elevating the level of services on the Sharon campus. An enhanced Sharon Hospital can also serve as a destination for service area residents who have opted to use NDH and VBMC in the past, but can now receive their care closer to home. Locally delivered care is best, when it is safe and feasible

Health Quest is a financially and strategically disciplined organization. We would not acquire Sharon Hospital and make significant investments (capital or otherwise) if we did not see the potential to achieve the projected growth and solid financial platform anticipated. We are confident in our ability to return Sharon Hospital to its former state of quality services, exceptional care and financial growth, much as we did with NDH. That hospital was nearly out of business when it became part of the Health Quest in 1999. Since then, we have undertaken two major building projects, replacing virtually all of the inpatient beds and the surgical operating suite and recovery room; added 16 licensed beds, with another 24-bed expansion planned; doubled the number of surgeons and primary care physicians on staff; and added the da Vinci and Navio surgical robots – investing $60 million just since 2014. NDH now has the best quality scores and financial margins in the Health Quest system. We expect to achieve comparable growth at Sharon.

Conclusion

Health Quest is eager to move forward with the purchase of Sharon Hospital and to make the necessary capital investments to achieve its publically stated goals and objectives. Health

Quest is in this for the long haul and we are making a commitment not just to maintain Sharon Hospital, but to enhance the accessibility and quality of the healthcare services available in the Sharon community. Health Quest has the financial and administrative resources to make this happen, and again, has committed to do so with specific actions, such as recruiting primary care and specialty physicians, enhancing existing services like cardiology, orthopedics and surgery, developing new services like oncology, making capital investments, and supporting routine maintenance expenditures. It is understood that the Sharon community does not want to see its hospital become a critical access facility or, worse yet, close. Health Quest presents the best option to ensure that Sharon Hospital survives to care for members of this community for generations to come.

Again, I thank you for your time and ask you to approve the CON for the transfer of Sharon Hospital to Vassar Connecticut, a non-profit member of Health Quest Systems. I am here to answer any questions you have after brief remarks by Nancy Heaton from the Foundation for Community Health.

The foregoing is my sworn testimony.

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Robert Friedberg
President & Chief Executive Officer
Health Quest Systems, Inc.

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Michael W. Browder
Executive Vice President & Chief Financial Officer,
RCCH HealthCare Partners

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Mike Browder and I am an Executive Vice President and the Chief Financial Officer of RCCH HealthCare Partners ("RCCH"). RCCH is the parent company of Essent Healthcare of Connecticut, Inc., which owns and operates Sharon Hospital ("Sharon" or the "Hospital"). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest Systems, Inc. ("Health Quest"). My testimony today will focus on Sharon's history as a for-profit hospital and the growth and prosperity achieved during our ownership of the Hospital; the unforeseen issues that have negatively impacted Sharon's viability under RCCH ownership; as well as our difficult decision to sell Sharon and our selection of Health Quest as the purchaser who could best meet the needs of the Sharon community and turn the Hospital around once again.

I hope my presentation will give OHCA and the community members present today – many of whom attended our community forum and asked thoughtful questions about the sale and its impact on their hospital and healthcare services – a better understanding of why RCCH has chosen to transition the Hospital to a local health system, which can provide benefits that simply are not available to Sharon as a standalone hospital within the RCCH system. For the reasons stated in our CON submissions and as I will discuss today, the sale Sharon is necessary to ensure

access to the highest-quality hospital services for Sharon area residents. We at RCCH therefore urge you to approve our CON request.

Acquisition of Sharon Hospital by Essent Healthcare

I am in the unique position among my colleagues of having been part of the original for-profit conversion of Sharon Hospital in 2002, the first of its kind in the State of Connecticut. At the time I served as Chief Financial Officer of Essent Healthcare, Inc. ("Essent"). Essent's business model was to acquire "essential" community hospitals and provide them with the financial resources and expertise to support their growth. [1] Sharon Hospital was the perfect fit for Essent given its remote location (designated as a "sole community provider" under 42 CFR 412.92) and the breadth of support for the Hospital among members of the Sharon community.

Essent went through an extensive regulatory approval process involving both OHCA and the Office of the Attorney General prior to acquiring Sharon Hospital. We made many commitments to the Sharon community as part of that process, including a promise to make significant capital investments in infrastructure and service at the Hospital. These included, among other things, a $16.5 million expansion project in 2006 that involved the renovation and modernization of Sharon's Labor and Delivery Unit, Emergency Department and MRI Service. Over the course of 10 years we added services and technology including, but not limited to: CADstream Technology for early detection of breast cancer; laser vein therapy; digital mammography, stroke center designation from the Connecticut Department of Public Health; a sleep center; a pain management clinic; an interventional radiology suite; wound care and

[1] Beginning in 2012, Essent when through several parent-level restructuring transactions that resulted in mergers with RegionalCare Hospital Partners ("RegionalCare") and Cappella Health ("Cappella"). This extended the new company's hospital portfolio into other regions and changed the make-up of its hospitals away from smaller community hospitals to include larger facilities located in and around urban areas.

hyperbaric medicine; and an upgraded CT scanner. The Hospital also improved its patient safety ratings and expanded community health programs during Essent's tenure.

Sharon Hospital met or exceeded our volume growth and financial expectations for many years. In 2005, for example, we exceeded the net earnings threshold above which we had agreed to contribute monies to the Foundation for Community Health, Inc. ("FCH"), the successor foundation established as part of the 2002 for-profit conversion. Looking at Sharon's historic financials (Sharon Hospital/Regional Healthcare Associates), we achieved a 7% margin (income before interest and income taxes) as recently as FY 2011, and our inpatient admissions around that time were approximately 3,000 annually.

Decision to Sell Sharon Hospital

Despite the prosperity that Sharon experienced, there were issues beyond Essent's control that would eventually lead to the financial decline that resulted in our decision to sell the Hospital. A series of market factors including ongoing cuts in reimbursement from state funding programs, an increase in self-pay activity that drove up bad debt, provider tax increases, and physician coverage-based costs for specialty call services, came together to threaten the financial viability of the hospital. As a result, net losses have increased from ($1.41 million) in FY 2014 to ($2.5 million) in FY 2016.[2]

In addition, both inpatients and outpatient volume at Sharon Hospital have been consistently declining in recent years. Sharon saw a 16% decrease in inpatients discharges between FY 2013 and FY 2016. This was due, in part, to a 5% decline in Emergency Department visits (which result in many of the Hospital's inpatient admissions) between FY 2014 and FY 2016, insurance plan design, increased consumerism, and closure of the Hospital's

[2] The latter excludes an $11.21 million impairment loss on long-lived assets.

oncology service in FY 2015. The Hospital also experienced a 22% decline in inpatient surgical cases between FY 2014 and FY 2016.

Decreases in volume have been tied, in large part, to Sharon's inability to recruit and retain physicians to practice in rural Northwest Connecticut. As larger local systems continued to expand and make inroads into the Sharon community, recruitment has become even more difficult for the Hospital. At the same time, changes in physician-hospital dynamics have made staffing physician services in the Sharon area increasingly cost-prohibitive.

Sharon is in essence a standalone hospital, albeit part of the RCCH system. We at RCCH believe that time is running out on the viability of standalone community hospitals that operate without the resources of local health system. One of the primary reasons for this is the ability of a local system (and in turn the inability of a system without local resources) to recruit physicians and staff community physician services in a cost-effective manner. Sharon's geographic isolation both within Connecticut and the RCCH system has made the recruitment of physicians to provide specialty services increasingly difficult. By way of example, Sharon was forced to close it sleep service in 2015, after the Medical Director relocated out of state and the Hospital was unable to recruit a replacement for the part-time position. Similarly, the Yale-New Haven oncology service at Sharon closed in 2015, after the doctors who provided care at the Hospital on a part-time basis retired. There are many more examples of services that have been curtailed due to the Hospital's inability to find physicians willing to relocate to Sharon for less-than-full-time work.

For those services where we were able to recruit, we often found only one or two physicians willing to work in Sharon. We then had to incur significant costs on locum tenens, because one or two physicians cannot realistically provide call for a medical specialty 24/7.

Note this is an issue that a system like Health Quest will not experience vis-à-vis Sharon because it already employs providers whose practices can be extended to cover the Sharon service area. These physician costs are already being borne by the Health Quest system. But for RCCH, the issues with recruitment and increasing coverage costs combined to negatively impact the Hospital's bottom line.

As Sharon's financial position has deteriorated we have done everything within reason to achieve maximum cost-savings (e.g. lowering supply costs through group purchasing, curtailing underutilized services), grow revenues and turn the Hospital around. Despite our best efforts we have reached the point where the revenue we can generate at Sharon with RCCH resources does not cover the fixed costs associated with operating the Hospital. We are unable to do what needs to be done to generate the necessary additional revenue – namely, recruit physicians to staff specialty services and reverse the outmigration of patients from Sharon to healthcare providers outside of the community. For these reasons, RCCH made the difficult decision to sell Sharon Hospital rather than see it reduced to a critical access facility or, worse yet, have to close altogether leaving the community without any hospital services.

Selection of Health Quest as Purchaser

In 2015, RCCH began exploring a wide range of strategic options for Sharon Hospital. Foremost in our minds was a desire to see Sharon remain a full-service hospital to provide care for a community that has always been important to us. In the interest of being as thorough as possible we considered both for-profit and not-for-profit, in-state and out-of-state alternatives. RCCH considered the sale of Sharon to another for-profit health system, but many of those we spoke with had geographic limitations similar to RCCH and we knew that would not work for Sharon. After weighing all viable options RCCH determined that the best result for Sharon and

the community it serves would come from affiliating with a larger regional health system such as Health Quest.

RCCH ultimately selected Health Quest to purchase Sharon Hospital because the company presented the best option in terms of proximity, resources and overall fit. Robert Friedberg, the President and CEO of Health Quest, is here today and he will give you more detail on how Sharon fits into the Health Quest system and what their plans are for the Hospital and the Sharon community. Of note, there is a substantial overlap in the service areas of Sharon and the existing Health Quest hospitals and providers. Recall that approximately 42% of Sharon's inpatient volume is New York residents, making a New York system a logical choice to acquire the Hospital.

Significantly, we see great potential in Health Quest's ability to recruit specialty physicians to the Sharon area. The Health Quest Medical Practice ("HQMP") has hundreds of providers located throughout Eastern New York, including in and around towns that are part of Sharon's historic service area. They have a network of physicians built into their cost structure that can be tapped to provide services in Sharon as needed, including on a part-time basis or for call coverage. Moreover, we understand that HQMP has resources and processes in place to facilitate recruitment of new physicians to practice in Sharon. Being part of the Health Quest system will give these new doctors the security, flexibility and mentorship benefits that come from practicing as part of a large group, something that RCCH could not offer with its limited local presence. This should add up to more patients staying local to Sharon for specialty care, increasing volume and revenue at the Hospital as a result.

RCCH was also impressed with Health Quest's commitment to make the capital investments in infrastructure and other improvements that are needed to move Sharon Hospital

forward. Given the issues that Sharon is experiencing, and RCCH's limited local resources, we are simply unable to make extensive investments in the Hospital while remaining fiscally prudent and accountable to our other system providers. Again, Mr. Friedberg will provide greater detail on what Health Quest has planned for Sharon, but we understand that the capital investment will be significant.

Health Quest is a system known for quality and excellence. We are pleased to know that Sharon will become part of a care network that offers the highest quality services, including tertiary care and specialty physician services, in a coordinated, accessible and cost-effective manner.

Conclusion

I have worked for healthcare systems my entire career and I can assure you that the decision to sell a hospital is never an easy one. Essent made a commitment to the Sharon community 15 years ago and we fulfilled that commitment to the best of our ability. We invested millions of dollars in Sharon Hospital, modernized facilities and infrastructure, and grew services, volume and revenue. Now for reasons that are in many respects beyond our control, RCCH no longer offers the best option for growth and prosperity for the Hospital. Therefore, the responsible thing to do for our company, the Hospital and the Sharon community is to return Sharon Hospital to non-profit status with Health Quest. We have done our due diligence and believe that putting Sharon into Health Quest's hands is the preferred course of action for a community hospital that we want to see succeed and exist for many years to come.

For these reasons I again urge you to approve our CON request. I would now like to introduce Mr. Friedberg. We will make ourselves available to answer questions once our presentation is concluded.

The foregoing is my sworn testimony.

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Michael W. Browder
Executive Vice President & Chief Financial Officer
RCCH HealthCare Partners

Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Docket No. 16-32133-CON

Prefiled Testimony of Glenn Loomis, MD, MSHM, FAAFP
Chief Medical Operations Officer, Health Quest Systems, Inc.
& President, Health Quest Medical Practice

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Glenn Loomis and I am the Chief Medical Operations Officer for Health Quest Systems, Inc. ("Health Quest") and President of Health Quest Medical Practice ("HQMP"). Thank you for this opportunity to speak in support of the CON Application for the transfer of ownership of Regional Healthcare Associates, LLC ("RHA") to a Connecticut medical foundation ("Medical Foundation") affiliated with Vassar Health Connecticut, Inc. ("Vassar Connecticut"). As my colleague Peter Cordeau mentioned, this transfer of ownership is part of a larger transaction involving the sale of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Connecticut, a subsidiary of Health Quest. My testimony today will focus on Health Quest's philosophy and practices around the provision of physician services, as well as our plans for the Connecticut Medical Foundation and the enhancement of physician services in Sharon. Establishment of the Medical Foundation will improve access to, and the quality of, healthcare for the Sharon community and we urge OHCA to approve this CON request along with the CON to transfer ownership of Sharon Hospital to Health Quest.

Background on Health Quest Medical Practice

I have served as the Chief Medical Operations Officer for Health Quest and President of HQMP since January of 2016. Prior to joining Health Quest, I managed large physician group practices in Kentucky, Indiana and Michigan. HQMP is the employed physician group of Health Quest. Formed in 2008, it has grown to nearly 300 providers in more than 25 specialties with

practice locations throughout the Mid-Hudson Valley region of New York. The practice continues to grow in terms of number of providers, geographic reach and number of patients. Last year HQMP saw approximately 250,000 unique patients.

HQMP is a physician-led organization, and HQMP physicians oversee all operational policies and decisions impacting the practice. Since I assumed a leadership position with HQMP we have brought on additional administrators, including a Chief Operating Officer and Chief Medical Officer, and hired additional personnel with expertise in revenue cycle operations and, notably, physician recruitment. HQMP utilizes a dyad-leadership model, which pairs physician leaders with administrators. This model allows individuals to focus on what they know best – for example, physician leaders are tasked with leading quality and patient safety initiatives while administrative leaders are tasked with day-to-day operations and activities that impact the cost-effectiveness of care.

Health Quest's Operation of the Connecticut Medical Foundation

Health Quest intends to operate the Connecticut Medical Foundation using the dyad-leadership model, as we have found that this model allows us to be most effective in delivering a positive patient experience and better health outcomes while controlling the cost of care. Like HQMP, the Medical Foundation will be subject to processes that encourage service excellence, quality, innovation, teamwork, and growth. The administrators and physician leaders from HQMP will work closely with the Medical Foundation to ensure that its immediate needs are met so that the healthcare needs of the Sharon community can be met. Specifically, our initial focus will be on infrastructure improvements and physician recruitment.

As my colleague Robert Friedberg testified earlier, Health Quest intends to use grant funds from the Foundation for Community Health, as well as its own operating funds, to

undertake significant capital improvements that will benefit both the Hospital and the Medical Foundation. This includes, notably, the conversion of the Hospital and Medical Foundation offices to an upgraded EMR platform. Upgrading to Cerner EMR will allow Sharon and the Medical Foundation to be fully integrated into the Health Quest system, affording patients maximum coordination of care between our various hospitals and providers.

Health Quest will also use the resources at its disposal to immediately address the physician recruitment needs at Sharon. As Mr. Friedberg mentioned, there is significant overlap in the service areas of HQMP and Sharon. We have physicians whose practices are located in and around the towns in Sharon's New York service area. In many cases their practices can easily be extended to include Sharon. These physicians can and will be repurposed to fill physician service needs in Sharon.

In addition, we have had tremendous success recruiting new physicians to HQMP and we expect to have similar success in Sharon. As a large group practice with a stable infrastructure and many experienced physicians to consult, HQMP is an attractive option for young physicians looking for mentorship as they begin their practices. This same support will be available to new physicians recruited to practice in and around Sharon. Health Quest also has a proven record of recruiting physicians to practice in rural communities like Sharon. In addition, whereas establishing a specialty physician practice in Sharon may be cost-prohibitive for an individual physician given fixed overhead and low patient volume, being part of a larger practice and healthcare system allows for costs to be spread over a larger number of patients, making these types of practices more cost-effective.

Our initial recruitment priorities for Sharon include medical specialties that have been non-existent or limited and for which we know there is a demand, as well as primary care

physicians. The specialties include oncology, orthopedics, cardiology, endocrinology, general surgery, and OB/GYN, to name a few. Our goal is to provide patients with more specialty care options and choice of providers so that they opt to receive care locally. When clinically indicated, local care is best for patient in terms of ease of access, follow-up care and ability for loved ones to be involved.

Note also that Health Quest intends to obtain Patient Centered Medical Home status for the Connecticut Medical Foundation, which will enhance access to care for patients, promote wellness and, if effective, reduce the overall cost of patient care. We will also be expanding our participation with various third-party payers to make it easier for patients in a border community such as Sharon to obtain covered services in either Connecticut or New York, thereby expanding patient choice. Also, the Medical Foundation will be a tax-exempt entity and, like other providers within the Health Quest system, will care for patient regardless of payer source and ability to pay consistent with its charitable status.

Conclusion

Thank you again for the opportunity to speak in support of the transfer of RHA to the Connecticut Medical Foundation and the larger transaction involving the sale of Sharon Hospital to Health Quest. Bringing physician services in Sharon under the Health Quest umbrella will vastly increase the resources available to these practices and their ability to expand to meet the healthcare needs of the community. This expansion will have a positive impact on the Hospital as well, ensuring that it remains a viable healthcare asset.

For these reasons, I again urge you to approve this CON request. We are available to answer any questions that you have.

The foregoing is my sworn testimony.

Glenn Loomis, MD, MSHM, FAAFP
Chief Medical Operations Officer
& President
Health Quest Medical Practice

Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Docket No. 16-32133-CON

Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer, Sharon Hospital

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Peter Cordeau and I am the Chief Executive Officer of Sharon Hospital ("Sharon" or the "Hospital"). With me today is Dr. Glenn Loomis, Chief Medical Operations Office for Health Quest Systems, Inc. ("Health Quest") and President of Health Quest Medical Practice ("HQMP). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Regional Healthcare Associates, LLC ("RHA") to a Connecticut medical foundation (the "Medical Foundation") affiliated with Vassar Health Connecticut, Inc. ("Vassar Connecticut"). This transfer of ownership is part of a larger transaction involving the sale of Sharon to Vassar Connecticut, a subsidiary of Health Quest. This transaction will return the Hospital to non-profit status and bring RHA and TriState Women's Services, LLC ("TriState") together as a non-profit medical foundation under Health Quest ownership.

The Hospital currently provides administrative and management services to RHA and TriState through Professional Services Agreements ("PSA"). Approving the transfer of ownership of RHA (and TriState) will result in the coordinated delivery of physician services in the greater Sharon area. In addition, it will give RHA and TriState access to the resources of Health Quest, including the operational expertise of HQMP. This coordination of care and access to Health Quest's practice-management resources will help to enhance the accessibility and quality of physician services in the Sharon community. For these reasons, we urge OHCA to

approve this CON request along with the CON to transfer ownership of Sharon Hospital to Health Quest.

Background and Proposed Acquisition of Regional Healthcare Associates

RHA is a multi-specialty physician practice with offices in Sharon, Kent and New Milford. The practice provides physician services including primary care, general surgery, orthopedic surgery, hospitalist medicine, OB/GYN, and urology. RHA is a for-profit, physician-owned large group practice that employs 11 physicians and ancillary providers. It serves more than 15,000 patients and has a service area that spans Northwestern Connecticut and the Mid-Hudson Valley region of New York. Sharon has a PSA in place with RHA through which it provides a variety of administrative functions. We provide senior management to RHA, which includes recruiting and training a professional management team to oversee practice operations, billing operations and staff recruitment/training. Sharon also provides day-to-day operational support for RHA including accounting, supply procurement, acquiring office space/securing leases, payroll, human resources, IT, accounts payable, marketing, and other general business functions. The senior management team at RHA works closely with its physicians and the Hospital to ensure that the practice is meeting its goal of supporting the healthcare needs of the community.

As detailed in our CON submissions, Health Quest intends to establish a non-profit Medical Foundation under Chapter 594b of the Connecticut General Statutes to acquire the assets of both RHA and TriState. These practices will be operated as part of the Health Quest system and in a manner similar to, and in coordination with, HQMP. As my colleague Dr. Loomis will discuss in greater detail, HQMP is a multi-specialty practice with nearly 300

physicians and providers, more than 25 specialties, and over 20 locations throughout the Mid-Hudson Valley region.

Benefits of Health Quest Ownership of Regional Healthcare Associates

As our CON submissions in this and the companion proceeding for the transfer of ownership of Sharon Hospital detail, physician services have been an historic issue in Sharon. Specifically, our ability to recruit and retain specialty physicians under RCCH HealthCare Partners ("RCCH") ownership of Sharon Hospital has been limited. This is largely a result of Sharon's status as a "standalone" hospital within the RCCH system – geographically isolated from other system hospitals and lacking a local provider network. Without these resources, we have been unable to find physicians willing to practice in remote Sharon on what is often a part-time basis due to limited demand for certain specialty services. For these reason, we have had to terminate services.

Some notable examples are our Sleep Center, which was forced to close when the Medical Director relocated out of state and we were unable to recruit a replacement, as well as oncology services. Yale-New Haven Hospital established an outpatient oncology service in Sharon, which it had to close in 2015 after the physicians who were covering our area announced their respective retirements. The need for these services was not full-time, and finding an oncologist willing to relocate to this area to establish a part-time practice was impossible. We also know that we are losing patients in need of specialty services such as orthopedics, cardiology, general surgery, endocrinology, and OB/GYN to name a few because of our inability to recruit providers with certain skill sets and/or to give patients the choices they desire. From a volume perspective, RHA experienced a 27% decline in outpatient visits between FY 2013 and

FY 2016 as a result of the loss of providers in specialties including cardiology, pain management, OB/GYN, primary care, and pediatrics.

As mentioned in the CON submissions related to the Hospital transfer, our inability to recruit the specialty physician necessary to keep patient local has an adverse fiscal impact on the Hospital. For example, the loss of outpatient oncology services correlates to a decrease in inpatient admissions. Similarly, the lack of available specialists at Sharon Hospital often causes EMS personnel to opt for alternative hospitals depending upon a patient's condition. This results in a decrease in Emergency Department volume at Sharon and the Emergency Department is by far our largest feeder of inpatient volume. In addition, for those services we do provide where there are only a few physicians located in Sharon, we incur significant costs for locum tenens call coverage.

We are confident in Health Quest's ability to bring specialty physician services back to Sharon. The extensive network of HQMP providers will allow physicians to be reallocated to Sharon, in some cases on a temporary or part-time basis, to support services. For some, this will simply be an extension of their practices to include the Sharon service area. HQMP physicians will also be available to cover call. More importantly, as Dr. Loomis will discuss, HQMP has the resources and a proven track record with the recruitment of new physicians to help us meet our staffing needs. These include physicians who are new to practice, as well as those who have existing practices and might be interested in relocating to Sharon. HQMP has a history of success in recruiting physicians to practice in rural communities, which speaks well of their ability to recruit for Sharon. Being part of the Health Quest system will also allow physicians to spread their costs out over a larger patient base, making it easier to justify practices in Sharon where the volume may not be sufficient to support the overhead of an independent practice.

Conclusion

We look forward to working with Health Quest as they implement their physician strategies in Sharon. It is encouraging to see the successes that HQMP has had in increasing access to, and the quality of, physician services in New York. We know they will be able to do the same for us, growing physician services so that Sharon area residents no longer need to leave the community for specialty care. For these reasons, we ask that you approve the CON to transfer RHA to the Medical Foundation as part of the Sharon Hospital sale.

I would now like to introduce Dr. Loomis who will tell you about HQMP and the company's plans for the Connecticut Medical Foundation. After Dr. Loomis's presentation is complete, we will be available to answer any questions that you have.

The foregoing is my sworn testimony.

_____

Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer
Sharon Hospital

Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Docket No. 16-32133-CON

Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer, Sharon Hospital

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Peter Cordeau and I am the Chief Executive Officer of Sharon Hospital ("Sharon" or the "Hospital"). With me today is Dr. Glenn Loomis, Chief Medical Operations Office for Health Quest Systems, Inc. ("Health Quest") and President of Health Quest Medical Practice ("HQMP). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Regional Healthcare Associates, LLC ("RHA") to a Connecticut medical foundation (the "Medical Foundation") affiliated with Vassar Health Connecticut, Inc. ("Vassar Connecticut"). This transfer of ownership is part of a larger transaction involving the sale of Sharon to Vassar Connecticut, a subsidiary of Health Quest. This transaction will return the Hospital to non-profit status and bring RHA and TriState Women's Services, LLC ("TriState") together as a non-profit medical foundation under Health Quest ownership.

The Hospital currently provides administrative and management services to RHA and TriState through Professional Services Agreements ("PSA"). Approving the transfer of ownership of RHA (and TriState) will result in the coordinated delivery of physician services in the greater Sharon area. In addition, it will give RHA and TriState access to the resources of Health Quest, including the operational expertise of HQMP. This coordination of care and access to Health Quest's practice-management resources will help to enhance the accessibility and quality of physician services in the Sharon community. For these reasons, we urge OHCA to

approve this CON request along with the CON to transfer ownership of Sharon Hospital to Health Quest.

Background and Proposed Acquisition of Regional Healthcare Associates

RHA is a multi-specialty physician practice with offices in Sharon, Kent and New Milford. The practice provides physician services including primary care, general surgery, orthopedic surgery, hospitalist medicine, OB/GYN, and urology. RHA is a for-profit, physician-owned large group practice that employs 11 physicians and ancillary providers. It serves more than 15,000 patients and has a service area that spans Northwestern Connecticut and the Mid-Hudson Valley region of New York. Sharon has a PSA in place with RHA through which it provides a variety of administrative functions. We provide senior management to RHA, which includes recruiting and training a professional management team to oversee practice operations, billing operations and staff recruitment/training. Sharon also provides day-to-day operational support for RHA including accounting, supply procurement, acquiring office space/securing leases, payroll, human resources, IT, accounts payable, marketing, and other general business functions. The senior management team at RHA works closely with its physicians and the Hospital to ensure that the practice is meeting its goal of supporting the healthcare needs of the community.

As detailed in our CON submissions, Health Quest intends to establish a non-profit Medical Foundation under Chapter 594b of the Connecticut General Statutes to acquire the assets of both RHA and TriState. These practices will be operated as part of the Health Quest system and in a manner similar to, and in coordination with, HQMP. As my colleague Dr. Loomis will discuss in greater detail, HQMP is a multi-specialty practice with nearly 300

physicians and providers, more than 25 specialties, and over 20 locations throughout the Mid-Hudson Valley region.

Benefits of Health Quest Ownership of Regional Healthcare Associates

As our CON submissions in this and the companion proceeding for the transfer of ownership of Sharon Hospital detail, physician services have been an historic issue in Sharon. Specifically, our ability to recruit and retain specialty physicians under RCCH HealthCare Partners ("RCCH") ownership of Sharon Hospital has been limited. This is largely a result of Sharon's status as a "standalone" hospital within the RCCH system – geographically isolated from other system hospitals and lacking a local provider network. Without these resources, we have been unable to find physicians willing to practice in remote Sharon on what is often a part-time basis due to limited demand for certain specialty services. For these reason, we have had to terminate services.

Some notable examples are our Sleep Center, which was forced to close when the Medical Director relocated out of state and we were unable to recruit a replacement, as well as oncology services. Yale-New Haven Hospital established an outpatient oncology service in Sharon, which it had to close in 2015 after the physicians who were covering our area announced their respective retirements. The need for these services was not full-time, and finding an oncologist willing to relocate to this area to establish a part-time practice was impossible. We also know that we are losing patients in need of specialty services such as orthopedics, cardiology, general surgery, endocrinology, and OB/GYN to name a few because of our inability to recruit providers with certain skill sets and/or to give patients the choices they desire. From a volume perspective, RHA experienced a 27% decline in outpatient visits between FY 2013 and

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As mentioned in the CON submissions related to the Hospital transfer, our inability to recruit the specialty physician necessary to keep patient local has an adverse fiscal impact on the Hospital. For example, the loss of outpatient oncology services correlates to a decrease in inpatient admissions. Similarly, the lack of available specialists at Sharon Hospital often causes EMS personnel to opt for alternative hospitals depending upon a patient's condition. This results in a decrease in Emergency Department volume at Sharon and the Emergency Department is by far our largest feeder of inpatient volume. In addition, for those services we do provide where there are only a few physicians located in Sharon, we incur significant costs for locum tenens call coverage.

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Conclusion

We look forward to working with Health Quest as they implement their physician strategies in Sharon. It is encouraging to see the successes that HQMP has had in increasing access to, and the quality of, physician services in New York. We know they will be able to do the same for us, growing physician services so that Sharon area residents no longer need to leave the community for specialty care. For these reasons, we ask that you approve the CON to transfer RHA to the Medical Foundation as part of the Sharon Hospital sale.

I would now like to introduce Dr. Loomis who will tell you about HQMP and the company's plans for the Connecticut Medical Foundation. After Dr. Loomis's presentation is complete, we will be available to answer any questions that you have.

The foregoing is my sworn testimony.

Peter R. Cordeau

Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer
Sharon Hospital

Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Docket No. 16-32133-CON

Prefiled Testimony of Glenn Loomis, MD, MSHM, FAAFP
Chief Medical Operations Officer, Health Quest Systems, Inc.
& President, Health Quest Medical Practice

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Glenn Loomis and I am the Chief Medical Operations Officer for Health Quest Systems, Inc. ("Health Quest") and President of Health Quest Medical Practice ("HQMP"). Thank you for this opportunity to speak in support of the CON Application for the transfer of ownership of Regional Healthcare Associates, LLC ("RHA") to a Connecticut medical foundation ("Medical Foundation") affiliated with Vassar Health Connecticut, Inc. ("Vassar Connecticut"). As my colleague Peter Cordeau mentioned, this transfer of ownership is part of a larger transaction involving the sale of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Connecticut, a subsidiary of Health Quest. My testimony today will focus on Health Quest's philosophy and practices around the provision of physician services, as well as our plans for the Connecticut Medical Foundation and the enhancement of physician services in Sharon. Establishment of the Medical Foundation will improve access to, and the quality of, healthcare for the Sharon community and we urge OHCA to approve this CON request along with the CON to transfer ownership of Sharon Hospital to Health Quest.

Background on Health Quest Medical Practice

I have served as the Chief Medical Operations Officer for Health Quest and President of HQMP since January of 2016. Prior to joining Health Quest, I managed large physician group practices in Kentucky, Indiana and Michigan. HQMP is the employed physician group of Health Quest. Formed in 2008, it has grown to nearly 300 providers in more than 25 specialties with

practice locations throughout the Mid-Hudson Valley region of New York. The practice continues to grow in terms of number of providers, geographic reach and number of patients. Last year HQMP saw approximately 250,000 unique patients.

HQMP is a physician-led organization, and HQMP physicians oversee all operational policies and decisions impacting the practice. Since I assumed a leadership position with HQMP we have brought on additional administrators, including a Chief Operating Officer and Chief Medical Officer, and hired additional personnel with expertise in revenue cycle operations and, notably, physician recruitment. HQMP utilizes a dyad-leadership model, which pairs physician leaders with administrators. This model allows individuals to focus on what they know best – for example, physician leaders are tasked with leading quality and patient safety initiatives while administrative leaders are tasked with day-to-day operations and activities that impact the cost-effectiveness of care.

Health Quest's Operation of the Connecticut Medical Foundation

Health Quest intends to operate the Connecticut Medical Foundation using the dyad-leadership model, as we have found that this model allows us to be most effective in delivering a positive patient experience and better health outcomes while controlling the cost of care. Like HQMP, the Medical Foundation will be subject to processes that encourage service excellence, quality, innovation, teamwork, and growth. The administrators and physician leaders from HQMP will work closely with the Medical Foundation to ensure that its immediate needs are met so that the healthcare needs of the Sharon community can be met. Specifically, our initial focus will be on infrastructure improvements and physician recruitment.

As my colleague Robert Friedberg testified earlier, Health Quest intends to use grant funds from the Foundation for Community Health, as well as its own operating funds, to

undertake significant capital improvements that will benefit both the Hospital and the Medical Foundation. This includes, notably, the conversion of the Hospital and Medical Foundation offices to an upgraded EMR platform. Upgrading to Cerner EMR will allow Sharon and the Medical Foundation to be fully integrated into the Health Quest system, affording patients maximum coordination of care between our various hospitals and providers.

Health Quest will also use the resources at its disposal to immediately address the physician recruitment needs at Sharon. As Mr. Friedberg mentioned, there is significant overlap in the service areas of HQMP and Sharon. We have physicians whose practices are located in and around the towns in Sharon's New York service area. In many cases their practices can easily be extended to include Sharon. These physicians can and will be repurposed to fill physician service needs in Sharon.

In addition, we have had tremendous success recruiting new physicians to HQMP and we expect to have similar success in Sharon. As a large group practice with a stable infrastructure and many experienced physicians to consult, HQMP is an attractive option for young physicians looking for mentorship as they begin their practices. This same support will be available to new physicians recruited to practice in and around Sharon. Health Quest also has a proven record of recruiting physicians to practice in rural communities like Sharon. In addition, whereas establishing a specialty physician practice in Sharon may be cost-prohibitive for an individual physician given fixed overhead and low patient volume, being part of a larger practice and healthcare system allows for costs to be spread over a larger number of patients, making these types of practices more cost-effective.

Our initial recruitment priorities for Sharon include medical specialties that have been non-existent or limited and for which we know there is a demand, as well as primary care

physicians. The specialties include oncology, orthopedics, cardiology, endocrinology, general surgery, and OB/GYN, to name a few. Our goal is to provide patients with more specialty care options and choice of providers so that they opt to receive care locally. When clinically indicated, local care is best for patient in terms of ease of access, follow-up care and ability for loved ones to be involved.

Note also that Health Quest intends to obtain Patient Centered Medical Home status for the Connecticut Medical Foundation, which will enhance access to care for patients, promote wellness and, if effective, reduce the overall cost of patient care. We will also be expanding our participation with various third-party payers to make it easier for patients in a border community such as Sharon to obtain covered services in either Connecticut or New York, thereby expanding patient choice. Also, the Medical Foundation will be a tax-exempt entity and, like other providers within the Health Quest system, will care for patient regardless of payer source and ability to pay consistent with its charitable status.

Conclusion

Thank you again for the opportunity to speak in support of the transfer of RHA to the Connecticut Medical Foundation and the larger transaction involving the sale of Sharon Hospital to Health Quest. Bringing physician services in Sharon under the Health Quest umbrella will vastly increase the resources available to these practices and their ability to expand to meet the healthcare needs of the community. This expansion will have a positive impact on the Hospital as well, ensuring that it remains a viable healthcare asset.

For these reasons, I again urge you to approve this CON request. We are available to answer any questions that you have.

The foregoing is my sworn testimony.

Glenn Loomis, MD, MSHM, FAAFP
Chief Medical Operations Officer, Health Quest Systems
& President, Health Quest Medical Practice

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: TRANSFER OF OWNERSHIP OF SHARON HOSPITAL TO VASSAR HEALTH CONNECTICUT, INC.	)	DOCKET NO. 16-32132-CON
	)	MARCH 29, 2017

NOTICE OF APPEARANCE

In accordance with Section 19a-9-28 of the Regulations of Connecticut State Agencies, please enter the appearance of Updike, Kelly & Spellacy, P.C. ("Firm") in the above-captioned proceeding on behalf of Essent Health Care of Connecticut, Inc. d/b/a Sharon Hospital, Sharon Hospital Holding Company, Health Quest Systems, Inc., and Vassar Health Connecticut, Inc. (collectively the "Applicants"). The Firm will appear and represent the Applicants at the public hearing on this matter, scheduled for April 5, 2017.

Respectfully Submitted,

ESSENT HEALTHCARE OF CONNECTICUT, INC. d/b/a/ SHARON HOSPITAL;
SHARON HOSPITAL HOLDING COMPANY;
HEALTH QUEST SYSTEMS, INC.; &
VASSAR HEALTH CONNECTICUT, INC.

By: _____

JENNIFER GROVES FUSCO, ESQ.
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CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 29th day of March, 2017 to the following parties:

Victor Germack
The Community Association
To Save Sharon Hospital
P.O. Box 612
Salisbury, CT 06068
victorger@pipeline.com

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer, Sharon Hospital

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Peter Cordeau and I am the Chief Executive Officer of Sharon Hospital ("Sharon" or the "Hospital"). With me today is Mike Browder, Executive Vice President and Chief Financial Officer of RCCH HealthCare Partners ("RCCH"), Robert Friedberg, President and Chief Executive Officer of Health Quest Systems, Inc. ("Health Quest") and Nancy Heaton, Chief Executive Officer of the Foundation for Community Health, Inc. ("FCH").

Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon to Vassar Health Connecticut, Inc. ("Vassar Connecticut"). With this transaction Sharon will become part of Health Quest, a non-profit regional healthcare system based out of Eastern New York that includes tertiary and community hospitals, a physician practice with several hundred providers, and various other healthcare facilities. As our CON submissions and hearing testimony have shown, the sale of Sharon Hospital to Vassar Connecticut represents the best option for restoring and revitalizing a hospital that the Sharon community has relied on to serve its healthcare needs for more than a century. For the many reasons articulated throughout this process, we at Sharon Hospital urge OHCA to approve our request for a CON to transfer ownership of the Hospital to the Health Quest system.

Background

Sharon Hospital is a 78-bed acute-care hospital located in the Northwest corner of Connecticut. We are one of the smallest and most remote hospitals in the state, located nearly 30

miles from the next closest acute-care general hospital. Sharon provides a full complement of hospital services to the community, subject to the limitations on certain specialty services that will be discussed here today and that have had a significant impact on our ability to drive volume and revenue at the Hospital.

We are somewhat unique among Connecticut hospitals in that a significant percentage of Sharon's patients originate from outside of the state. In FY 2016, for example, 42% of our inpatient discharges were of New York residents. Our primary and secondary service areas extend well into Eastern New York, overlapping with those of Health Quest's other system hospitals and providers. Sharon is also an aging community with approximately 40% of the Hospital's service area population projected to be over the age of 55 by FY 2021. Moreover, as OHCA is well aware, Sharon became the first for-profit acute-care hospital in Connecticut when it was purchased by Essent Healthcare, Inc. ("Essent"), RCCH's predecessor, in 2002.

I have served as CEO of Sharon Hospital since November of 2015, first in an interim capacity and since March of 2016, on a permanent basis. Before that I served as Sharon's Chief Nursing and Chief Operating Officer. In each of these roles I have interfaced with Hospital administration and staff, as well as members of the Sharon community. In my short time at Sharon I have come to understand just how much the Hospital is valued both by those who work here and those who live in and around Sharon. I can also see clearly the significant financial and operational issues the Hospital is facing and the impact that these issues have had on our ability to provide access to the highest quality healthcare services. And perhaps more so than others who are not in the Hospital every day, I understand that these issues are systemic and will not be resolved without the sale of Sharon to Health Quest.

Decision to Sell Sharon Hospital

As you will hear from my colleagues at RCCH and Health Quest, it was a perfect storm that led us to this place where we are requesting permission to sell Sharon to Vassar Connecticut and restore the Hospital to non-profit status. As Mike Browder will testify, Essent has delivered on its promises to make the capital and other investments and commitments necessary to turnaround and sustain a Hospital that was on the verge of closing in the early 2000s. Essent invested in infrastructure and services, including complete overhauls of the Labor and Delivery Unit and Emergency Department, and brought prosperity to the Hospital that lasted through its first decade of ownership.

Recently, however, the Hospital's bottom line was hit hard by factors largely outside of our control, including cuts in Medicaid reimbursement, a provider tax levied by the Connecticut General Assembly that negatively impacted Sharon, increased cost of delivering physician services with limited provider availability (e.g. call-coverage costs), and an inability to recruit and retain the physicians necessary to maintain certain medical specialty services (e.g. oncology) within the community. With the increased tax burdens, lower reimbursement, and outmigration of patients in need of specialty services that are either unavailable or available in limited capacity within the Sharon community, the Hospital has seen a consistent decrease in its financial performance.

You will also hear from Mr. Browder that while RCCH did all it could to make the Hospital viable, the company understood when it was time to pursue other strategic options to meet the healthcare needs of the Sharon community. RCCH made the responsible decision to sell the Hospital and, through extensive due diligence, determined that Health Quest was the best fit for Sharon on multiple levels. Mr. Friedberg will discuss the synergies among Health Quest

and Sharon and the System's plans for the Hospital in greater detail. I can tell you from what I have seen over the last several months, Health Quest's mission and vision fit squarely with the mission and vision of Sharon Hospital. Health Quest understands Sharon's problems and has a plan and the resources necessary to address those problems for the benefit of our community.

Involvement of the Sharon Community

It is apparent to anyone who has worked at Sharon for any length of time how much this Hospital means to the community. We have heard from families who have had generations born at Sharon and who have a vested interest in ensuring that this Hospital survives. We have taken the time to listen to community members' concerns about the proposed sale of Sharon Hospital, both in one-on-one meetings and at a Community Forum held on March 16th in this same room. There were approximately 40 members of the Sharon community in attendance and they spent nearly two hours asking questions of Messrs. Browder and Friedberg about the transaction and the Hospital's future. We did our collective best to explain why the sale of Sharon is necessary, Health Quest's plans for the Hospital and why this change will be beneficial. It was a spirited discussion that focused largely on Health Quest's commitment to Sharon and how it will work to expand and enhance service availability in our community. We also touched on the uncertainty around Federal healthcare reform and the role that digital healthcare technology will play in the provision of services in rural areas such as Sharon. We hope that the forum helped assuage any concerns on the part of the community about the impact of the sale of Sharon Hospital on the accessibility, quality and cost-effectiveness of services.

In addition to the community forum, our CON submissions are publically available, including copies that we provided to the Sharon Town Hall and The Hotchkiss Library of Sharon. And my door is always open to anyone in the community who wants to discuss this

transaction of other matters related to Sharon Hospital. This will continue to be the case going forward under Health Quest leadership.

Lastly, we have had numerous Town Hall meetings with Hospital staff to discuss the proposed transaction with Health Quest and respond to any questions or concerns that they have. Thus far the feedback that we have gotten from Hospital staff about this sale has been universally positive.

I personally am extremely excited to complete this transaction and see Sharon Hospital move forward under Health Quest leadership. Just as RCCH concluded that Health Quest was the best fit for Sharon, I believe the same based on my dealings with the company thus far and the commitment they have already shown to this community and our Hospital. Change is always difficult, but in a case like Sharon it is absolutely necessary. I believe that Health Quest has the resources and wherewithal to make Sharon Hospital thrive once again, and that change will be a positive one for all involved.

Thank you again for your time. I would now like to introduce my colleagues Mike Browder and Robert Friedberg who will tell you a little more about the impetus for this transaction and Health Quest's plans for Sharon Hospital. Nancy Heaton will also speak briefly about FCH's role with the new non-profit Hospital.

The foregoing is my sworn testimony.

Peter R. Cordeau

Peter R. Cordeau, RN, BSN, MBA
Chief Executive Officer
Sharon Hospital

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Michael W. Browder
Executive Vice President & Chief Financial Officer,
RCCH HealthCare Partners

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Mike Browder and I am an Executive Vice President and the Chief Financial Officer of RCCH HealthCare Partners ("RCCH"). RCCH is the parent company of Essent Healthcare of Connecticut, Inc., which owns and operates Sharon Hospital ("Sharon" or the "Hospital"). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest Systems, Inc. ("Health Quest"). My testimony today will focus on Sharon's history as a for-profit hospital and the growth and prosperity achieved during our ownership of the Hospital; the unforeseen issues that have negatively impacted Sharon's viability under RCCH ownership; as well as our difficult decision to sell Sharon and our selection of Health Quest as the purchaser who could best meet the needs of the Sharon community and turn the Hospital around once again.

I hope my presentation will give OHCA and the community members present today – many of whom attended our community forum and asked thoughtful questions about the sale and its impact on their hospital and healthcare services – a better understanding of why RCCH has chosen to transition the Hospital to a local health system, which can provide benefits that simply are not available to Sharon as a standalone hospital within the RCCH system. For the reasons stated in our CON submissions and as I will discuss today, the sale Sharon is necessary to ensure

access to the highest-quality hospital services for Sharon area residents. We at RCCH therefore urge you to approve our CON request.

Acquisition of Sharon Hospital by Essent Healthcare

I am in the unique position among my colleagues of having been part of the original for-profit conversion of Sharon Hospital in 2002, the first of its kind in the State of Connecticut. At the time I served as Chief Financial Officer of Essent Healthcare, Inc. ("Essent"). Essent's business model was to acquire "essential" community hospitals and provide them with the financial resources and expertise to support their growth.[1] Sharon Hospital was the perfect fit for Essent given its remote location (designated as a "sole community provider" under 42 CFR 412.92) and the breadth of support for the Hospital among members of the Sharon community.

Essent went through an extensive regulatory approval process involving both OHCA and the Office of the Attorney General prior to acquiring Sharon Hospital. We made many commitments to the Sharon community as part of that process, including a promise to make significant capital investments in infrastructure and service at the Hospital. These included, among other things, a $16.5 million expansion project in 2006 that involved the renovation and modernization of Sharon's Labor and Delivery Unit, Emergency Department and MRI Service. Over the course of 10 years we added services and technology including, but not limited to: CADstream Technology for early detection of breast cancer; laser vein therapy; digital mammography, stroke center designation from the Connecticut Department of Public Health; a sleep center; a pain management clinic; an interventional radiology suite; wound care and

[1] Beginning in 2012, Essent when through several parent-level restructuring transactions that resulted in mergers with RegionalCare Hospital Partners ("RegionalCare") and Cappella Health ("Cappella"). This extended the new company's hospital portfolio into other regions and changed the make-up of its hospitals away from smaller community hospitals to include larger facilities located in and around urban areas.

hyperbaric medicine; and an upgraded CT scanner. The Hospital also improved its patient safety ratings and expanded community health programs during Essent's tenure.

Sharon Hospital met or exceeded our volume growth and financial expectations for many years. In 2005, for example, we exceeded the net earnings threshold above which we had agreed to contribute monies to the Foundation for Community Health, Inc. ("FCH"), the successor foundation established as part of the 2002 for-profit conversion. Looking at Sharon's historic financials (Sharon Hospital/Regional Healthcare Associates), we achieved a 7% margin (income before interest and income taxes) as recently as FY 2011, and our inpatient admissions around that time were approximately 3,000 annually.

Decision to Sell Sharon Hospital

Despite the prosperity that Sharon experienced, there were issues beyond Essent's control that would eventually lead to the financial decline that resulted in our decision to sell the Hospital. A series of market factors including ongoing cuts in reimbursement from state funding programs, an increase in self-pay activity that drove up bad debt, provider tax increases, and physician coverage-based costs for specialty call services, came together to threaten the financial viability of the hospital. As a result, net losses have increased from ($1.41 million) in FY 2014 to ($2.5 million) in FY 2016.[2]

In addition, both inpatients and outpatient volume at Sharon Hospital have been consistently declining in recent years. Sharon saw a 16% decrease in inpatients discharges between FY 2013 and FY 2016. This was due, in part, to a 5% decline in Emergency Department visits (which result in many of the Hospital's inpatient admissions) between FY 2014 and FY 2016, insurance plan design, increased consumerism, and closure of the Hospital's

[2] The latter excludes an $11.21 million impairment loss on long-lived assets.

oncology service in FY 2015. The Hospital also experienced a 22% decline in inpatient surgical cases between FY 2014 and FY 2016.

Decreases in volume have been tied, in large part, to Sharon's inability to recruit and retain physicians to practice in rural Northwest Connecticut. As larger local systems continued to expand and make inroads into the Sharon community, recruitment has become even more difficult for the Hospital. At the same time, changes in physician-hospital dynamics have made staffing physician services in the Sharon area increasingly cost-prohibitive.

Sharon is in essence a standalone hospital, albeit part of the RCCH system. We at RCCH believe that time is running out on the viability of standalone community hospitals that operate without the resources of local health system. One of the primary reasons for this is the ability of a local system (and in turn the inability of a system without local resources) to recruit physicians and staff community physician services in a cost-effective manner. Sharon's geographic isolation both within Connecticut and the RCCH system has made the recruitment of physicians to provide specialty services increasingly difficult. By way of example, Sharon was forced to close it sleep service in 2015, after the Medical Director relocated out of state and the Hospital was unable to recruit a replacement for the part-time position. Similarly, the Yale-New Haven oncology service at Sharon closed in 2015, after the doctors who provided care at the Hospital on a part-time basis retired. There are many more examples of services that have been curtailed due to the Hospital's inability to find physicians willing to relocate to Sharon for less-than-full-time work.

For those services where we were able to recruit, we often found only one or two physicians willing to work in Sharon. We then had to incur significant costs on locum tenens, because one or two physicians cannot realistically provide call for a medical specialty 24/7.

Note this is an issue that a system like Health Quest will not experience vis-à-vis Sharon because it already employs providers whose practices can be extended to cover the Sharon service area. These physician costs are already being borne by the Health Quest system. But for RCCH, the issues with recruitment and increasing coverage costs combined to negatively impact the Hospital's bottom line.

As Sharon's financial position has deteriorated we have done everything within reason to achieve maximum cost-savings (e.g. lowering supply costs through group purchasing, curtailing underutilized services), grow revenues and turn the Hospital around. Despite our best efforts we have reached the point where the revenue we can generate at Sharon with RCCH resources does not cover the fixed costs associated with operating the Hospital. We are unable to do what needs to be done to generate the necessary additional revenue – namely, recruit physicians to staff specialty services and reverse the outmigration of patients from Sharon to healthcare providers outside of the community. For these reasons, RCCH made the difficult decision to sell Sharon Hospital rather than see it reduced to a critical access facility or, worse yet, have to close altogether leaving the community without any hospital services.

Selection of Health Quest as Purchaser

In 2015, RCCH began exploring a wide range of strategic options for Sharon Hospital. Foremost in our minds was a desire to see Sharon remain a full-service hospital to provide care for a community that has always been important to us. In the interest of being as thorough as possible we considered both for-profit and not-for-profit, in-state and out-of-state alternatives. RCCH considered the sale of Sharon to another for-profit health system, but many of those we spoke with had geographic limitations similar to RCCH and we knew that would not work for Sharon. After weighing all viable options RCCH determined that the best result for Sharon and

the community it serves would come from affiliating with a larger regional health system such as Health Quest.

RCCH ultimately selected Health Quest to purchase Sharon Hospital because the company presented the best option in terms of proximity, resources and overall fit. Robert Friedberg, the President and CEO of Health Quest, is here today and he will give you more detail on how Sharon fits into the Health Quest system and what their plans are for the Hospital and the Sharon community. Of note, there is a substantial overlap in the service areas of Sharon and the existing Health Quest hospitals and providers. Recall that approximately 42% of Sharon's inpatient volume is New York residents, making a New York system a logical choice to acquire the Hospital.

Significantly, we see great potential in Health Quest's ability to recruit specialty physicians to the Sharon area. The Health Quest Medical Practice ("HQMP") has hundreds of providers located throughout Eastern New York, including in and around towns that are part of Sharon's historic service area. They have a network of physicians built into their cost structure that can be tapped to provide services in Sharon as needed, including on a part-time basis or for call coverage. Moreover, we understand that HQMP has resources and processes in place to facilitate recruitment of new physicians to practice in Sharon. Being part of the Health Quest system will give these new doctors the security, flexibility and mentorship benefits that come from practicing as part of a large group, something that RCCH could not offer with its limited local presence. This should add up to more patients staying local to Sharon for specialty care, increasing volume and revenue at the Hospital as a result.

RCCH was also impressed with Health Quest's commitment to make the capital investments in infrastructure and other improvements that are needed to move Sharon Hospital

forward. Given the issues that Sharon is experiencing, and RCCH's limited local resources, we are simply unable to make extensive investments in the Hospital while remaining fiscally prudent and accountable to our other system providers. Again, Mr. Friedberg will provide greater detail on what Health Quest has planned for Sharon, but we understand that the capital investment will be significant.

Health Quest is a system known for quality and excellence. We are pleased to know that Sharon will become part of a care network that offers the highest quality services, including tertiary care and specialty physician services, in a coordinated, accessible and cost-effective manner.

Conclusion

I have worked for healthcare systems my entire career and I can assure you that the decision to sell a hospital is never an easy one. Essent made a commitment to the Sharon community 15 years ago and we fulfilled that commitment to the best of our ability. We invested millions of dollars in Sharon Hospital, modernized facilities and infrastructure, and grew services, volume and revenue. Now for reasons that are in many respects beyond our control, RCCH no longer offers the best option for growth and prosperity for the Hospital. Therefore, the responsible thing to do for our company, the Hospital and the Sharon community is to return Sharon Hospital to non-profit status with Health Quest. We have done our due diligence and believe that putting Sharon into Health Quest's hands is the preferred course of action for a community hospital that we want to see succeed and exist for many years to come.

For these reasons I again urge you to approve our CON request. I would now like to introduce Mr. Friedberg. We will make ourselves available to answer questions once our presentation is concluded.

The foregoing is my sworn testimony.

Michael W. Browder
Executive Vice President & Chief Financial Officer
RCCH HealthCare Partners

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Robert Friedberg
President & Chief Executive Officer,
Health Quest Systems, Inc.

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Robert Friedberg and I am the President and Chief Executive Officer of Health Quest Systems, Inc. ("Health Quest"). Thank you for this opportunity to speak in support of the CON Application for the transfer of ownership of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest, to be operated as a non-profit, charitable entity. My testimony today will focus on Health Quest's decision to acquire Sharon Hospital and why we believe it is a perfect fit for both the community and our broader system. I will also discuss what Health Quest has planned for capital improvements at Sharon Hospital and how we intend to enhance the availability of services in the primary and secondary services areas of the Hospital through focused physician recruitment and other initiatives. Lastly, I will touch on our new partnership with the Foundation for Community Health ("FCH") and why we believe their continued funding and involvement with Sharon Hospital governance going forward will be of great benefit to the Sharon community. Health Quest's acquisition of Sharon Hospital presents tremendous opportunities both for the Hospital and our existing providers to improve access to, and the provision of, healthcare services in and around Northwestern Connecticut. We at Health Quest therefore urge you to approve our CON request.

Background on Health Quest

Health Quest is a leading non-profit healthcare system based in Lagrangeville, New York, currently serving the Mid-Hudson Valley. The system includes three medical centers: Vassar Brothers Medical Center ("VBMC") in Poughkeepsie; Northern Dutchess Hospital ("NDH") in Rhinebeck; and Putnam Hospital Center in Carmel. We also operate Health Quest Medical Practice ("HQMP"), a network of nearly 300 physicians and providers, encompassing more than 25 specialties, practicing at our hospitals and at more than 20 offices located throughout the Mid-Hudson Valley. Health Quest also operates urgent care centers, a home care agency and The Thompson House, a skilled nursing facility, all located in New York.

Health Quest is a non-profit, tax-exempt organization that provides care to all patients regardless of ability to pay. In FY 2016, Health Quest provided more than $40 million in free and reduced-cost care. In addition, Health Quest reinvested substantially in its hospitals, facilities and providers. In the last three years alone, Health Quest has committed more than $750 million to improve VBMC, NDH, PHC, and HQMP. Hospitals operated by non-profit entities are considered community assets. Thus, they are governed by, and management is accountable to, boards of trustees that represent the interests of the local community. This will be the case with Sharon Hospital once it is acquired by Health Quest.

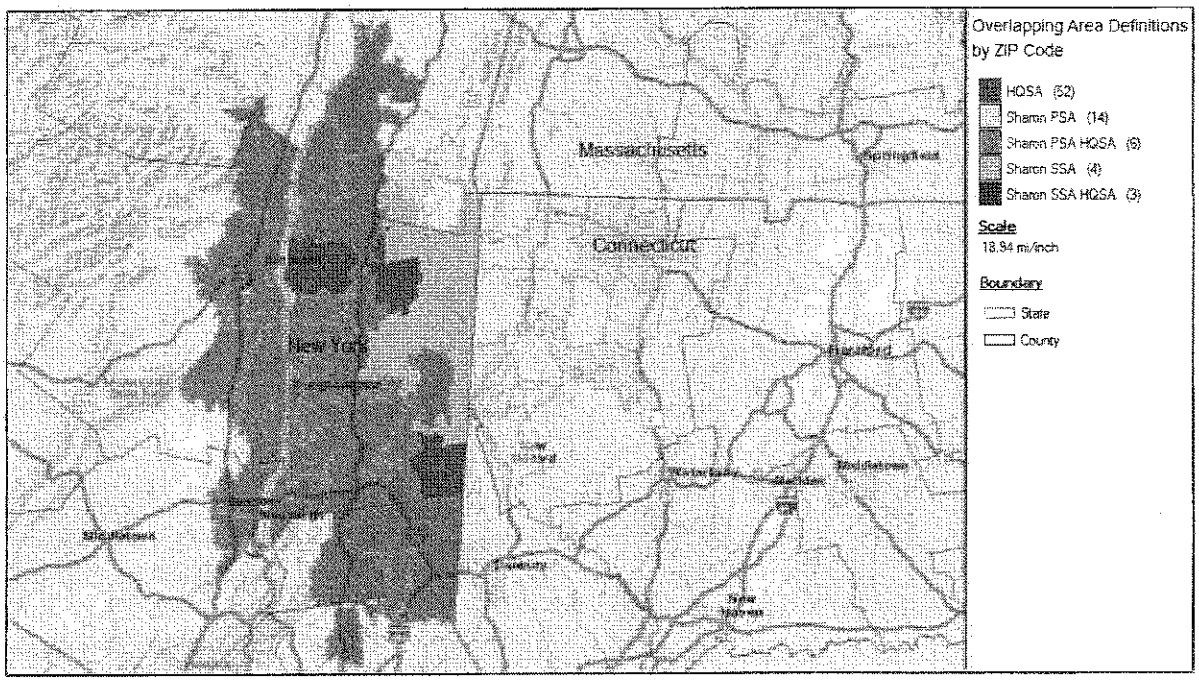
Health Quest's Mission is to deliver exceptional healthcare to the communities we serve. Our Vision is to be the region's leading healthcare organization recognized nationally for quality, safety, service and compassion. We have implemented this Mission and Vision through, among other things, striving for top-decile performance in quality and patient and employee satisfaction. As a measure of our success, Health Quest Medical Practice currently boasts an 80% physician

satisfaction rating. Among our existing facilities, NDH is leading the way for our hospitals with a patient satisfaction level that is nearly top-decile.

Health Quest's Mission and Vision will be extended to Northwest Connecticut and the surrounding community served for over a century by Sharon Hospital. Health Quest is driven by a core set of values that include Respect, Excellence, Accountability, Compassion, and Honor. Each of these values will apply equally to Health Quest's ownership and operation of Sharon Hospital going forward.

Decision to Acquire Sharon Hospital

Health Quest has had an interest in Sharon Hospital historically and, in fact, considered acquiring the hospital in the early 2000s before the former non-profit owners opted to sell to Essent, a for-profit entity. Our interest is based on common philosophies among our organizations, as well as great synergies that exist in terms of geography and services. As detailed in our CON submissions, Health Quest is a natural fit for Sharon Hospital (and vice versa) because of its geographic location and proximity to our other providers such as VBMC and NDH, and many of the HQMP offices. Given this geographic proximity there is necessarily overlap in the service areas of Sharon Hospital and the Health Quest providers. As the map below shows there is substantial overlap both in primary and secondary service areas extending far into New York:



In FY 2016 alone, more than 2,300 patients residing in the New York primary and secondary service areas of Sharon Hospital were discharged from Health Quest hospitals. Many more patients residing in these areas use HQMP for their physician services.

These synergies present opportunities for both organizations. Referral patterns show that patients from the Sharon Hospital primary and secondary service areas can and do obtain services at tertiary care centers such as VBMC with some regularity. These patients will now have the ability to obtain tertiary services at VBMC, if they so choose and it is clinically indicated, in a more coordinated manner inclusive of a common EMR and other Health Quest System practices. On the other hand, patients from the overlapping services areas who use Health Quest hospitals in New York can choose to obtain their services (subject to any clinical counter-indications) at Sharon Hospital and remain within Health Quest. In fact, both NDH and VBMC are experiencing capacity issues and we look forward to serving some of the patients at

Sharon Hospital. It is because of these types of synergies that the acquisition of Sharon Hospital makes tremendous sense for Health Quest.

Benefits to Sharon Hospital & the Sharon Community of Health Quest Ownership

Health Quest is committed to returning Sharon Hospital to the growth and prosperity it has experienced within the recent past. This will be achieved by, among other things, capital investments in infrastructure; leveraging local resources to recruit primary care and specialty physicians to practice in Sharon; and partnering with FCH to give the local community a say in Sharon Hospital and ensure that community healthcare needs are being met.

Capital Expenditures

Health Quest understands that its investment in Sharon Hospital does not end with its purchase of the Hospital. Sharon Hospital has significant and immediate capital needs and Health Quest is committed to completing many improvements within its first several years of ownership. For example, one of the largest and most costly capital expenditures involves upgrade and modernization of the EMR for Sharon Hospital and associated physician practices. Health Quest will replace the existing EMR system with Cerner, thereby linking Sharon Hospital to all existing Health Quest providers via a common digital platform. This project is expected to cost approximately $5 million. Health Quest is also planning the addition of geropsychiatric beds, expanding the existing Senior Behavioral Health Unit, a service for which there is limited capacity and tremendous demand. Along with the addition of these beds Health Quest will renovate space for clinical services including, but not limited to, medical oncology and infusion. These projects are expected to cost $3.5 million combined.

Health Quest also intends to renovate Sharon Hospital's Intensive Care Unit ("ICU"), including the addition of telemedicine equipment. This will allow Sharon Hospital to keep more

patients local by providing remote access to intensivists and other specialists, rather than transferring patients to other facilities. The ICU project is expected to cost approximately $1.5 million. In addition, Health Quest will make all of the Hospital's medical/surgical beds telemetry capable in order to enhance patient care and safety. This project will cost over $1 million. Moreover, Health Quest is considering the purchase of a da Vinci Robot so that additional general, gynecological and urological surgeries can be performed using this new technology. This equipment would cost approximately $2.5 million.

It should be noted that all of this is in addition to the normal course of business infrastructure maintenance and upgrades that are coming due in the near future. For example, there are boilers and an oil tank that need to be replaced and necessary HVAC upgrades, which will cost approximately $600,000. Health Quest will also undertake to "refresh" the aging infrastructure at Sharon Hospital to make it a more modern and appealing healthcare destination.

Health Quest fully understands the need to undertake these capital expenditures in order to meet its performance objectives at Sharon Hospital and improve the quality and accessibility of care. We are committed to moving forward and spending the necessary capital to ensure that Sharon Hospital has the appropriate physicians, equipment and facilities to best meet the needs of the Sharon community. As mentioned in the CON, a portion of this investment will be funded by a conditional grant from FCH. However, a vast majority will be funded by Health Quest through its cash reserves. Health Quest has a proven record of investing the necessary capital in its hospitals and facilities to maintain and expand the care available in the communities we serve. We intend to make significant investments in Sharon Hospital over the short and long-term to accomplish the same objectives, as previously noted.

Physician Recruitment

As Mike Browder mentioned in his testimony, one of the biggest hurdles RCCH faced in operating Sharon Hospital was its inability to recruit specialty physicians to practice in Sharon, primarily because of the lack of patient demand and other RCCH physicians to provide back-up and coverage. RCCH operated Sharon Hospital as a standalone hospital and, as such, had no local network of physicians to call upon. The sale of Sharon Hospital to Vassar Connecticut (Health Quest) will solve this issue. As my colleague Dr. Glenn Loomis will testify in the companion hearing on the transfer of Regional Healthcare Associates to a Connecticut Medical Foundation affiliated with Health Quest, the full resources of Health Quest will be available to the Connecticut Medical Foundation to assist with recruitment of physicians. Health Quest has a dedicated team of in-house physician recruiters whose only role is to identify physician recruits and employ them within the Health Quest System. We use a physician-led approach to practice and offer attractive compensation and benefits. We provide the security of a large group practice, which is attractive to younger physicians who want to be mentored and who do not want the responsibility for providing a specialty physician service to fall on their shoulders alone.[1]

HQMP has been extremely successful in its recent physician recruitment efforts. In FY 2016 alone we recruited 47 physicians to practice in the Mid-Hudson Valley region of New York, including 13 primary care physicians and 34 specialists. We expect to recruit at least another 40 physicians in FY 2017. Several of HQMP's offices are located in rural areas and medically underserved communities. We have been successful recruiting physicians to these

[1] Health Quest will also be implementing a Graduate Medical Education program system-wide beginning in FY 2019. Initial specialties will include family medicine and surgery. We expect to have 250 residents among our system hospitals by FY 2024. This program will serve as a pipeline for new physicians who want to continue practicing with the Health Quest system post-residency.

locations, which we believe speaks well of our ability to recruit physicians to practice in the Sharon primary and secondary service areas. Moreover, whereas previously a physician might not have wanted to relocate to Sharon for a part-time practice we can now repurpose our own physician to share time between practice locations in New York and Connecticut.

Our plans for Sharon Hospital are simple in this regard. Our first priority is to recruit and repurpose physicians (primary and specialty) in order to establish services that are not presently available in the Sharon community. This includes, notably, oncology services, which have not been available since Yale-New Haven closed its Smilow location in Sharon in 2015. We will also enhance other services where we know that patients are leaving the service area due to backlogs or limited physician availability or choice, for example cardiology, orthopedics, general surgery, and OB/GYN. As far as cardiology is concerned, Health Quest has three physicians committed to provide services in Sharon. With respect to orthopedics, Sharon physicians perform a small fraction (4%) of the approximately 650 total joint and spine surgeries for service area residents annually. We expect to recruit physicians who will be able to address the demand for these services directly in the community. General surgery is another area where Sharon Hospital is losing 80-90% of service area cases. Health Quest intends to help recapture this volume as well. We will also recruit to enhance patient choice for providers such as OB/GYNs where we know, for example, that some women are self-selecting providers outside of the community.

We also expect that the expansion of specialty services in the Sharon community will instill renewed confidence in Sharon Hospital on the part of local EMS providers. These providers will be more comfortable transporting patients to Sharon if they know there are specialty physicians available to provide needed care, whereas now they might select an alternate

hospital in order to avoid a second transport if the patient needs services that are not currently available.

Moreover, Health Quest intends to expand digital platforms that will allow for consultation by specialists outside of the community. We believe that this type of accessibility is an important aspect of how rural healthcare will be delivered in years to come.

Enhancing access and choice for physician services should also drive volume and revenue growth, as was the case historically. And, as Mr. Browder mentioned, the fixed costs associated with repurposed physicians are already being borne by Health Quest. In addition, HQMP physicians are able to cover call at Sharon at a lower cost than the locum tenens cost of coverage that Sharon Hospital contracts for presently. These cost savings, which are available by virtue of Sharon's membership in Health Quest, will contribute favorably towards the Hospital's financial improvement.

Foundation for Community Health

I would also like to speak briefly about the partnership that Health Quest has undertaken with the Foundation for Community Health ("FCH"). FCH is the successor organization to the Sharon Area Community Health Foundation, which was established to receive the proceeds of the sale of Sharon Hospital's assets to Essent in 2002. FCH is providing Health Quest with a $3 million conditional Asset Purchase Grant, towards the purchase of Sharon Hospital. Subsequently, FCH will provide an additional $6 million conditional Working Capital Grant to fund strategic investments in Sharon Hospital including direct physician and provider costs, investment in equipment, facility upgrades, ambulatory networks, IT infrastructure, and other strategic programmatic investments.

Our partnership with FCH is possible through the return of Sharon Hospital to a non-profit, charitable and tax-exempt organization. This will allow FCH to reinvest funds that were originally intended for Sharon Hospital but never achieved due to the Hospital's for-profit tax status. Now, as a tax-exempt organization, the funds can be directly provided in order to enhance the quality and accessibility of healthcare services for the community. We look forward to working with FCH in a meaningful way to benefit the health of Sharon area residents.

As part of our arrangement with the foundation, FCH is entitled to nominate 12 members (80%) of the initial Sharon Hospital Board under Vassar Connecticut ownership. These nominees will serve staggered terms and a number of the nominees will remain on the Board for a full six years. As their Chief Executive Officer Nancy Heaton will tell you in her remarks this afternoon, FCH has already conducted its due diligence and provided Health Quest with an exceptional group of nominees who we are interviewing and expect to appoint to the new Hospital Board in the near future. These nominees are from diverse personal and professional backgrounds and represent all corners of the Sharon Hospital service area, including both Connecticut and New York.

Once the terms of these FCH-nominated Board members expire new members will be nominated by the Sharon Hospital Board in the normal course and approved by Health Quest. Health Quest is absolutely committed to having local representation on Sharon Hospital Board going forward. We understand from operating other hospitals that local representation is critical to understanding and addressing the needs and concerns of the communities we serve.

In addition, as a tax-exempt hospital, we will be required to develop and implement a Community Health Needs Assessment ("CHNA") for the Sharon service area and to update that assessment periodically as required by law. The CHNA process for Health Quest hospitals is a

collaborative one involving clinicians, local boards of health, community members, and others who provide valuable input on community health priorities. We expect to be able to utilize FCH as a resource in this regard.

Projected Enhancement of Sharon Hospital

We understand that our volume and financial projections show significant growth in Sharon Hospital during Health Quest's first three years of operation. However we believe these projections are consistent with what has been achieved at Sharon Hospital historically and attainable given Health Quest's resources (human resources, financial resources, operational expertise and resources) and business plan. As Mr. Browder testified, Sharon Hospital/Regional Healthcare Associates achieved a 7% margin (income before interest and income taxes) as recently as FY 2011. We are projecting a consolidated (Sharon Hospital/Regional Healthcare Associates) margin of 6% by FY 2020. This is consistent with, and in many instances less than, the operating margins achieved by other Connecticut hospitals in FYs 2015 and 2016. Attached as Exhibit A is a comparison and summary of hospital operating margin data, compiled using audited financial statements and other information collected by OHCA. This data shows that each year there were seven (7) Connecticut hospitals with higher operating margins than what is projected for Sharon Hospital, including two (2) hospitals with operating margins in excess of 10%. It should also be noted that Health Quest hospitals have historically exceeded the average operating margins of hospitals in New York. For example, VBMC had an operating margin in excess of 6% last year, where the New York state average is just over 1%.

The projected growth at Sharon Hospital and RHA reflects Health Quest's commitment to invest, grow and expand services and access in and around Sharon. Expectations for Sharon's future are high, but are by no means out of line with what is occurring across Connecticut

hospitals today. There is tremendous upside capacity at Sharon Hospital. With the local resources of Health Quest and our ability to recruit and repurpose physicians and grow specialty services, our projections are entirely achievable. There are patients who are leaving the service area because ether specialty services are not available or are not to their liking. We can and will bring these patients back by elevating the level of services on the Sharon campus. An enhanced Sharon Hospital can also serve as a destination for service area residents who have opted to use NDH and VBMC in the past, but can now receive their care closer to home. Locally delivered care is best, when it is safe and feasible

Health Quest is a financially and strategically disciplined organization. We would not acquire Sharon Hospital and make significant investments (capital or otherwise) if we did not see the potential to achieve the projected growth and solid financial platform anticipated. We are confident in our ability to return Sharon Hospital to its former state of quality services, exceptional care and financial growth, much as we did with NDH. That hospital was nearly out of business when it became part of the Health Quest in 1999. Since then, we have undertaken two major building projects, replacing virtually all of the inpatient beds and the surgical operating suite and recovery room; added 16 licensed beds, with another 24-bed expansion planned; doubled the number of surgeons and primary care physicians on staff; and added the da Vinci and Navio surgical robots – investing $60 million just since 2014. NDH now has the best quality scores and financial margins in the Health Quest system. We expect to achieve comparable growth at Sharon.

Conclusion

Health Quest is eager to move forward with the purchase of Sharon Hospital and to make the necessary capital investments to achieve its publically stated goals and objectives. Health

Quest is in this for the long haul and we are making a commitment not just to maintain Sharon Hospital, but to enhance the accessibility and quality of the healthcare services available in the Sharon community. Health Quest has the financial and administrative resources to make this happen, and again, has committed to do so with specific actions, such as recruiting primary care and specialty physicians, enhancing existing services like cardiology, orthopedics and surgery, developing new services like oncology, making capital investments, and supporting routine maintenance expenditures. It is understood that the Sharon community does not want to see its hospital become a critical access facility or, worse yet, close. Health Quest presents the best option to ensure that Sharon Hospital survives to care for members of this community for generations to come.

Again, I thank you for your time and ask you to approve the CON for the transfer of Sharon Hospital to Vassar Connecticut, a non-profit member of Health Quest Systems. I am here to answer any questions you have after brief remarks by Nancy Heaton from the Foundation for Community Health.

The foregoing is my sworn testimony.

Robert Friedberg
President & Chief Executive Officer
Health Quest Systems, Inc.

EXHIBIT A

HOSPITAL STATEMENT OF OPERATIONS AND MARGIN DATA

	FY 2016			FY 2015		
	OPERATING MARGIN	NON-OPER MARGIN	TOTAL MARGIN	OPERATING MARGIN	NON-OPER MARGIN	TOTAL MARGIN
ASCENSION HEALTH						
SAINT VINCENT'S	-1.40%	1.42%	0.02%	-0.94%	-2.74%	-3.68%
EASTERN CT HEALTH NETWORK						
MANCHESTER (moved to Prospect)		Not available		4.79%	-0.88%	3.91%
ROCKVILLE (moved to Prospect)		Not available		-5.63%	-0.85%	-6.47%
HARTFORD HEALTHCARE CORP						
BACKUS	10.82%	9.43%	20.24%	14.04%	-0.28%	13.76%
HARTFORD	4.60%	1.80%	6.40%	5.66%	-0.67%	4.99%
HOSP OF CENTRAL CT	1.91%	3.08%	4.99%	-0.86%	-0.32%	-1.18%
MIDSTATE	8.47%	3.42%	11.89%	7.38%	-1.16%	6.21%
WINDHAM	-17.29%	-1.66%	-18.96%	-5.41%	-1.43%	-6.84%
WESTERN CT HEALTH NETWORK						
DANBURY	-0.66%	4.35%	3.69%	-2.40%	1.50%	-0.91%
NORWALK	0.96%	8.22%	9.18%	4.24%	5.84%	10.07%
YALE NEW HAVEN HSC						
BRIDGEPORT	7.78%	1.18%	8.96%	10.95%	0.19%	11.14%
GREENWICH	8.67%	0.51%	9.18%	9.08%	-1.57%	7.51%
YALE-NEW HAVEN	3.13%	2.60%	5.73%	4.50%	-0.16%	4.33%
INDIVIDUAL HOSPITALS						
BRISTOL	-2.14%	0.77%	-1.36%	0.39%	0.58%	0.96%
CT CHILDERNS	1.09%	0.93%	2.02%	7.47%	1.42%	8.90%
DEMPSEY	5.29%	2.32%	7.61%	5.30%	2.23%	7.52%
GRIFFIN	10.74%	-1.23%	9.51%	5.12%	-1.64%	3.48%
HUNGERFORD (moving to Hartford Hospital)	-5.71%	1.65%	-4.06%	-1.16%	2.40%	1.24%
L&M (moving to Yale New Haven)	1.25%	2.70%	3.95%	1.73%	2.71%	4.44%
MIDDLESEX	6.09%	3.07%	9.16%	1.39%	1.91%	3.30%
MILFORD	0.95%	0.15%	1.11%	-7.38%	0.17%	-7.20%
SAINT FRANCIS (part of Trinity)	1.35%	0.25%	1.59%	0.08%	-2.63%	-2.55%
SAINT MARYS (moved to Trinity)		Not available		7.13%	0.96%	8.09%
STAMFORD	7.47%	0.30%	7.77%	9.33%	-0.12%	9.21%
WATERBURY (moved to Prospect)		Not available		-5.85%	1.08%	-4.78%

[1]Hospital only. Based on income before intercompany fees and income taxes.

FY 2016 HOSPITAL STATEMENT OF OPERATIONS AND MARGIN DATA*

	FY 2016									
	NET PATIENT REVENUE	OTHER OP REVENUE	REV FROM OPERATIONS	NET OPER EXPENSES	GAIN/LOSS OPERATIONS	NON-OPER REVENUE	REVENUE O/(U) EXP	OPERATING MARGIN	NON-OPER MARGIN	TOTAL MARGIN
ASCENSION HEALTH										
SAINT VINCENT'S	$408,148,000	$21,611,000	$429,759,000	$435,859,000	($6,100,000)	$6,206,000	$106,000	-1.40%	1.42%	0.02%
EASTERN CT HEALTH NETWORK										
MANCHESTER (moved to Prospect)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
ROCKVILLE (moved to Prospect)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
HARTFORD HEALTHCARE CORP										
BACKUS	$300,144,000	$5,677,000	$305,821,000	$269,290,000	$36,531,000	$31,823,000	$68,354,000	10.82%	9.43%	20.24%
HARTFORD	$1,063,296,000	$105,622,000	$1,168,918,000	$1,114,116,000	$54,802,000	$21,400,000	$76,202,000	4.60%	1.80%	6.40%
HOSP OF CENTRAL CT	$358,394,000	$15,023,000	$373,417,000	$366,064,000	$7,353,000	$11,884,000	$19,237,000	1.91%	3.08%	4.99%
MIDSTATE	$214,452,000	$15,532,000	$229,984,000	$209,817,000	$20,167,000	$8,148,000	$28,315,000	8.47%	3.42%	11.89%
WINDHAM	$66,926,000	$2,823,000	$69,749,000	$81,614,000	($11,865,000)	($1,141,000)	($13,006,000)	-17.29%	-1.66%	-18.96%
WESTERN CT HEALTH NETWORK										
DANBURY	$621,214,000	$19,327,000	$640,541,000	$644,970,000	($4,429,000)	$29,126,000	$24,697,000	-0.66%	4.35%	3.69%
NORWALK	$372,224,000	$13,954,000	$386,178,000	$382,146,000	$4,032,000	$34,584,000	$38,616,000	0.96%	8.22%	9.18%
YALE NEW HAVEN HSC										
BRIDGEPORT	$472,739,000	$41,059,000	$513,798,000	$473,366,000	$40,432,000	$6,144,000	$46,576,000	7.78%	1.18%	8.96%
GREENWICH	$368,015,000	$15,716,000	$383,731,000	$350,290,000	$33,441,000	$1,960,000	$35,401,000	8.67%	0.51%	9.18%
YALE-NEW HAVEN	$2,547,180,000	$145,705,000	$2,692,885,000	$2,606,236,000	$86,649,000	$71,896,000	$158,545,000	3.13%	2.60%	5.73%
INDIVIDUAL HOSPITALS										
BRISTOL	$133,544,821	$3,643,010	$137,187,831	$140,143,704	($2,955,873)	$1,070,208	($1,885,665)	-2.14%	0.77%	-1.36%
CT CHILDERNS	$358,221,226	$29,900,949	$388,122,175	$383,842,980	$4,279,195	$3,648,257	$7,927,452	1.09%	0.93%	2.02%
DEMPSEY	$337,300,000	$22,995,000	$360,295,000	$340,779,000	$19,516,000	$8,551,000	$28,067,000	5.29%	2.32%	7.61%
GRIFFIN	$163,963,272	$4,146,002	$168,109,274	$150,278,226	$17,831,048	($2,037,603)	$15,793,445	10.74%	-1.23%	9.51%
HUNGERFORD (moving to Hartford Hospital)	$110,242,061	$6,483,839	$116,725,900	$123,502,173	($6,776,273)	$1,961,328	($4,814,945)	-5.71%	1.65%	-4.06%
L&M (moving to Yale New Haven)	$326,461,025	$31,451,397	$357,912,422	$353,326,579	$4,585,843	$9,936,909	$14,522,752	1.25%	2.70%	3.95%
MIDDLESEX	$380,107,000	$11,182,000	$391,289,000	$366,706,000	$24,583,000	$12,384,000	$36,967,000	6.09%	3.07%	9.16%
MILFORD	$62,023,918	$5,924,574	$67,948,492	$67,298,998	$649,494	$102,709	$752,203	0.95%	0.15%	1.11%
SAINT FRANCIS (part of Trinity)	$730,461,000	$40,641,000	$771,102,000	$760,698,000	$10,404,000	$1,925,000	$12,329,000	1.35%	0.25%	1.59%
SAINT MARYS (moved to Trinity)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
STAMFORD	$494,196,000	$17,552,000	$511,748,000	$473,412,000	$38,336,000	$1,520,000	$39,856,000	7.47%	0.30%	7.77%
WATERBURY (moved to Prospect)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

*Compiled based on the audited financial statements available on OHCA's website

SH000924
03/29/2017

FY 2015 HOSPITAL STATEMENT OF OPERATIONS AND MARGIN DATA*

	FY 2015									
	NET PATIENT REVENUE	OTHER OP REVENUE	REV FROM OPERATIONS	NET OPER EXPENSES	GAIN/LOSS OPERATIONS	NON-OPER REVENUE	REVENUE O/(U) EXP	OPERATING MARGIN	NON-OPER MARGIN	TOTAL MARGIN
ASCENSION HEALTH										
SAINT VINCENT'S	$402,610,000	$18,338,000	$420,948,000	$424,794,000	($3,846,000)	($11,242,000)	($15,088,000)	-0.94%	-2.74%	-3.68%
EASTERN CT HEALTH NETWORK										
MANCHESTER (moved to Prospect)	$176,292,453	$12,387,148	$188,679,601	$179,724,323	$8,955,278	($1,638,670)	$7,316,608	4.79%	-0.88%	3.91%
ROCKVILLE (moved to Prospect)	$63,002,481	$2,225,773	$65,228,254	$68,867,915	($3,639,661)	($546,692)	($4,186,353)	-5.63%	-0.85%	-6.47%
HARTFORD HEALTHCARE CORP										
BACKUS	$285,528,000	$7,003,000	$292,531,000	$251,581,000	$40,950,000	($825,000)	$40,125,000	14.04%	-0.28%	13.76%
HARTFORD	$980,435,000	$114,818,000	$1,095,253,000	$1,033,675,000	$61,578,000	($7,290,000)	$54,288,000	5.66%	-0.67%	4.99%
HOSP OF CENTRAL CT	$339,152,000	$13,989,000	$353,141,000	$356,161,000	($3,020,000)	($1,143,000)	($4,163,000)	-0.86%	-0.32%	-1.18%
MIDSTATE	$212,392,000	$14,407,000	$226,799,000	$210,264,000	$16,535,000	($2,603,000)	$13,932,000	7.38%	-1.16%	6.21%
WINDHAM	$77,602,000	$4,764,000	$82,366,000	$86,761,000	($4,395,000)	($1,158,000)	($5,553,000)	-5.41%	-1.43%	-6.84%
WESTERN CT HEALTH NETWORK										
DANBURY	$592,876,000	$16,591,000	$609,467,000	$624,338,000	($14,871,000)	$9,265,000	($5,606,000)	-2.40%	1.50%	-0.91%
NORWALK	$355,511,000	$16,016,000	$371,527,000	$354,816,000	$16,711,000	$23,036,000	$39,747,000	4.24%	5.84%	10.07%
YALE NEW HAVEN HSC										
BRIDGEPORT	$466,074,000	$32,055,000	$498,129,000	$443,456,000	$54,673,000	$944,000	$55,617,000	10.95%	0.19%	11.14%
GREENWICH	$348,844,000	$14,393,000	$363,237,000	$330,759,000	$32,478,000	($5,622,000)	$26,856,000	9.08%	-1.57%	7.51%
YALE-NEW HAVEN	$2,457,990,000	$68,887,000	$2,526,877,000	$2,413,364,000	$113,513,000	($4,162,000)	$109,351,000	4.50%	-0.16%	4.33%
INDIVIDUAL HOSPITALS										
BRISTOL	$133,327,930	$3,838,007	$137,165,937	$136,633,273	$532,664	$795,166	$1,327,830	0.39%	0.58%	0.96%
CT CHILDERNS	$293,034,805	$18,806,567	$311,841,372	$288,197,545	$23,643,827	$4,501,314	$28,145,141	7.47%	1.42%	8.90%
DEMPSEY	$337,300,171	$22,995,416	$360,295,587	$340,779,258	$19,516,329	$8,202,084	$27,718,413	5.30%	2.23%	7.52%
GRIFFIN	$142,949,359	$5,691,910	$148,641,269	$141,153,441	$7,487,828	($2,396,689)	$5,091,139	5.12%	-1.64%	3.48%
HUNGERFORD (moving to Hartford Hospital)	$113,735,730	$6,810,204	$120,545,934	$121,979,246	($1,433,312)	$2,960,711	$1,527,399	-1.16%	2.40%	1.24%
L&M (moving to Yale New Haven)	$325,022,845	$31,431,251	$356,454,096	$350,127,953	$6,326,143	$9,936,909	$16,263,052	1.73%	2.71%	4.44%
MIDDLESEX	$357,637,000	$13,367,000	$371,004,000	$365,752,000	$5,252,000	$7,212,000	$12,464,000	1.39%	1.91%	3.30%
MILFORD	$60,372,640	$3,567,807	$63,940,447	$68,666,088	($4,725,641)	$111,904	($4,613,737)	-7.38%	0.17%	-7.20%
SAINT FRANCIS (part of Trinity)	$649,233,000	$35,438,000	$684,671,000	$684,142,000	$529,000	($17,533,000)	($17,004,000)	0.08%	-2.63%	-2.55%
SAINT MARYS (moved to Trinity)	$251,921,000	$8,206,000	$260,127,000	$241,388,000	$18,739,000	$2,522,000	$21,261,000	7.13%	0.96%	8.09%
STAMFORD	$476,413,000	$17,239,000	$493,652,000	$447,673,000	$45,979,000	($582,000)	$45,397,000	9.33%	-0.12%	9.21%
WATERBURY (moved to Prospect)	$192,703,886	$6,461,805	$199,165,691	$210,952,866	($11,787,175)	$2,169,188	($9,617,987)	-5.85%	1.08%	-4.78%

*Data obtained from OHCA website: "Statewide Hospital Margin Data"

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Prefiled Testimony of Nancy Heaton
Chief Executive Officer, Foundation for Community Health, Inc.

Good afternoon Hearing Officer Hansted and members of the OHCA Staff. My name is Nancy Heaton and I am the Chief Executive Officer of the Foundation for Community Health, Inc. ("FCH"). Thank you for this opportunity to speak in support of the CON Application for transfer of ownership of Sharon Hospital ("Sharon" or the "Hospital") to Vassar Health Connecticut, Inc. ("Vassar Connecticut"), a subsidiary of Health Quest Systems, Inc. ("Health Quest"). FCH is the successor entity to the Sharon Area Community Health Foundation ("SACHF"), which established in connection with the for-profit conversion of Sharon in 2002. With the anticipated return of Sharon to a non-profit hospital, FCH will be providing grant funds to assist with both the purchase of and strategic investment in the Hospital by Health Quest. FCH will also be given the opportunity to nominate a significant percentage of the initial Sharon Hospital Board under Health Quest ownership. FCH looks forward to this new partnership and ability to collaborate with our community hospital in ways that were not possible when Sharon was a for-profit facility. For these reasons, we urge OHCA to approve Applicants' request for a CON to transfer ownership of Sharon Hospital to Health Quest.

Background on Foundation for Community Health

FCH (originally formed as SACHF) is the "conversion foundation" approved by the Office of the Attorney General under Sections 19a-486 et seq. of the Connecticut General Statutes to receive the net proceeds of the sale of Sharon Hospital to Essent Healthcare of Connecticut, Inc. in 2002. FCH was also the recipient of all restricted and non-restricted funds

and income and legacies left in wills and from trusts that were originally designated to go to the former non-profit Hospital. FCH is a public charity within the meaning of the Code and, more specifically, a "supporting organization" that derives its tax-exempt status from the support it provides to other organizations in conducting charitable activities. In the case of FCH, our supported organizations include Berkshire Taconic Community Foundation, Community Foundation of the Hudson Valley, and Northwest Connecticut Community Foundation.

FCH's mission is to maintain and improve the physical and mental health of the residents of the area historically served by Sharon Hospital. We have been a leader and catalyst for the development of innovative and effective rural health delivery systems that focus on prevention, access and community-level collaboration. FCH accomplishes its mission through activities that include, but are not limited to, collaboration and advocacy, issuing grants, evaluating existing healthcare services, making program-related investments, and conducting research. Our grant of funds to Health Quest for the acquisition of Sharon and ongoing strategic investments in the Hospital is consistent with our mission and the purposes of our supported organizations, which include enhancing community health in the Sharon Hospital catchment area.

Decision to Partner with Health Quest – Asset Purchase & Working Capital Grants

The Foundation for Community Health, through its board and senior leadership, has determined that the greatest impact we can have on healthcare in the Sharon community is to assist Health Quest in returning Sharon to a non-profit hospital and community asset. We have conducted our due diligence, including visiting other Health Quest System hospitals and having extensive discussions with Health Quest management about their plans for Sharon. Based on this diligence and Health Quest's pledge of capital and resources, FCH is confident in Health Quest's ability to revitalize Sharon Hospital and certain of its long-term commitment to the

Sharon community. I can assure you, FCH would not be providing such a substantial grant to Health Quest if this was not the case.

As OHCA is aware, FCH has agreed to provide Health Quest with $9 million in grants in connection with the acquisition, operation and improvement of Sharon Hospital. This includes a $3 million Asset Purchase Grant, which will be used to fund a portion of the purchase price. It also includes a $6 million Working Capital Grant that will be used to fund "Investments" in Sharon. These include such items as direct physician and provider costs, equipment acquisitions, facility upgrades, investments in ambulatory networks, IT infrastructure upgrades, and other strategic programmatic investments. All Investments must directly benefit Sharon Hospital. We are aware of some of the investments that Health Quest has planned already, including EMR upgrades and service line expansions (e.g. oncology) that we believe will greatly enhance the quality and accessibility of healthcare services in the Sharon area.

FCH's funding under the Working Capital Grant covers a percentage of actual investments made by Health Quest at Sharon. It was important to our Board that Health Quest cover a percentage of each investment reimbursed by FCH in order to ensure the company's ongoing commitment to our Hospital and the community. Moreover, Health Quest is reimbursed on an annual basis for investments and FCH's obligation to fund investments through the Working Capital Grant ceases if all monies are not spent in Health Quest's first four years of operation. We believe this process will serve as incentive for Health Quest to move forward with needed capital investments as expeditiously as possible.

In addition, the question has been asked whether the grant of $9 million to Health Quest will impair FCH's ability to make other necessary grants to promote community health. First note that after disbursement of $9 million in grants to Health Quest, FCH will still have

approximately $16 million with which to continue its charitable mission in and around Sharon. Moreover, under the terms of the Grant Agreement between Health Quest and FCH, Health Quest has agreed to assist FHC in maintaining its existing level of community activities for the next ten years, either through direct funding or the assumption of community services and programs that would otherwise be funded by FCH. Lastly, the Grant Agreement contemplates a capital campaign whereby the funds provided by FCH to Health Quest for purposes of restoring Sharon Hospital to a non-profit community asset and enhancing care may be replenished through charitable giving.

Furthermore, we would like to point out certain safeguards in the Grant Agreement regarding the funding arrangement between FCH and Health Quest. Specifically, there are provisions that require the return of grant funds to FCH if Health Quest sells or closes the Hospital within the first five years or the Hospital loses its tax exemption. While we do not expect this to be the case, we want to assure OHCA that our investment is protected. In addition, the Grant Agreement requires Health Quest to maintain services at Sharon Hospital in accordance with any Order issued by this agency.

FCH's Right to Nominate Sharon Hospital Board Members

As part of the Grant Agreement with Health Quest, FCH has been given the right to nominate 12 of 15 members of the initial non-profit Sharon Hospital board. These nominees will serve staggered terms, giving FCH nominees a majority stake in the Sharon board for at least six years. We have already completed an extensive process, with the help of a consultant, which included identifying, vetting, interviewing and recommending our board nominees to Health Quest.

Our goal was to assemble a diverse group of community constituents. We were looking for individual with a stake in Sharon Hospital – those who reside in the service area and whose families obtain their healthcare services at Sharon. The nominees represent different interests within the Sharon community, come from all corners of the Sharon service area (including Connecticut and New York), and have varied professional backgrounds. There are nominees with expertise in healthcare and marketing, small business owners, and individuals who serve on other non-profit boards. We have also included nominees that represent the interest of the average healthcare consumer in the Sharon area.

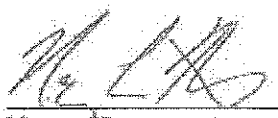
After the terms of the FCH-nominated board members have expired, the Sharon board itself will be responsible for nominating replacements, subject to Health Quest board approval. In our experience, this is similar to the process in place for most non-profit boards. It is our understanding that Health Quest is committed to having local representation and perspective on the Hospital's board and we are confident that they will appoint members of the community to serve for many years beyond the tenure of FCH's initial appointees.

Conclusion

Speaking for myself and members of the FCH board, we are pleased to see the Hospital returned to non-profit status. This provides FCH with opportunities to collaborate on issue related to community health that simply were not possible with a for-profit Sharon Hospital. FCH has identified significant health needs in our community and we look forward to partnering with Health Quest to address these needs going forward.

Thank you again for this opportunity to speak in support of the CON Application for approval to transfer ownership of Sharon Hospital to Health Quest. I am available to answer any questions you have about FCH or our involvement with this transaction.

The foregoing is my sworn testimony.



Nancy Keaton
Chief Executive Officer
Foundation for Community Health

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.
Docket No. 16-32132-CON

Transfer of Ownership of Regional Healthcare Associates, LLC
to a Subsidiary of Vassar Health Connecticut, Inc.
Docket No. 16-32133-CON

RESPONSES TO HEARING ISSUES

Per OHCA's request, below are written response to Hearing Issues dated March 17, 2017:

1. Provide a list prioritizing critical/immediate (over next 2-3 years) capital and operational improvements, including upgrades or strategic investments for the Hospital.

RESPONSE:

Below is a table listing all projects that Health Quest Systems, Inc. ("Health Quest") intends to undertake during the first two to three years following its acquisition of Sharon Hospital ("Sharon" or the "Hospital"). It should be noted that Health Quest, as it is not yet the owner of Sharon Hospital, has not completed a detailed strategic or capital plan for the Hospital. Moreover, Health Quest has not yet received input from the Sharon community about the needs for Sharon Hospital. Health Quest's final plan may well be amended once it has had the opportunity to better assess the capital needs and service needs of the Hospital. The final plan will be based on this detailed analysis and understanding of the capital and service requirements. The below table includes a description of the proposed project, its approximate capital cost, the funding source, and the estimated commencement/completion date. In addition, please note the following:

- When Health Quest is listed as a funding source this refers to the company's cash reserves and income from operations;
- When the Foundation for Community Health, Inc. ("FCH") is listed as a funding source this means until the Working Capital Grant funds are exhausted, after which projects will be fully funded by Health Quest;
- Health Quest has had various reviews undertaken and has further refined the costs of its proposed capital projects as follows:
    - The Cerner EMR upgrade, which was estimated at $3 to $3.5 million, will cost approximately $5 million;
    - The replacement and upgrade of boilers and underground storage tanks is estimated to be $600,000, which is less than was projected in initial CON submissions;
    - The renovation of space at the Hospital for the addition of beds to the Geropsychiatric Unit is estimated to cost $2 million, as opposed to the $1.5 million initially projected; and
    - Renovation of space for Medical Oncology/Infusion and other clinical services has been estimated at $1.5 million.

Anticipated Capital Improvements & Strategic Investments, FY 2017 – FY 2019

Project List	Description	Funding Source	Time to Complete
Conversion to Cerner Electronic Health Record ($5,000,000)	This project will replace the existing EMR at Sharon Hospital and RHA/TriState Offices	Health Quest and Foundation for Community Health	9 months, starting in July 2017, ending in April 2018
Life Safety and Regulatory Upgrades ($600,000)	This project will involve the removal and replacement/upgrade the boilers and underground fuel tanks	Health Quest and Foundation for Community Health	6 months, starting in July 2017, ending in December, 2017
Expansion of the Geropsychiatric Unit ($2,000,000)	This renovation project will increase the number of beds in the Geropsychiatry unit to accommodate additional demand for these services locally, as well as to make this a destination service for Health Quest patients	Health Quest and Foundation for Community Health	12 months, starting in January 2018, ending in December 2018
Renovation for Medical offices, including Oncology and Infusion ($1,500,000)	This will provide office space for additional physicians to be recruited to the area, including primary care, oncology, endocrinology and cardiology. It will also involve renovation of space for the addition of an infusion center for providing chemotherapy for oncology patients. Chemo infusion is not currently offered at Sharon Hospital	Health Quest and Foundation for Community Health	9 months, starting in October of 2017, ending in June 2018
Purchase of DaVinci Robot ($2,500,000)	Health Quest will purchase and install a DaVinci Robot, which is used for a variety of surgical procedures, reducing blood loss and decreasing recovery time. This is a new service for Sharon Hospital.	Health Quest and Foundation for Community Health	3 months, starting in January 2019, ending in April of 2019

Project List	Description	Funding Source	Time to Complete
ICU Renovation/Monitor Upgrades ($1,500,000)	Health Quest will renovate and install telemedicine equipment in the ICU, allowing Sharon to keep more patients in the Hospital by providing direct access to intensivists and specialists at VBMC.	Health Quest and Foundation for Community Health	4-6 months, starting in January/March 2019, ending in June 2019
Installing Wireless Telemetry on Medical/Surgical Unit ($1,000,000)	Health Quest will make all medical/surgical beds at the Hospital telemetry capable, improving patient care and safety.	Health Quest and Foundation for Community Health	3 months, starting in April 2019, ending in June 2019

Health Quest has also identified more than $1 million in cost savings opportunities available to Sharon Hospital once it becomes part of the Health Quest System. These savings are largely made possible due to the proximity of Sharon Hospital and Health Quest, which allows greater synergies than the relationship with its existing owner RCCH. These cost savings are in addition to those that may be achieved as a result of shared corporate services such as legal, compliance, human resources, IT, planning, and finance across Health Quest. In addition, Health Quest is evaluating whether it can save on Sharon's current medical malpractice expenses, which total $1.1 million annually.

Anticipated Annual Cost Savings

Area	Description	Annual Cost Savings
Pharmacy	Reduce Drug Costs	$31,500
Medical/Surgical	Reduce Supply Costs	$91,000
Purchased Services	Reduce Contract Costs	$227,000
Locum Tenens	Cost to staff with temporary nurses and physicians	$120,000
Coding	Discontinue use of third party coders	$150,000
Marketing	Use internal resources	$200,000
Equipment Maintenance	Discontinue use of outside services	$200,000

2. For each response to question one above, provide:
    a. The funding source; and
    b. The length of time estimated to implement each.

RESPONSE:

See Responses to Question 1 above.

3. Explain how the Hospital currently solicits, conveys to the Hospital Board and addresses community input and concerns. Furthermore, describe how the Hospital will continue to solicit, convey to the Hospital Board and address community input and concerns following the transfer of ownership.

RESPONSE:

Below are descriptions of the processes in place at the existing Sharon Hospital, and that will be put into place at the new Sharon Hospital, to solicit, convey to the Hospital Board and address community input and concerns.

Existing Sharon Hospital

Under current for-profit ownership, Sharon Hospital has both a Local Governing Board and an Advisory Board of Trustees ("Local Advisory Board"). The Local Governing Board derives its authority from the Essent Healthcare of Connecticut, Inc. corporate board and deals with issues relating to day-to-day operations at the Hospital. Authority has been delegated to the Local Governing Board to oversee matters including, but not limited to, physician credentialing, evaluation of performance of local management, and monitoring of clinical quality efforts. The Local Advisory Board was established pursuant to the Attorney General Order authorizing the conversion of Sharon to ensure a level of community involvement with the for-profit Hospital. It is comprised of elected public officials from the Sharon area, members of the Sharon Hospital Medical Staff, community members, and representatives of RCCH (formerly Essent Healthcare, Inc.).

There are numerous ways in which current Hospital administration solicits input and concerns from the local community. As Peter Cordeau, the CEO of Sharon Hospital, mentioned in his testimony he has an "open door" policy and is continually meeting with members of the community to discuss issues related to Sharon. Mr. Cordeau and other senior administrators have offices located off of the main lobby of the Hospital and are likely more accessible than any other hospital administrators in Connecticut. Sharon community members are encouraged to call or simply walk in and request a meeting if they have concerns to be addressed, including patient-care complaints.

In addition, Hospital administrators hold community forums and one-on-one meetings at local business establishments, newspapers and even at individual community members' homes. The forums are open to the public and Mr. Cordeau and his colleagues use these

meetings as an opportunity to solicit input and respond to any and all questions posed to them. Mr. Cordeau also has monthly meetings with community physicians, who relay any concerns that they hear from their patients. In addition, the Hospital conducts outreach on social media to both solicit input and keep the community apprised of matters related to Sharon.

Lastly, the Hospital solicits input from the Local Advisory Board, which was established to be the eyes and ears of the Sharon community in the absence of a non-profit hospital board. It is comprised of local community members including the Sharon First Selectman, the Hospital CEO, and residents from Sharon and surrounding towns.

Any and all comments or concerns raised by the community through any of these channels are shared among local Hospital administrators, RCCH corporate representatives, and members of the Local Governing Board (most of whom are community members), as necessary to inform decisions and resolve issues.

New Sharon Hospital

Health Quest will restore Sharon Hospital governance to a non-profit board. As mentioned in other submissions, the new Sharon board will be comprised, initially, of 12 members nominated by the FCH. As discussed below, these individuals represent a cross-section of the Sharon community from which the Hospital expects to solicit input and hear and address community concerns. Mr. Cordeau and his colleagues will also continue their "open door" policy under Health Quest ownership, with an understanding that input from local consumers is critical to meeting community needs and ensuring the future success of Sharon Hospital.

Specific to addressing community health needs, Health Quest will use the same process at Sharon that it uses at each of its other hospitals. Each Health Quest hospital has a Community Needs Committee consisting of hospital board members, physicians, staff, and members of the community. For instance, representatives from the Dutchess and Putnam Counties of Health are on the Northern Dutchess Hospital ("NDH"), Vassar Brothers Medical Center ("VBMC") and Putnam Hospital Center ("PHC") committees, respectively. Because issues of the aging are important in the NDH service area, there is representation from local NGOs on aging. At PHC, as the sole mental health provider in the county, there is representation from local mental health agencies.

Each of the hospital Community Needs Committees is responsible for identifying issues related to community need that the hospital and Health Quest should address in their respective service areas. These committees each develop a three year community service plan for their areas, which is reviewed for progress at each meeting and updated annually. Every three years Health Quest conducts a Community Needs Assessment. They have done this in conjunction with the Dutchess County Department of Health for NDH and VBMC and with the Putnam County Department of Health for PHC. As part of this process, Health Quest also conducts community forums on community health needs. They provide financial support for the County to conduct the survey and then use the results of the survey in the development of a Community Service Plan. Health Quest also conducts an annual symposium in conjunction with the County Health Departments regarding community health.

Health Quest just completed its Community Needs Assessment in 2016, and has developed its Community Service Year Plans for 2017, 2018 and 2019 based on this assessment. A copy of Health Quest's most-recent Community Service Plan is attached as Exhibit A. This plan, along with links to the assessments for Dutchess and Putnam Counties, may be found on Health Quest's website. They also distribute hard copies of the plan throughout Health Quest's service area. The Community Needs Committees give regular reports to their respective hospital boards.

In Sharon, Health Quest proposes to work with FCH and the local health departments to prepare its Community Needs Assessment. Health Quest would use as a starting point the Community Needs Assessment that FCH completed a few years ago. Health Quest would also work with these agencies to get advice on the membership of the Sharon Hospital Community Needs Committee. Health Quest would then develop a Community Service Plan for the area that incorporates the information from the assessment, from interviews and/or community forums that Health Quest would have. The Community Service Plan would be for 2018 and 2019, to put Sharon on the same cycle as the other Health Quest hospitals. In 2019, Health Quest would undertake a new Community Needs Assessment, just as they will do for the other System hospitals that year, which will become the basis for their next Community Service Plan, covering 2020-2022.

4. Please describe how the Hospital's board make-up currently incorporates representation of local health care consumers and how the Applicant will do so following implementation of the proposal.

RESPONSE:

The Hospital's Local Governing Board has nine (9) voting members, including seven (7) who reside in the local community and are representative of local healthcare consumers. The current Board Chair, Howard Fuhr, and member Dr. Robert Schnurr live in Sharon. Members Rusty Chandler and Dr. Jeremy Roth live in the surrounding towns of Salisbury and Cornwall, respectively. Member Dr. Donald Soucier lives outside of the service area, but he has served as the Chief of Cardiology at Sharon Hospital for 15 years. Patricia Chamberlain, Superintendent of Region 1 Public Schools and a Sharon resident is also a member, as is Waterbury Republican-American reporter and Kent resident Ruth Epstein. The Sharon Hospital CEO, Peter Cordeau, is a member and resides in Goshen. The only out-of-state voting member of the Board is Robert Jay, a representative of RCCH.

As previously mentioned, Health Quest will establish a local non-profit board once it acquires Sharon Hospital. This board will have responsibility for quality, physician credentialing and identifying community needs. The board will be populated by individuals who live in the service area. Health Quest relied heavily on FCH to identify 12 nominees for the newly constituted Sharon Hospital board. FCH hired an outside consultant and developed criteria for board member identification. FCH identified individuals from all parts of the Sharon service area, including Connecticut and New York, so that the board would have geographic diversity. FCH proposed nominees who could contribute their time and talents to develop a high functioning board for Sharon Hospital. After interviews and further

vetting of the potential board members, the nominations were presented to the Health Quest board for approval. The terms for the board members were staggered to allow for an orderly transition to new board members over time.

The new board will have a nominating committee, which will identify potential future board members from within the Sharon Hospital service area. These potential members will be interviewed and vetted and presented to the Health Quest board for approval. This is the exact process used to populate the boards of the other hospitals within the Health Quest system, which ensures adequate input from local healthcare consumers.

Note also that the Connecticut Office of Attorney General has relieved Health Quest of its obligation to continue the Local Advisory Board established by the for-profit Sharon Hospital because the new non-profit board will properly represent the community's needs.

EXHIBIT A

2016-2018

Community Service Plan

A Community Needs Assessment and Community Health Implementation Plan for:

Northern Dutchess Hospital

Putnam Hospital Center

Vassar Brothers Medical Center

December 2016

healthquest.org

VASSAR BROTHERS MEDICAL CENTER
PUTNAM HOSPITAL CENTER
NORTHERN DUTCHESS HOSPITAL
HEALTH QUEST MEDICAL PRACTICE, PC

HEALTHQUEST

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03/29/2017

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Introduction

Health Quest's Community Service Plan and Community Health Implementation Plan were developed based upon both Federal and New York State Guidelines.

The New York State Guidelines were designed to meet the Prevention Agenda goals. The Prevention Agenda 2013-2018 is New York State's health improvement plan for 2013 through 2018, developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of the Department of Health, in partnership with organizations across the state. This plan involves a mix of organizations including local health departments, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities and address health disparities. This collaboration informs a five-year plan designed to demonstrate how communities across the state can work together to improve the health and quality of life for all New Yorkers.

The Prevention Agenda features five priority areas:

- Prevent chronic diseases
- Promote healthy and safe environments
- Promote healthy women, infants and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated Infections

The Prevention Agenda has five overarching goals:

- Improve health status in five priority areas and reduce racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities.
- Advance a 'Health in all Policies' approach to address broad social determinants of health.
- Create and strengthen public -private and multi-stakeholder partnerships to achieve public health improvement at state and local levels.
- Increase investment in prevention and public health to improve health, control health care costs and increase economic productivity.
- Strengthen governmental and nongovernmental public health agencies and resources at state and local levels.

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities.

In addition, the Prevention Agenda serves as a guide to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act and to local health departments as they work with their community to develop mandated Community Health Assessments. Community Service Plans (CSPs) are a New York State requirement for improving the health and well-being of our communities through a collaborative approach led by hospitals and healthcare systems. Healthcare organizations are required to create and implement CSPs to address identified health priorities in the communities they serve and map out strategies to achieve goals. Healthcare organizations must identify two Prevention Agenda priorities and a health disparity that will be addressed with community partners based on assessment and engagement process.

Hospitals share their CSPs with the public and update the Department of Health on their progress.

Mission

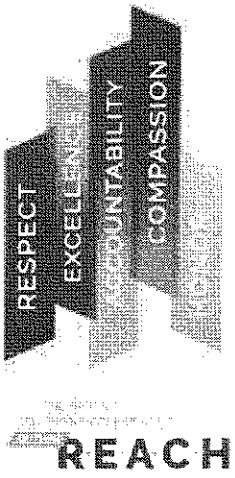
Our Mission is to deliver exceptional healthcare to the communities we serve by pursuing the highest standards of quality, safety, service and compassion.

Vision

Our Vision is to be the region's leading healthcare organization, recognized nationally for its quality, safety, service and compassion. Our dedication and investment in people, technology and facilities, distinguishes us as the provider of choice for patients, families and employees.

Values

Our Mission and Vision will only be attained through the commitment and motivation of our leaders, our employees, our physicians, and our volunteers. Our Values spell **REACH**. Together, demonstrating these **REACH** values is how we put patients and families first:



Respect – We treat everyone with dignity.

Excellence – We strive to achieve increasingly higher standards in quality, safety, service and compassion.

Accountability – We recognize that each employee plays a significant role in meeting the needs of our patients, and take ownership for our actions and our commitments.

Compassion – We believe that the nature of our roles requires us to extend empathy to our patients, their families, and each other.

Honor – We support each other and work as a team. We celebrate and acknowledge individual and collective success, and demonstrate integrity in everything we do.

Health Quest has deep roots in the Hudson Valley

Health Quest is a local family of 501c(3) hospitals and healthcare providers in the Hudson Valley. Our three award-winning hospitals — Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brothers Medical Center — have deep roots in their respective communities and work together to provide quality care for our patients.

Whether you visit a Health Quest facility for emergency or urgent care or for specialty services in which Health Quest ranks nationally, you can trust you will receive compassionate care from trained, dedicated physicians, nurses and support staff.

In the ever-changing healthcare landscape, Health Quest continues to promote health and wellness while serving the medical needs of individuals and families in the region.

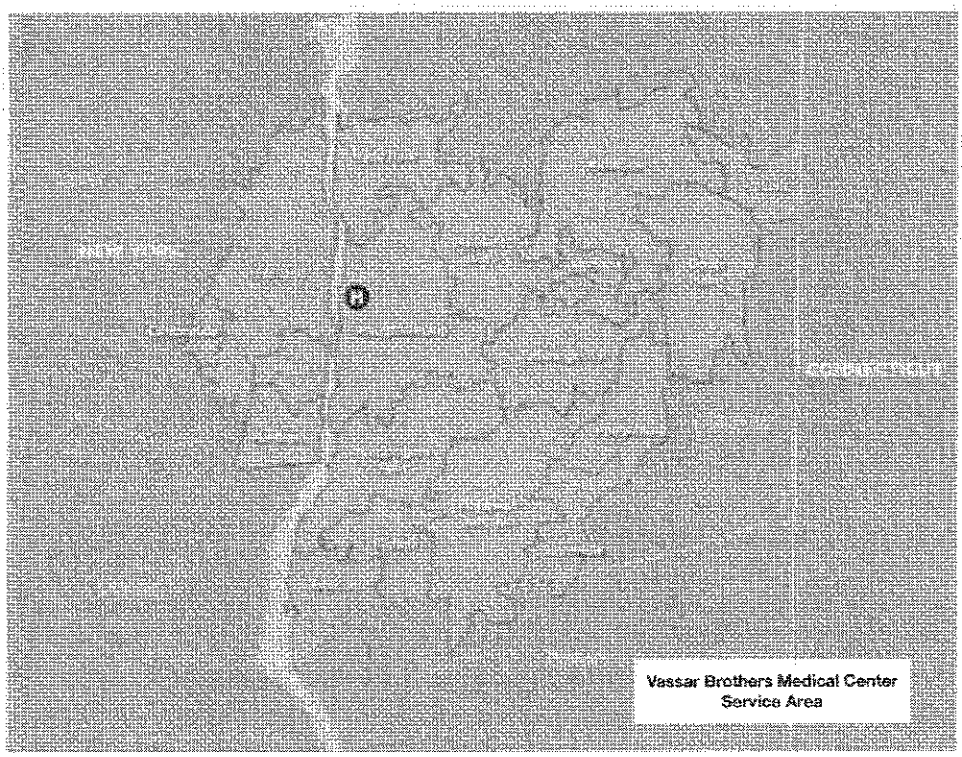
Health Quest was formed through an affiliation of three local hospitals: Northern Dutchess Hospital (Rhinebeck, NY), Putnam Hospital Center (Carmel, NY) and Vassar Brothers Medical Center (Poughkeepsie, NY). Health Quest also includes affiliated healthcare providers Health Quest Medical Practice and The Heart Center. Together, these hospitals and healthcare providers have devoted themselves to the development of clinical specialties and medical programs and services.

We also count among our partners long-term care facilities, a free-standing radiation oncology center, urgent care centers, a multi-specialty medical practice and a home care service.

Health Quest provides a continuum of care — care that is accessible, care that allows people in our community to stay close to home for all the healthcare services they need. It's about fostering a continuity of care that inspires confidence. This is reinforced by the unilateral commitment Health Quest has from our Board of Directors, healthcare providers, employees, volunteers and community members all working together to meet to the expectations and trust our communities place in us.

Community Served

Vassar Brothers Medical Center



Vassar Brothers Medical Center (VBMC) is a 365-bed facility that has served New York's Mid-Hudson Valley since 1887. Located in Poughkeepsie, VBMC has established centers of excellence in cardiac services, cancer care and women and children's health services. As a regional medical center, Vassar houses the area's first and only cardiothoracic surgery program between Westchester and Albany and the only Level III Neonatal Intensive Care Unit (NICU) in the region for premature, underweight and critically ill infants. Innovative procedures and services have been brought to the VBMC campus, including robotic orthopedic surgery, liver surgery, interventional neuroradiology, thoracic surgical oncology and transcatheter aortic valve replacement (TAVR), negating the need to travel for this care.

VBMC is building a 696,000-square-foot, seven-level patient pavilion with 264 private medical/surgical patient rooms and 30 critical care rooms that will solidify its place as the destination of choice for patients in the region. The first patient is expected to be cared for in the building in mid-2019.

VBMC recently became a Level II Trauma Center (provisional status), further advancing the vision to provide the community with local access to state-of-the-art medical care.

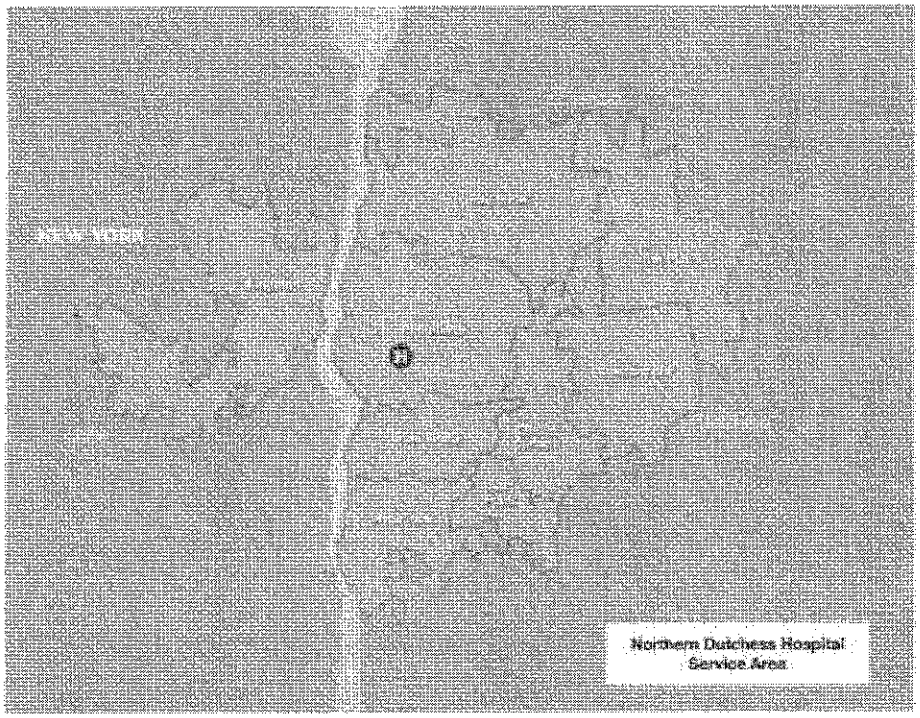
The Dyson Center for Cancer Care, located on the Vassar campus, is designed to accommodate patients and their families while providing radiation therapy, stereotactic radiosurgery and a wide variety of support groups.

VBMC						
	Total Population			*% Change Total*		
Age Cohort	**2016**	***2021***	***2026***	**'16-'21**	***'21-'26***	***'16-'26***
0-14	43,921	41,144	38,543	-6.3%	-6.3%	-12.2%
15-44	105,900	105,177	104,459	-0.7%	-0.7%	-1.4%
45-64	80,806	78,599	76,452	-2.7%	-2.7%	-5.4%
65-84	36,916	43,277	50,734	17.2%	17.2%	37.4%
85+	5,689	5,854	6,024	2.9%	2.9%	5.9%
Total	**273,232**	**274,051**	**276,212**	**0.3%**	**0.8%**	**1.1%**
F 15-44	51,619	51,060	50,507	-1.08%	-1.08%	-2.15%

Source: The Nielsen Company

VBMC's primary service area includes the southernmost half of Dutchess County, up to and including the Town of Hyde Park, as well as the easternmost parts of Orange and Ulster counties. Like many communities in New York State, the VBMC service area is experiencing minimal population growth with gradual declines in the numbers of young families and children. The largest demographic is 15-44 (39% of the total service area population), however the most significant growth is expected in the number of residents aged 65 and older. From 2016 to 2026, the percent change in the 65 plus age range is projected to be 43%. The average household income in the VBMC service area is $92,716. A high school diploma or GED is the highest level of education completed by 27% of the service area age 25 and older. (Source: The Neilsen Company).

Northern Dutchess Hospital



Northern Dutchess Hospital (NDH) is a 68-bed acute care, community hospital located in Rhinebeck, NY. NDH provides a comprehensive range of emergency, medical and surgical services offered through various specialty departments, including the Bone and Joint Center, Neugarten Family Birth Center, Emergency Department, Women's View, Dyson Center for Women's Imaging, Center for Healthy Aging, Wound Care and Hyperbaric Therapy Center, Cardio-Diagnostic Center, Outpatient Nutrition Department, Sleep Disorders Center, Paul Rosenthal Rehabilitation Center, outpatient rehabilitation service and our medically based Wellness Center.

The new Northern Dutchess Hospital Martin and Toni Sosnoff patient pavilion, which opened in February 2016, has turned a 111-year old hospital into a modern medical facility. The 87,000 square foot pavilion advances the clinical care available to local residents. From the spacious, private rooms to the state-of-the-art surgical suites equipped with minimally invasive technology, patients and their families no longer need to travel outside of the area for advanced medical care. With the new patient pavilion, Northern Dutchess Hospital has created a healing environment where modern medicine meets compassionate care.

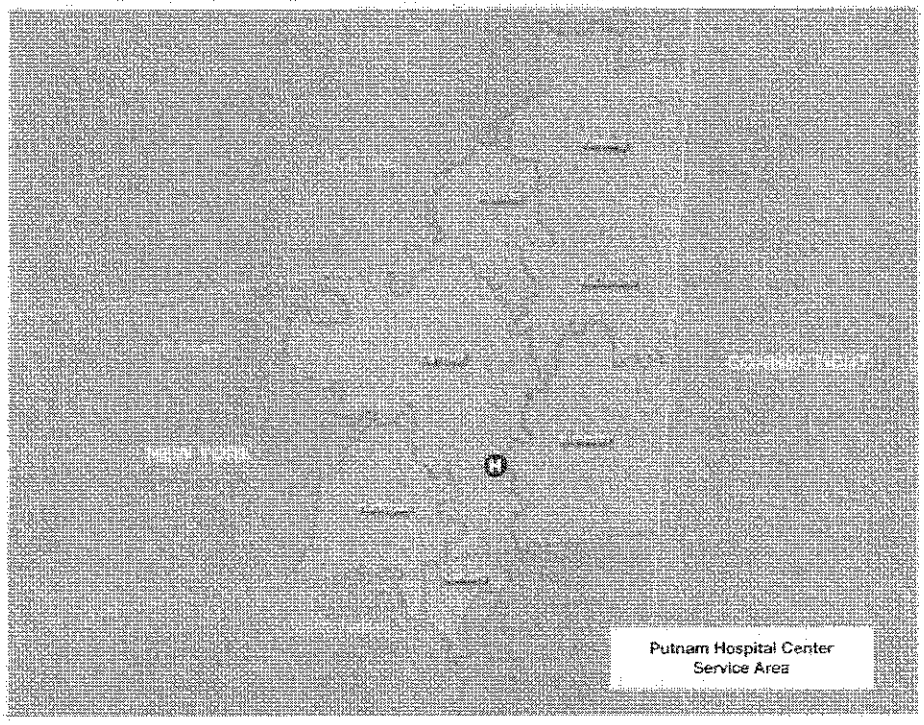
NDH						
	Total Population			% Change Total		
Age Cohort	2016	2021	2026	'16-'21	'21-'26	'16-'26
0-14	13,174	12,402	11,675	-5.9%	-5.9%	-11.4%
15-44	31,335	31,200	31,066	-0.4%	-0.4%	-0.9%
45-64	27,067	25,233	23,523	-6.8%	-6.8%	-13.1%
65-84	14,970	17,101	19,535	14.2%	14.2%	30.5%
85+	2,672	2,797	2,928	4.7%	4.7%	9.6%
Total	**89,218**	**88,733**	**88,727**	**-0.5%**	**0.0%**	**-0.6%**
F 15-44	15,649	15,553	15,458	-0.61%	-0.61%	-1.22%

Source: The Nielsen Company

As its name suggests, NDH's service area includes Dutchess County from Hyde Park north. It also includes several adjacent zip codes in Ulster County and some of the southernmost towns in Columbia County. Like the neighboring VBMC service area, population growth is projected to be limited to people aged 65 and older.

The highest populated age group is 15-44 (35% of the total service area population), however the most significant growth is expected in the number of residents aged 65 and older. From 2016 to 2026, the percent change in the 65 plus age range is projected to be 40%. The average household income in the NDH service area is $81,237. A high school diploma or GED is the highest level of education completed by 28% of the service area age 25 and older. (Source: The Neilsen Company).

Putnam Hospital Center



Putnam Hospital Center (PHC) is a 164-bed, acute care hospital offering medical, surgical, psychiatric and 24-hour emergency services. As the only hospital in Putnam County, Putnam Hospital Center has been serving the needs of Putnam, northern Westchester and southern Dutchess counties since 1964.

PHC provides a comprehensive range of inpatient and outpatient services offered through various specialty departments that include advanced orthopedic, robotic and bariatric surgeries; neurosciences including minimally-invasive spinal surgeries, stroke care and a sleep disorders lab; a blood management program; psychiatric care including a partial-hospitalization program; a comprehensive cancer program; maternity; 24/7 emergency care; the Center for Wound Healing, PHC Sleep Disorders Center and four Outpatient Physical Rehabilitation satellite facilities.

PHC						
	Total Population			% Change Total		
Age Cohort	2016	2021	2026	'16-'21	'21-'26	'16-'26
0-14	15,535	14,062	12,729	-9.5%	-9.5%	-18.1%
15-44	34,165	34,428	34,693	0.8%	0.8%	1.5%
45-64	31,587	30,614	29,671	-3.1%	-3.1%	-6.1%
65-84	15,348	18,286	21,786	19.1%	19.1%	41.9%
85+	2,305	2,486	2,681	7.9%	7.8%	16.3%
Total	**98,940**	**99,876**	**101,560**	**0.9%**	**1.7%**	**2.6%**
F 15-44	16,343	16,318	16,293	-0.15%	-0.15%	-0.31%

Source: The Nielsen Company

Eighty percent of PHC's patient population comes from the eastern half of Putnam, with the service area extending north to the southeast corner of Dutchess County and south to select bordering zip codes in northern Westchester County.

The overall population in the PHC service area is projected to grow slightly, but a decline is projected among children and women of childbearing age. The highest populated age range is 15-44 (35% of the total service area population), however from 2016 to 2026, the percent change in the 65 plus age range is projected to be 58.3%. The average household income in the Putnam Hospital service area is $119,818. A high school diploma or GED is the highest level of education completed by 27% of the service area age 25 and older. (Source: The Neilsen Company).

The Community Health Needs Assessment Process

The Health Quest hospitals participated in community needs assessment updates and community health improvement plan development with both Dutchess and Putnam Counties. Although our service areas differ, hindering our ability to submit a combined Community Health Assessment and Improvement Plan, we worked closely with both counties to form our individual plans.

Because our hospitals recently completed a community health needs assessment as part of the DSRIP process and the NYS Department of Health is not asking for a new comprehensive health assessment for the 2016-2018 cycle, we followed these state guidelines in our planning:

- collaborate with community partners to review community health data from recently completed health assessments, including updated data on the priority health issues;

- identify two Prevention Agenda priorities and one health disparity in the community based on the data;
- develop and submit an implementation plan that describes the evidence based interventions being implemented and the process measures being used to track progress toward these priorities; and
- demonstrate evidence of collaboration among LHDs, hospitals and community organizations in selecting new or confirming existing priorities and addressing them.

In addition to a thorough review of data and health priorities, the priorities selected by the committees represent priorities that are attainable at this time and that are aligned with each hospital's mission and service area demographics.

Because the communities and processes involved varied between the counties, this document will discuss each county separately. The Dutchess County Department of Behavioral and Community Health opted to complete a health assessment update based on the above requirements; the Putnam County Department of Health completed a comprehensive assessment.

Dutchess County

Vassar Brothers Medical Center and Northern Dutchess Hospital

Dutchess County embraces an inclusive and collaborative process for community planning. The Dutchess County Department of Behavioral & Community Health partnered with the local hospital systems, Health Quest and MidHudson Regional Hospital, to conduct a community health improvement stakeholder forum on October 18, 2016. Nearly one hundred representatives from healthcare agencies, behavioral health services, county agencies, and community organizations took part in the event to discuss community health priorities and review CHIP strategies. Agency and organizational partners also participate in ongoing dialogue through the Dutchess County Chronic Disease Coalition (which Health Quest is a member of) and the Dutchess County Substance Abuse Workgroup.

Community Health Indicator Review Process

The Department of Behavioral & Community Health routinely monitors numerous sources of data on health and wellbeing in Dutchess County, using tools including the NYS Prevention Agenda Dashboard, the Hudson Valley Community Dashboard, NYS Department of Health Community Health Indicator Reports, Sub-County Indicator Reports, NYS Cancer Registry Statistics, NYS Open Data (including the Expanded Behavioral Risk Factor Surveillance System), County Health Rankings and Roadmaps, the Kids Wellbeing Indicators Clearinghouse (KWIC), the MidHudson Valley Community Profiles, and the U.S. Census Bureau's American FactFinder.

The Department also conducts surveillance from original data including communicable disease reports, vital statistics (births and deaths), emergency department visits and hospital admissions from the Statewide Planning and Research Cooperative System (SPARCS), treatment service reports from the Office of Alcoholism and Substance Abuse Services (OASAS), and local surveys.

The annual Dutchess County Community Health Status Report, published in May 2016, summarizes these many data sources, examining disparities and providing comparisons to upstate New York and Healthy People 2020 goals, where available. The Community Health Status Report served as a guide to both VBMC and NDH as we prepared our Community Service Plan for 2016-2018.

Additionally, the County provided a Community Health Assessment Data Review that was used in conjunction with Health Status Report and the Prevention Agenda Dashboard to inform the selection of Health Quest's two priority areas. The Community Health Assessment Data Review looked at improving/worsening health status (5-10 years) and compared us to NYS, excluding NYC, where data are available.

In the fall of 2016, the Dutchess County Department of Behavioral and Community Health conducted a survey to assess the top priorities of the community. The survey period culminated with the half-day, county-wide Community Health Improvement Plan Stakeholder Forum. The purpose of the forum was to review the results of the recent survey and develop a locally relevant, comprehensive action plan to improve the health and lives of the residents of Dutchess County. The stakeholder sample included representatives from hospitals and healthcare, behavioral health services, county government, education and community-based organizations.

Through data review and stakeholder engagement, Dutchess County has confirmed the following Prevention Agenda priorities and disparity focus areas for the 2016-2018 period. The three overarching areas remain unchanged from the original 2013-2016 plan, with the new addition of tobacco use prevention and cessation as core components of the chronic disease focus area.

- Prevent Chronic Disease:
    - Reduce obesity
    - Reduce illness and death related to tobacco use

    - Increase access to high quality chronic disease preventive care and management
- Promote Mental Health & Prevent Substance Abuse:
    - Prevent substance abuse; in particular, prevent overdose due to opioids
- Promote a Safe & Healthy Environment:
    - Reduce the burden of tick-borne disease (Dutchess County specific priority area)

While insect-related disease does not fit into any NYS Prevention Agenda categories, it was a health concern for Dutchess County residents in the 2013-2016 assessment, as well as again in the current community survey.

In addition to the County forum, the Vassar Brothers Medical Center and Northern Dutchess Hospital Community Health Needs Committees held workgroups with hospital staff, physicians, Dutchess County Department of Behavioral and Community Health staff and community members to review the recently completed DSRIP Needs Assessment, the Community Health Assessment Data Review, the 2015 Dutchess County Health Status Report, internal discharge data, SPARCS data, the New York State Prevention Agenda Dashboard and the County Health Rankings Roadmap.

Vassar Brothers Medical Center and Northern Dutchess Hospital Community Health Committees identified the following two priorities:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment (Reduce Fall Risks Among Vulnerable Populations)

In choosing Promotion of a Healthy and Safe Environment, VBMC and NDH deviated from the Dutchess County Department of Behavioral and Community Health's selected priorities. In New York State, fall-related injuries are the leading cause of injury hospitalizations among children ages 0-14 and adults 25 years and older. Falls are the leading cause of unintentional injury deaths for those 45 years and older. Falls can result in serious injuries, such as traumatic brain injuries or fractures. There is also a heavy financial burden to fall-related injuries. Falls Account for $1.7 billion in annual hospitalization charges and $145.3 million in annual outpatient emergency department changes (NYS DOH). In our combined service areas, almost 50% of the population is over 45 (46%). Aging related health issues was the fourth most important issue identified in the stakeholder survey following mental health, substance abuse and chronic disease. With our service area projected to age significantly in the next ten years and falls and

fracture from falls making up 10% of the Emergency Department visits at VBMC and 11% at NDH in 2015, we felt the need to address this priority.

County Priorities Not Formally Addressed by Health Quest

1. **Reduce Tick and Insect-related Diseases** – While we did not select this as a priority this year, it was a priority for both VBMC and NDH in our prior Community Service Plan (2013-2016). We will continue to support this initiative through our on-going partnership with the Dutchess County Department of Behavioral and Community Health. Health Quest representatives will sit on the newly-formed tick-borne disease prevention workgroup and we will continue with community education around tick and insect-related diseases.

2. **Prevent Substance Abuse** – While this issue was undoubtedly of great importance to our committees, VBMC and NDH elected not to address this with a formal initiative at this time because we do not have licensed substance abuse beds. MidHudson Region Hospital of Westchester has licensed behavioral and substance abuse beds and provides services to Dutchess County residents. We will look for ways to support the County in this initiative – ie. space for training, physician speakers, medication take-back days.

Community Health Improvement Plan/Implementation Strategy

Vassar Brothers Medical Center and Northern Dutchess Hospital

Priority Area #1: Prevent Chronic Diseases– *Reduce chronic disease and obesity in children and adults*

Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems (Source: CDC).

Health risk behaviors are unhealthy behaviors that you can change. Among these health risk behaviors—lack of exercise or physical activity and poor nutrition—cause much of the illness, suffering, and early death related to chronic diseases and conditions. According to the CDC, in 2011, more than half (52%) of adults aged 18 years or older did not meet recommendations for aerobic exercise or physical activity. In addition, 76% did not meet recommendations for muscle-strengthening physical activity.

Physical activity is one of the highlights of Health Quest's implementation strategy for the next several years. Regular physical activity is important for good health, and it's especially

important in losing weight or maintaining a healthy weight. Physical activity also helps to reduce high blood pressure; reduce risk for type 2 diabetes, heart attack, stroke, and several forms of cancer; reduce arthritis pain and associated disability; reduce risk for osteoporosis and falls and reduce symptoms of depression and anxiety.

The committees also felt nutrition, healthy lifestyle choices and diabetes support complement the need for physical activity. Both NDH and VBMC have added additional interventions and activities that focus on these topics. Health Quest Medical Practice is currently developing a formal Diabetes Center, which is expected to launch in 2017, and we expect to add additional evidence-based programming around diabetes in years two and three.

Health Quest is excited to participate in new, innovative programs like the Microgreens Project in the City of Poughkeepsie, where 6% of the population does not receive many of the vital nutrients needed for desirable health outcomes. The first project of its kind in the community will increase the awareness about the importance of eating proper nutrients to prevent certain diseases and other undesirable health outcomes. This project will provide nutrient-dense food, in the form of microgreens, to certain segments of the population at no cost. Microgreens will be used in two key demographic groups: young children (in the City of Poughkeepsie School District) and senior citizens (recipients of congregate meals at senior centers and home-delivered meals). The partners in the program, including registered dietitians from Health Quest, will monitor participants' intake of the nutrients, as well as the improved health outcomes.

Additionally, adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities (CDC). Nearly half of all adults with disabilities get no aerobic physical activity, an important health behavior to help avoid these chronic diseases (CDC). Health Quest will explore partnerships with community organizations that serve adults with disabilities to include them in the Get Fit Program.

Priority Area #2: Promote a Healthy and Safe Environment - *Reduce falls and associated hospital admissions among vulnerable populations*

Health Quest is dedicated to providing the community with knowledge to improve physical mobility, quality of life and maximize independence in older adults. With increased education and assessment efforts, the goal is to reduce falls and increase awareness of falls risks. There are several free programs and activities available in Dutchess County to help reduce fall risks and help individuals remain independent and safe in their homes.

In addition to our programs for adults and seniors, VBMC is committed to reducing falls among children 14 and under. The most common causes of fall-related hospitalizations for children include: slipping or tripping, falling from playground equipment, falling from bed, and falling on or from stairs or steps. Education and awareness can help reduce these types of falls. In Ulster County, where 18% of our patient populations reside, the rate of emergency department visits due to falls per 10,000, aged 1-4 years, has significantly worsened. (NYS Prevention Agenda Dashboard).

Health Quest has a unique opportunity to educate young community caregivers on fall prevention in our babysitting class that prepares adolescents to care for infants and young children. We will adjust this curriculum to include information the NYS Childhood Fall Prevention Toolkit.

Vassar Brothers Medical Center Implementation Plan

NYS Prevention Agenda Priority Area #1: Prevent Chronic Disease

Focus Area	Chronic Disease and Obesity in Children and Adults
Goal:	1. Create community environments that promote and support healthy food and beverage choices and physical activity. 2. Expand the role of healthcare and health service providers in obesity prevention.
Objective 1:	**Expand Opportunities for safe physical activity in the community** 1. Increase enrollment in the Get Fit Hudson Valley Fitness Challenge for next 3 years. 2. Host educational seminars each year in conjunction with Get Fit
Objective 2:	**Expand school, community and employee wellness programs** 1. Offer one Chronic Disease Self-Management and One Diabetes Self-Management session per year a. Increase attendance at sessions 2. Initiate worksite challenges to create walking groups and walking paths as part of Get Fit in order to provide employees with opportunities for physical activities. Develop programs with 3 worksites by 2018. (AHA) 3. Offer employee wellness programs to our own 6000+ employees 4. Pursue a partner to develop a Fun, Food, Fitness Program for kids age 8-13 in VBMC market
Objective 3:	**Increase Breastfeeding** • Pursue Baby-Friendly Designation by 2018
Objective 4:	**Create Community Environments that promote and support healthy food choices** 1. Sponsor the Poughkeepsie Plenty Mobile Farmers Market in 2017/2018 2. Provide registered dietitians and support at community events to

	discuss healthy options and cooking ideas
Objective 5:	**Prevent childhood obesity through early child-care and schools.** 1. Sponsor the Dutchess County/City of Poughkeepsie Microgreens Project 2. Partner with Microgreens project to evaluate results
Objective 6:	**Vassar will support the Dutchess County Department of Behavioral and Community Health to achieve the following:** 1. Yearly Obesity Conference 2. Host the Chronic Disease Networking Group 3. Hospital compliance to new NYSDOH Breastfeeding Regulations effective 2017.
Interventions/Activities:	1. Bi-annual Get-Fit Hudson Valley Challenge (Spring & Fall) a. Develop educational series to complement Get Fit Challenge 2. Pursue Baby-Friendly Designation. Evaluate criteria to certification. 3. Provide new moms with information and support on breastfeeding and healthy diets for their babies 4. Poughkeepsie Plenty Mobile Market 5. Microgreens Project 6. Self-management programming – Chronic Disease and Diabetes 7. Create, distribute and provide educational services to the community and providers a. Author 12 Healthy Nutrition/Healthy Habits columns in community papers and online per year b. Build targeted topics into educational lecture series with Poughkeepsie Senior Centers, Marist Center for Lifetime Studies c. Host one "Dinner with the Doc" on Chronic Disease/Nutrition per year – one focus should be on children and nutrition/diabetes
Partners:	Dutchess County Department of Behavioral and Community Health, City of Poughkeepsie, Dutchess County, DC Office of the Aging, Health Quest Medical Practice, Get Fit Partners, Poughkeepsie Plenty, American Heart Association, Northern Dutchess Hospital, Putnam Hospital Center
Outcome Measures:	**Short-term measures** 1. Increase number of people enrolled in Get Fit 10% per challenge 2. Maintain the average entry per participant between 8-10 year one; Increase average entry per participant by 20% a year thereafter 3. Grow Get Fit community by 5% over 3 years - from 3,783 members to 3,975 4. Increase unique web users by 5% for Get Fit per year 5. Develop 3 worksite wellness sites for Get Fit in 3 years 6. Become a certified Baby Friendly Hospital by 2018 7. Attendance at DSM and CDSM programs 8. Number of Healthy Columns authored in one year - 12 per year 9. Review results of Microgreens project to evaluate success and determine how to utilize results after 2-year pilot. 10. Have a plan for a Fun, Food, Fitness Program for kids age 8-13 in

	VBMC market 11. Number of attendees at lectures and events (utilize new CRM tool when implemented to track new patients in key areas). 12. Number of people who request more information from Health Quest **Long-Term Measures** Reduce the percentage of adults and children who are overweight or obese
Evidence Base:	https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/docs/breastfeeding_fact_sheet.pdf http://www.health.ny.gov/prevention/nutrition/wic/breastfeeding/ http://www.cdc.gov/healthyweight/physical_activity/index.html

NYS Prevention Agenda Priority Area #2: Promote a Healthy and Safe Environment

Focus Area	Promote a Healthy and Safe Environment
Goal:	1. Reduce falls and associated hospital admissions among vulnerable populations – children age 0-14 and adults 65+ 2. Increase education and awareness of resources available to the community
Objective 1:	**Promote community-based programs for fall prevention** 1. Sponsor and host the Matter of Balance Program 2. Host one session at a Health Quest hospital each year 3. Increase referrals from HQMP to Matter of Balance Programs 4. Train community workers in evidence-based intervention programs for older adults such as Tai Chi: Moving for Better Balance and A Matter of Balance.
Objective 2:	**Implement Falls Prevention Screening Program in Health Quest Medical Practice for patients**
Objective 3:	**Increase awareness among community and providers about the resources and programs available**
Objective 4:	**Expand Education** 1. Develop injury prevention outreach program with VBMC Trauma team 2. Increase education of inpatients on fall risks while hospitalized a. Use inpatient stays as an educational opportunity – develop Preventing Falls Brochure for VBMC 3. Develop Fall Curriculum for Babysitting Classes offered through Health Quest 4. Create Social Media educational/awareness campaign for falls prevention – youth and adult 5. Add Falls Prevention to pediatric discharge instructions 6. Create a pediatric-specific Falls Handout for patients in pediatric unit

Interventions/ Activities:	1. Sponsor and host the Matter of Balance Program in partnership with the DC Office of the Aging 2. Create an informational page/resources page Health Quest website 3. Create, distribute and provide educational services to the community and providers a. Author or pitch one Fall Prevention/Healthy Habits blog/columns in community papers and online b. Build targeted topics into educational lecture series with Poughkeepsie Senior Centers, Marist Center for Lifetime Studies. One session to include: yoga, arthritis, balance c. Create educational brochures to be used during hospitalization and to go home with patients 4. By Q1 2017, add NYS Childhood Fall Prevention Toolkit materials to Babysitting Class curriculum
Partners:	Dutchess County Department of Behavioral and Community Health, DC Office of the Aging, City of Poughkeepsie, Health Quest Medical Practice, Health Quest Community Education
Outcome Measures:	1. By Q1 2017 add NYS Childhood Fall Prevention Toolkit materials to Babysitting Class curriculum 2. Increase enrollment in Babysitting Class by 20% over 3 years 3. By Q4 2017, have Falls Prevention information implemented in the EMR to auto-generate for pediatric patients. 4. By end of Q2 2017, develop a Falls Prevention brochure specific to pediatric population 5. MOB Program Outcomes a. Attendance of participants b. First session and last session survey results c. 6-month survey 6. Number of attendees at lectures and events (utilize new CRM tool when implemented to track new patients in key areas). 7. Number of new contacts created or people who request Health Quest info 8. Dedicate one Social Media Post a month to injury and falls preventions
Evidence Base:	https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults/ http://www.cdc.gov/homeandrecreationalsafety/falls/compendium.html http://www.cdc.gov/arthritis/basics/physical-activity-overview.html https://www.health.ny.gov/prevention/injury_prevention/children/toolkits/childhood_fall/

Northern Dutchess Hospital Implementation Plan

NYS Prevention Agenda Priority Area #1: Prevent Chronic Disease

Focus Area	Chronic Disease and Obesity in Children and Adults
Goal:	1. Create community environments that promote and support healthy food and beverage choices and physical activity. 2. Expand the role of health care and health service providers in obesity prevention.
Objective 1:	**Expand Opportunities for safe physical activity in the community** 1. Increase enrollment in the Get Fit Hudson Valley Fitness Challenge for next 3 years. 2. Host educational/physical activity events in the community 3. Host one Fun, Food Fitness class for kids age 8-13 per year
Objective 2:	**Expand school, community and employee wellness programs** 1. Initiate worksite challenges to create walking groups and walking paths as part of Get Fit in order to provide employees with opportunities for physical activities. Partner with VBMC, PHC and AHA to develop programs with 3 worksites by 2018. 2. Offer employee wellness programs to our own 6000+ employees
Objective 3:	**Promote evidence-based care to manage chronic diseases.** 1. Offer at least one CDC National Diabetes Prevention Program (NDPP) to the community per year
Objective 4:	**NDH will support the Dutchess County Department of Behavioral and Community Health to achieve the following:** • Yearly Obesity Conference • Host the Chronic Disease Networking Group
Interventions/Activities:	1. Bi-annual Get-Fit Hudson Valley Challenge (Spring & Fall) a. Develop educational series to complement Get Fit Challenge 2. Fun, Food Fitness class for kids age 8-13 3. CDC National Diabetes Prevention Program 4. Implement employee wellness/fitness center incentives for Health Quest Employees 5. Create, distribute and provide educational services to the community and providers a. Author 12 Healthy Nutrition/Healthy Habits columns in community papers and online b. Build targeted topics into educational lecture series c. Host one "Dinner with the Doc" on Chronic Disease/Nutrition per year
Partners:	Dutchess County Department of Behavioral and Community Health, Health Quest Medical Practice, Get Fit Partners, American Heart Association, Putnam Hospital Center, Vassar Brothers Medical Center, QTAC NY
Outcome Measures:	**Short-Term Measures:** 1. Increase number of people enrolled in Get Fit 10% per challenge 2. Maintain the average entry per participant between 8-10 year one;

	Increase average entry per participant by 20% a year thereafter 3. Grow Get Fit community by 5% over 3 years - from 3,783 members to 3,975 4. Increase unique web users by 5% for Get Fit per year 5. Attendance in the NDPP Program 6. Average weight loss achieved at 12 months – minimum of 5% of starting body weight. 7. Participants in the NDPP will record physical activity minutes at 60% or more of all sessions attended. 8. Pre and post survey of Fun, Food, Fitness participants to track knowledge gained through the program. **Long-Term Measures** Reduce the percentage of adults who are overweight or obese Age-adjusted hospital discharge rate for diabetes per 10,000 population
Evidence Base:	https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/docs/ebi_fact_sheet.pdf http://www.cdc.gov/healthyweight/physical_activity/index.html http://www.qtacny.org/programs/national-diabetes-prevention-program/

NYS Prevention Agenda Priority Area #2: Promote a Healthy and Safe Environment

Focus Area	Promote a Healthy and Safe Environment
Goal:	Decrease falls among seniors, age 65 and older and associated hospital admissions
Objective 1:	**Promote community-based programs for fall prevention** 1. Sponsor and host the Matter of Balance Program 2. Host one session at a Health Quest hospital each year 3. Increase referrals from HQMP to Matter of Balance Programs 4. Train community workers in evidence-based intervention programs for older adults such as Tai Chi: Moving for Better Balance and A Matter of Balance.
Objective 2:	**Increase awareness among community and providers about the resources and programs available** 1. Partner with Rhinebeck Rotary to promote their Community Improvement program (small home repairs) to identify fall hazards and remediate in the community.
Objective 3:	**Implement a Driver Assessment Program to help identify deficiencies after falls that impact head/neck or back.**
Objective 4:	**Expand Body & Harmony Fall Prevention Clinic (PT and Pharmaceutical assessment for falls)**
Objective 5:	**Increase education of inpatients on fall risks while hospitalized**

Interventions/Activities:	1. Sponsor and host the Matter of Balance Program in partnership with the DC Office of the Aging 2. Create an informational page/resources page Health Quest website 3. Create, distribute and provide educational services to the community and providers a. Author Fall Prevention/blog columns in community papers and online b. Build targeted topics into educational lecture series with Center for Healthy Aging and NDH. Topics to include: yoga, arthritis, balance. c. Create educational brochures to go home with patients d. Use inpatient stays as an educational opportunity – develop Preventing Falls Brochure e. Dedicate one Social Media Post a month to falls and falls preventions
Partners:	Dutchess County Department of Behavioral and Community Health, DC Office of the Aging, City of Poughkeepsie, Health Quest Medical Practice, Rhinebeck Rotary
Outcome Measures:	1. Number of referrals to Driver Assessment Program 2. MOB Program Outcomes a. Attendance of participants b. First session and last session survey results c. 6-month survey 3. Number of attendees at lectures and events (utilize new CRM tool when implemented to track new patients in key areas). 4. Increase frequency and attendees at Body & Harmony Fall Prevention Clinic 5. Dedicate one Social Media Post a month to falls and falls preventions
Evidence Base:	https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults/ http://www.cdc.gov/homeandrecreationalsafety/falls/compendium.html http://www.cdc.gov/arthritis/basics/physical-activity-overview.html

Putnam County

Putnam County Needs Assessment

Putnam Hospital Center

Putnam Hospital Center has a long-standing and well-established relationship with the Putnam County Department of Health (DOH). Health assessment activities, public health education campaigns, and emergency and response activities have been worked on jointly for more than a decade.

The Putnam County DOH initiated and continues to facilitate the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process with community partners in order to develop the Community Health Assessment (CHA). Established partnerships, including the Live Healthy Putnam Coalition, the Mental Health Provider Group, and Putnam Hospital Center's Community Health Needs Committee, have been joined by new alliances, the Suicide Prevention Task Force and the Communities That Care (CTC) Coalition, providing guidance and support in the areas of mental health and substance abuse. Each group brings a particular agenda and strength to the collective; all work in concert with the ultimate goal to improve the health of the community.

The MAPP process uses four unique assessments to determine community priorities: Community Health Status, Local Public Health System, Community Themes and Strengths, and Forces of Change. These assessments inform the development of the Community Health Improvement Plan (CHIP). More than 85 organizations participated in these assessments and greater than 600 Putnam County residents responded to the community survey. Through the MAPP process two overarching priorities were identified and served as a foundation for developing the Putnam County CHIP: Prevent Chronic Diseases and Promote Mental Health and Prevent Substance Abuse.

A third priority was recently added to the Putnam CHIP: Promote a Healthy and Safe Environment. This change came because Putnam Hospital Center and the county Office for Senior Resources will be implementing programs to prevent falls in the growing elderly population.

The Putnam Department of Health Annual Health Summit, which was held on June 7, 2016, provided an excellent platform to present and discuss data, review existing strategies and select priorities to concentrate on in the upcoming year.

Following the Summit, the Putnam Hospital Center Community Health Needs Committee held workgroup sessions with hospital staff, physicians, Putnam County Department of Health staff

and community members to review the recently completed DSRIP Needs Assessment, results of the Putnam County Community Asset Survey, internal discharge data, SPARCS data, the New York State Prevention Agenda Dashboard and the County Health Rankings Roadmap.

The Putnam Hospital Center Community Health Committee identified the following priorities:

1. Prevent Chronic Diseases
2. Promote Mental Health and Prevent Substance Abuse

Additionally, PHC decided to address a third priority:

3. Promote a Healthy and Safe Environment (Reduce Fall Risks Among Vulnerable Populations)

Community Health Improvement Plan/Implementation Strategy

Putnam Hospital Center

Priority Area #1: Prevent Chronic Diseases – *Reduce chronic disease and obesity in children and adults*

Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems (Source: CDC).

Health risk behaviors are unhealthy behaviors you can change. Among these health risk behaviors—lack of exercise or physical activity, poor nutrition—cause much of the illness, suffering, and early death related to chronic diseases and conditions. According to the CDC, in 2011, more than half (52%) of adults aged 18 years or older did not meet recommendations for aerobic exercise or physical activity. In addition, 76% did not meet recommendations for muscle-strengthening physical activity.

Physical activity is one of the highlights of Health Quest's implementation strategy for the coming years. Regular physical activity is important for good health, and it's especially important if you're trying to lose weight or to maintain a healthy weight. Physical activity also helps to maintain weight, reduce high blood pressure, reduce risk for type 2 diabetes, heart attack, stroke, and several forms of cancer, reduce arthritis pain and associated disability, reduce risk for osteoporosis and falls and reduce symptoms of depression and anxiety.

The committee also felt nutrition, healthy lifestyle choices and diabetes support complement the need for physical activity. PHC has added additional interventions and activities that focus on these topics.

Priority Area #2: Promote Mental Health and Prevent Substance Abuse - *Promote mental, emotional and behavioral (MEB) well-being in the community and Prevent Substance Abuse and other Mental Emotional Behavioral Disorders*

As the only hospital in the Health Quest system with a comprehensive behavioral health program, the PHC Community Health Needs Committee felt this should be a priority for them. Our Health Quest behavioral health team is made up of specially trained physicians, licensed social workers, crisis intervention specialists and mental health workers.

The PHC Committee overwhelmingly agreed with the Mental Health Priority identified through the MAPP process.

Priority Area #3: Promote a Healthy and Safe Environment - *Reduce falls and associated hospital admissions among senior age 65+*

Although they will not be formally reporting on this priority, it was important to the committee to select a third priority so they could partner with NDH and VBMC on fall prevention best practices.

Putnam Hospital Center Implementation Plan

NYS Prevention Agenda Priority Area #1: Prevent Chronic Diseases

Focus Area	Chronic Disease and Obesity in Children and Adults
Goal:	1. Create community environments that promote and support healthy food and beverage choices and physical activity. 2. Expand the role of health care and health service providers in obesity prevention.
Objective 1:	**Expand opportunities for safe physical activity in the community** 1. Increase enrollment in the Get Fit Hudson Valley Fitness Challenge for next 3 years. 2. Host educational/physical activity events in the community
Objective 2:	**Expand school, community and employee wellness programs** 1. Initiate worksite challenges to create walking groups and walking paths as part of Get Fit in order to provide employees with opportunities for physical activities. Partner with VBMC, NDH and Putnam DOH to develop programs with 3 worksites by 2018. a. Include PHC as a Getfit location 2. Offer employee wellness programs (gym reimbursement) to our own 6000+ employees
Objective 3:	**Promote evidence-based care to manage chronic diseases.** 1. Offer one Chronic Disease Self-Management Class per year (may transition to NDPP) 2. Implement the CDC National Diabetes Prevention Program (NDPP) at PHC

	a. Year 1: Identify staff to train, work with NDH for best practices to implement program at PHC, develop metrics b. Offer one DPP class in year 2 and 3 3. Work with Mental Health Association to offer these programs to their clients
Objective 4:	**Increase awareness among community and providers about the resources and programs available** 1. Highlight community programs that support initiative
Objective 5:	**PHC will support the Putnam County Health to achieve the following:** • Expand chronic disease self-management into the community • Explore a county-wide collaborative to offer the National Diabetes Prevention Program
Interventions/Activities:	1. Bi-annual Get-Fit Hudson Valley Challenge (Spring & Fall) 2. Host educational/physical activity events in the community 3. Offer Chronic Disease Self-Management Program (may transition entirely to NDPP due to lack of participation) 4. Implement National CDC Diabetes Prevention Program at PHC 5. Implement employee wellness/fitness center incentives for Health Quest Employees 6. Create, distribute and provide educational services to the community and providers a. Author 2-4 Healthy Nutrition/Healthy Habits columns in community papers and online b. Build targeted topics into educational lecture series c. Host one "Dinner with the Doc" on Chronic Disease/Nutrition per year 7. Highlight community programs that support initiative – like Communities that Care "Kooking with Kids" initiative
Partners:	Putnam County Department of Health, Health Quest Medical Practice, Get Fit Partners, Putnam Hospital Center, Vassar Brothers Medical Center, QTAC NY, VNA HV, Putnam County Mental Health Association
Outcome Measures:	**Short-Term Measures:** 1. Increase # of people enrolled in Get Fit 10% per challenge 2. Maintain the average entry per participant between 8-10 year one; Increase average entry per participant by 20% a year thereafter 3. Grow Get Fit community by 5% over 3 years - from 3,783 members to 3,975 4. Increase unique web users by 5% for Get Fit per year 5. Participation in the Chronic Self-Management Program/Review retention rates 6. Develop metrics in year one for NDPP program; implement in year two (will be similar to NDH metrics) 7. Number of attendees at lectures and events 8. Track number of email addresses obtained and people who request information. 9. Increase participation at PHC sponsored community events

	Long-Term Measures Reduce the percentage of adults who are overweight or obese Age-adjusted hospital discharge rate for diabetes per 10,000 population
Evidence Base:	https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/ebi/docs/ebi_fact_sheet.pdf http://www.cdc.gov/healthyweight/physical_activity/index.html http://www.gtacny.org/programs/national-diabetes-prevention-program/

NYS Prevention Agenda Priority Area #2: Promote Mental Health and Prevent Substance Abuse

Focus Area	Promote Mental Health And Prevent Substance Abuse
Goal:	1. Promote mental, emotional and behavioral (MEB) well-being in the community 2. Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
Objective 1:	**Increase community awareness of warning signs of suicide and available resources** 1. Host/sponsor One Safe Talk per year 2. Host/Sponsor One Asist Program a year 3. Host/Sponsor One Mental Health First Aid
Objective 2:	**Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults** 1. Host medication take-back event at PHC twice a year with Communities that Care, NCADD and Putnam Sheriff (Spring & Fall) 2. Host Opioid Substance Abuse Conference once a year with Communities that Care and NCADD
Objective 3:	**Increase awareness among community and providers about the resources and programs available** 1. Author blog/columns in community papers and online 2. Promote programs to HQMP offices 3. Develop Social Media Campaign
Objective 4:	**Continue to increase internal screening and communication to PHC patients that began in 2013-2016 Community Service Plan**
Interventions/Activities:	1. Offer one Safe Talk per year a. Utilize newly created survey results from Safe Talk participants to analyze program 2. Offer one Asist Program per year 3. Develop/Implement the Mental Health First Aid Program 4. Create, distribute and provide educational services to the community and providers a. Author blog/columns in community papers and online b. Promote programs to HQMP offices c. Develop Social Media Campaign
Partners:	Putnam County DOH, HQMP, Communities that Care, NCADD, Mental Health Association, Putnam County Sheriff

Outcome Measures:	1. Utilize newly created survey results from Safe Talk participants to analyze program 2. Develop metrics for Mental Health First Aid in year one 3. Number of Attendees at Mental Health First Aid; grow base by 10% in year 2 4. Evaluate Assist Program by creating a survey a. After class attendees will be able to: i. Identify people who have thoughts of suicide ii. Understand how your beliefs and attitudes can affect suicide interventions iii. Seek a shared understanding of the reasons for thoughts of suicide and the reasons for living 5. Expand reach of social media campaign; increase views and reach of posts
Evidence Base:	https://www.mentalhealthfirstaid.org/cs/ http://www.sprc.org/resources-programs/suicide-alertness-everyone-safetalk https://www.omh.ny.gov/omhweb/suicide_prevention/training/asist.html

NYS Prevention Agenda Priority Area #3: Promote a Healthy and Safe Environment

Focus Area	Promote a Healthy and Safe Environment
Goal:	Decrease falls among seniors, age 65 and older and associated hospital admissions
Objective 1:	**Promote and expand community-based programs for fall prevention** 1. Explore Tai Chi for Falls Prevention Program at PHC 2. Develop and host Yoga program for core strength and falls prevention 3. Develop fall prevention educational outreach at local senior housing communities and senior community centers a. Health Fairs will include falls and balance screening topics
Objective 3:	**Develop a Body & Harmony Fall Prevention/Gait Clinic (similar to NDH)** 1. PT and Pharmaceutical assessment for falls
Objective 4:	**Increase awareness among community and providers about the resources and programs available**
Objective 5:	**Increase education of inpatients on fall risks while hospitalized** 1. Use inpatient stays as an educational opportunity – develop Preventing Falls Brochure for PHC
Objective 6:	**Partner with Putnam County DOH to Explore the creation of a County-wide Falls Prevention Task Force**

Interventions/Activities:	1. Develop and implement a Body & Harmony Fall Prevention/Gait Clinic (use best practices from NDH) 2. Develop fall prevention educational outreach at local senior housing communities and senior community centers 3. Potential Tai Chi for Falls Prevention Program at PHC 4. Health Fairs will include falls and balance screening topics 5. Create, distribute and provide educational services to the community and providers 6. Author Fall Prevention/blog columns in community papers and online 7. Build targeted topics into PHC educational lecture series. Topics to include: yoga, arthritis, balance. 8. Dedicate one Social Media Post a month to falls and falls preventions 9. Implementation of Prevention of Falls Brochure to inpatient community a. Create educational brochures to go home with patients 10. Creation of Task force by end of year one
Partners:	Vassar Brothers Medical Center, Northern Dutchess Hospital, Putnam County Department of Health, Putnam County Office of Senior Resources, Health Quest Medical Practice
Outcome Measures:	1. Attendance at Fall Prevention/Gait Clinics 2. Number of attendees at lectures and events (utilize new CRM tool when implemented to track new patients in key areas). 3. Implementation of Prevention of Falls Brochure to IP community 4. Number of attendees at Health Fairs 5. Increase the number of outreach events to senior housing and senior centers 6. Task force development by end of year one
Evidence Base:	https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-programs-for-older-adults/ http://www.cdc.gov/homeandrecreationalsafety/falls/compendium.html http://www.cdc.gov/arthritis/basics/physical-activity-overview.html

Dissemination to the Public

Health Quest will make the Community Health Needs Assessment and three-year Community Service Plan available in PDF format in the About Us section of www.healthquest.org. A public awareness campaign will be rolled out in the first half of 2017 to drive the community to the website. These efforts may include a press release, posts on social media and internal communications to staff and leadership. In addition, printed copies of these documents will be made available to the public (free of charge) in the administrative offices at Health Quest Corporate offices, Northern Dutchess Hospital, Putnam Hospital Center and Vassar Brother Medical Center. Printed copies will be sent to all Health Quest and individual hospital Board Members and members of the Community Health Needs Committees for further dissemination to the community.

Our partner agency, the Putnam County Department of Health also makes the Health Quest Community Health Needs Assessment and three-year Community Service Plan available on their website (http://www.putnamcountyny.com/health/data/).

Maintaining Engagement and Tracking Progress

Each Health Quest hospital has a Community Health Needs Committee (CHNC) with representation from board members, the executive team, hospital staff, community members and representatives from the local health departments. By charter, the CHNCs are tasked with overseeing the development and updating of community health needs assessments, monitoring the hospitals' responses to the assessment to ensure that the identified healthcare needs are being met and reporting back to the hospital and Health Quest boards. Additionally, representatives from all hospitals participate in community boards and task forces that keep them in regular touch with community partners. The CHNCs meet quarterly to review progress toward the goals stated in this document and determine if any changes to objectives are required. Project-specific workgroups at each hospital also meet regularly to implement the tactics outlined in this document.

Health Quest would like to extend its sincerest thanks to the Putnam County Department of Health and Dutchess County Department of Behavioral and Community Health for their contributions and assistance creating this report.

Appendix/Links

Dutchess County Community Health Status Report

Dutchess County Needs Assessment and Community Health Improvement Plan

Putnam Needs Assessment and Community Health Improvement Plan

One Region, One CNA DSRIP Needs Assessment

NYS Prevention Agenda

User, OHCA

From: victorger@pipeline.com
Sent: Wednesday, March 29, 2017 5:29 PM
To: User, OHCA
Cc: Jennifer Groves Fusco; Hawes, Gary W.; Charlene LaVoie; Lazarus, Steven
Subject: Re: Testimony Resubmitted By CASSH for April 5, 2017 Public Hearing
Attachments: 3-29-17 Testimony Submitted From CASSH.docx

To: Ms.Yvonne T. Addo, Deputy Commissioner, Office of Health Care Access
and Mr. Kevin T. Hansted, Hearing Officer

Testimony Resubmitted by The Community Association to Save Sharon Hospital
for the April 5, 2017 Public Hearing

There is one word change on Page 1 of our Testimony
Please note the one word typo correction on page 1 -
the word **Association** to replace Foundation-

It Should Now Read:

Testimony Submitted by The Community Association to Save Sharon Hospital

Please replace the first page. Thank you.

Victor Germack
Vice President
The Community Association to Save Sharon Hospital

The Community Association to Save Sharon Hospital

P.O. Box 612
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victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

March 29, 2017

Ms. Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capital Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Certificate of Need: Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Testimony Submitted by The Community Association to Save Sharon Hospital

For the Public Hearing to be held by the Department of Public Health Office of Health Care Access on April 5, 2017 at Sharon Town Hall, Sharon, CT.

Some sixteen years ago, I testified as the Vice President of The Association to Save Sharon Hospital (CASSH) at the original CON public hearing in Sharon, CT. before Attorney General Blumenthal and the Office of Health Care Access concerning the sale of Sharon Hospital to Essent Healthcare. Since then, Sharon Hospital has had three corporate owners, its services have deteriorated, patient volume has declined, and it is unprofitable. My testimony today seems even more important than it was sixteen years ago as Sharon Hospital today only has one more chance for it to become a viable entity.

In general, we support non-profit hospitals as a better alternative than the for-profit model. On a preliminary basis, subject to our reservations, we support the planned sale of Sharon Hospital to Health Quest provided certain additional information, not provided in the CON, is furnished, and certain written assurances are obtained from Health Quest about the extent and amount of their financial commitment to Sharon Hospital.

In addition, we seek certain specific changes to the existing Foundation's Grant Agreement, dated September 13, 2016, between the Foundation, Health Quest, and Berkshire Taconic Community Foundation, Inc. (The "Agreement") which will remedy certain shortcomings in the Agreement. We have outlined specific recommendations below that we hope the Office of Healthcare Access will adopt. We have also written to the Attorney General asking him to represent the public interest which is embodied in The Foundation for Community Health since they are providing the majority of the financing for this purchase; and not to do so would be an abrogation of the Attorney General's constitutional duties

We have asked the Attorney General to review and then mandate, in the public interest, certain specific changes in the existing Foundation's Grant Agreement, which will remedy certain shortcomings in the Agreement. We have outlined below specific recommendations for changes which we hope that the Office of Health Care Access and the Attorney General will adopt.

We feel that the Agreement, as it is currently written, is not a 'good deal' for the community, is 'one-sided', and is not fair for those who have contributed to the Foundation. It is unfair and prejudicial to the public interest, to the interests of the Foundation contributors and to those individuals in the Community who initially contributed to Sharon Hospital, prior to its initial conversion in 2002 and subsequently from 2002 to the present. Those who contributed to the Foundation between 2002 and the present were contributing in the expectation and knowledge that their contributions would be going to the stated purpose of helping fund worthwhile health care projects in our Community, not that their funds would be committed to buy Sharon Hospital.

1. **There Is No Binding Commitment by Health Quest to Continue to Financially Support Sharon Hospital for a Specified Period of Time and, or For a Specific Amount:**
   As the financial and operating numbers in the CON show, Sharon Hospital has been in decline for a long period of time – over the past several years, the Hospital has been cutting staff and services, losing quality doctors by attrition and poor management by three corporate owners, leading to a decline in the number of both in-and outpatients. This has caused many former patients and potential patients to seek health care elsewhere. We met with Sharon Hospital's management on March 6, 2017 to get additional insight into their operation. They said that they only had 6 inpatients that week in the Hospital, and in the prior week, they had only admitted one new inpatient. They said that the emergency room is the main driver of inpatients and that a real cultural change is necessary for the EMS groups that bring patients to the Hospital and transfer them out. They feel that they lose some 500 patients annually who get transferred-out because Sharon Hospital lacks the specialists and the services. They also mentioned the negative impact of the Connecticut 6% hospital provider tax which cost them some $3.1 million last year. This wasn't a surprise to us, as all you have to do is read the local newspapers, speak to the doctors, and speak to the former

patients who have given up on Sharon Hospital. In a small, local Community, such as ours, news travels mainly by word of mouth and referrals.
Since it took such a long time for Sharon Hospital to decline, it will also take a long period of time, for the word to travel that Sharon Hospital is a quality health resource once again for former patients to return and new ones to approach the Hospital. This takes time, staying power and money

The business plan and financial projections as set forth in the CON by Health Quest for Sharon Hospital are too aggressive and are just not believable. We took the financial worksheets that were submitted in the CON for Sharon Hospital and Regional Healthcare Associates and consolidated them into a separate worksheet, Exhibit 1 which is attached. The reason for the consolidation is that for financial reporting purposes, both entities are combined. Exhibit 1 shows Sharon Hospital returning to profitability in two short years – earning $5.2 million – by 2018. In the CON, in a response to a question by OHCA, Sharon Hospital showed in its Incremental Growth Projections, discharges increasing by 53% between 2016 actual and 2018. Exhibit 1 projects adding incremental operating revenue of $17.5 million in the first two years (2017 and 2018) with an associated operating profit margin of 45.1% on this incremental revenue base. This is a very high unjustified margin. The CON financial projections show an operating profit margin for Sharon Hospital in 2018 of 6.9% on its projected total revenue of $74.9 million. The projected operating profit margin is higher that any hospital has ever achieved in Connecticut in recent years. Using OHCA's 2015 financial results for Connecticut listed on their website (FY 2015 Hospital Health System – Statement of Operations Data - the latest year that OHCA has made this information publicly available), the hospital with the best operating profit margin in Connecticut is Yale-New Haven which reached 4.5% for 2015. In fact, of the 17 hospital systems listed and reported in the OHCA data, just 10 systems showed profitable profit margins, and most did not exceed a 1% operating profit margin. There is no reason to believe that in just two short years Sharon Hospital can turn around and outperform every other hospital in Connecticut. The Sharon Hospital CON projections are just not believable and these projections cast serious doubt on the soundness of Health Quest's overall business plan for the New Sharon Hospital. <u>We would like to see realistic business and operating projections</u>.

What is missing in the CON is a lack of the detailed explanations and the level of support on how Health Quest will implement the Sharon Hospital turnaround and make their projected results happen. It will take years for Sharon Hospital to reach a significant level of profitability and then only, with solid management, leadership and underlying financial support from Health Quest.

There are no contractual minimum levels of financial support that are set forth by Health Quest in the Agreement, or in the CON. Nor is Health Quest bound to support Sharon Hospital for any minimum period of time. The Foundation is committing $9 million to Sharon Hospital which may never be recovered, if the Hospital fails under Health Quest ownership. What this means, in the meantime, is that the Foundation will have $9 million less to spend on worthy health-related

Community projects throughout our area. Additionally, there is no contractual guarantee contained in the Agreement, that Health Quest won't come back to the Foundation and ask for more financial support.

We would therefore ask that Health Quest commit to financially and operationally supporting Sharon Hospital for a minimum period of 10 years, and commit that they will not ask the Foundation for any additional financial support

2. **Detailed CON Review and Requests for Information and Clarification**
We have noted in our review of the CON, a number of inadequate or incomplete responses to the questions raised by the OHCA staff. Some of these are:

   A. In its CON, Health Quest states that, "Vassar Connecticut expects to maintain current services for a period of three years, subject to patient demand and the availability of physicians and other clinical providers and staff" – what exactly does this guarantee to our Community? Health Quest should make a long-term commitment to provide essential medical at New Sharon Hospital for a minimum period of 10 years. This should be a minimum requirement.
   B. How much working capital is needed to finance the operation of Sharon hospital until 'real' profitability is achieved. We don't know now as we have a business plan/financial projection that is not believable, and no cash flow projection has been submitted. Please furnish the working capital requirements over time.
   C. In a response to a question asked by OHCA, to "explain the 143% increase in inpatient discharges or outpatient visits to cover financial incremental expenses between FY 2018 and FY 2019 as stated on page 44 of the application. How did the Applicants arrive at this increase in incremental inpatient and outpatient utilization?" The answer does not appear to be responsive, and is somewhat confusing. It doesn't explain the increase in utilization and, furthermore, using the specific discharge rate of $10,000 per discharge, and $300 for each outpatient visit, generates revenue of $4,254,90 in 2019 – way in excess of the total estimated incremental costs of $2,125,000. Would Health Quest please explain this?
   D. How does Health Quest's charity or indigent care policy differ from that provided by Sharon Hospital – and on a going forward basis, and using Health Quest's charity care policy at New Sharon Hospital, how many patients will be covered and to what degree, compared to Sharon Hospital's existing policy? Will Sharon Hospital's charity care patients be better off or worse off under Health Quest's charity care program, and by how much?
   E. The CON states that capital improvements will cost, at least $11.5 million. We believe that this may be materially understated. At the March 16, 2017 Public Forum, Mr. Friedberg, President of Health Quest, said that they will put capital into retrofit some areas but physical plant is not likely to need expansion. Upon information and belief, we understand that Sharon Hospital paid for an energy efficiency and savings program/energy audit that Trane conducted, approximately two years ago. It showed that Sharon Hospital is still burning grade 6 fuel oil (which is not permitted in New York – and is terribly dirty

stuff) – and they must convert the system and make a fuel change over to burning cleaner fuel which is absolutely essential. We read in the Con, that the Hospital is planning to spend some $1.5 million and take an old oil tank out of the ground and make a partial change in their energy generation system. The main boilers will still be over 50 years old. We understand that the energy study showed that a complete change and energy upgrade would cost approximately $5 million, but would generate savings of approximately $400,000 plus in annual utility savings. Sharon Hospital's private equity owner did not want to spend for this program or incur additional debt. Does Health Quest intend to invest to upgrade the energy generation and improve the Hospital's energy efficiency?

F. Health Quest says that "Sharon Hospital is projecting to add a total of eighteen (18) full time positions through FY 2020, all of which are non-physician positions". It also says it will add "48 additional full time employees through FY 2020". How many full time physicians will be added to Sharon Hospital and when? Will they be primary care or what will be their specialty – can this be broken out? Will these physicians be working solely at Sharon Hospital, or will they be dividing their time at other Health Quest hospitals? Will Health Quest provide a staffing spreadsheet by timing, specialty and location - spelling out the above information?

G. In Sch. 4.16 Tax Returns, it says that Regional Healthcare Associates LLC has not filed its federal or state income tax returns or paid any corresponding income taxes for the last 2 fiscal years ending 9/30/14 and 9/30/15. We were told at our March 6 meeting with Sharon Hospital management that this was a clerical issue., and that they are treated as a partnership for Federal and State income tax. As full disclosure, we still would like to see the returns and understand why they weren't timely filed. When will these returns be filed?

3. **The Foundation for Community Health Involvement in the Purchase of Sharon Hospital and Suggested Changes in the Structure, Governance and Oversight**

The Foundation has currently $25 million in assets which includes the Essent Healthcare purchase price, existing endowment funds at the time of sale in 2002, and funds raised and interest earned since then. The Grant Agreement requires that the Foundation restrict $9 million of its funds, or 36%, of its total funds. This will dramatically negatively impact the Foundation's future annual grant making ability to the Community which it has successfully implemented over the past 15 years. The $9 million also represents over 56% of the $16 sale amount that the Foundation received from the sale of Sharon Hospital to Essent Healthcare in 2002. In fairness to the many contributors to Sharon Hospital, pre 2002, and to the Foundation, post 2002, we urge the Attorney General and the Office of Healthcare Access to mandate the changes that we have recommended below, and to make this a fairer and more equitable structure and agreement and protect the public interest.

A. Coverage by the Attorney General:
Since the Foundation is a public charity within the meaning of Code 501(c) (3), it comes under the jurisdiction and review of the Attorney General of Connecticut.

B. Purchase Price:
Under the Grant Agreement, the Foundation is committing $9 million (which become restricted funds) in grants to Health Quest. 60% of the Sharon Hospital acquisition purchase price - $3 million out of the $5 million total purchase price will be committed by the Foundation and another $6 million in Investment up to 4 years is being committed to Health Quest.

Since the Foundation is not the buyer of Sharon Hospital and is only helping Health Quest finance the acquisition, why then does it have to put in 60% of the purchase price? By any manner of comparison, Health Quest, as the owner of Sharon Hospital, does not have enough financial stake and financial commitment in this planned purchase. Additionally since the Foundation does not get a carried ownership interest, or have a real governance role at Sharon Hospital or gets its investment back if the Hospital is sold to a third party after the first five years of ownership, then the Foundation's agreement to fund the $3 million is not prudent or fair.

We suggest that a purchase investment of only $1 or 2 million by the Foundation would be appropriate – given the limited stated representation that the Foundation will have on the Sharon Hospital Board of Trustees (just an advisory board), the Health Quest Board of Trustees (just one seat) and its lack of an ownership, carried interest or no governance role as it is currently stated in the Agreement. These issues are spelled out in greater detail below.

C. Working Capital Grant:
These grants totaling $6 million "…are dedicated for actual direct cost outlays associated with Health Quest's strategic investments at New Sharon Hospital including, without limitation, investments in direct physician and provider costs, investments in strategic equipment, facility upgrades, investments in ambulatory networks, investments in information technology infrastructure, and other strategic programmatic investments (collectively, "Investments")". We don't believe that paying for direct physician and provider costs are strategic investments – what they are is normal operating costs. Health Quest should be providing enough working capital to support Sharon Hospital's ongoing operations, including physician costs.

We would suggest that the Grant Agreement language pertaining to the Working Capital Grant should be changed to remove any references to investments in, or paying for direct physician and provider costs.

D. Return of Grant Amount:
If Sharon Hospital is sold to a third party after the first five years of ownership by Health Quest, then the Foundation does not get its asset purchase grant and, or its capital grant returned.
This is unfair to the public interest and to the Foundation. We would suggest that it should be changed so that if Sharon Hospital is sold to a third party during the first 15 years of ownership by Health Quest, then the Foundation should get its asset purchase grant, and working capital grant, less all Capital Campaign Funds raised to date by the Foundation, returned to it.

E. Governance – Sharon Board of Trustees:
The Grant Agreement provides that the Foundation can have up to 12 representatives (80% of the total) serve on the Sharon Board of Trustees (which is basically a local advisory group) which will be composed of 15 members. There are three groups of Trustees with different terms, but in no event is there a contractual right for the Foundation to have its representatives serve as trustees after the sixth year.
This is unfair and we would suggest that it should be changed so that after the sixth year, there will continue to be a majority of the trustees who will be selected by the Foundation and who will serve on the Sharon Hospital Board of Trustees as long as Sharon Hospital is owned by Health Quest, and part of its system.

F. Governance – Health Quest Board of Trustees:
The Grant Agreement states that, "The Chair of the Board of Trustees of New Sharon Hospital shall serve ex-officio on the Health Quest Board of Trustees." There is not enough board representation by the Foundation on the Health Quest Board of Trustees given the Agreement's current requirement that the Foundation invest $9 million into New Sharon Hospital.

We would suggest that at least three members of the New Sharon Hospital Board of Trustees be named to the current 18 members Health Quest Board of Trustees, and that they be full voting members as long as Sharon Hospital is owned by Health Quest.

G. Annual Information Reporting to the Community to be Required:
To serve and inform the Community on its progress in improving Sharon Hospital, the Grant Agreement should be modified to require that the Sharon Hospital Board of Trustees will issue a written annual report to the Community, no later than March 1 of the following year, on the state of Sharon Hospital as it pertains to the services offered, the quality of health, physician recruitment, hospital services added, patients serviced and discharged – inpatients and outpatients, the financial results, and whatever other critical information the Sharon Hospital Board feels it needs to present to the Community.

H. A Monitor Should Be Added:
We would suggest that a monitor be appointed by either the Attorney General or OHCA for the first five years, following the purchase of Sharon Hospital by Health

Quest, to insure that the terms of the Agreement are followed and there is an equitable accounting of the funds given by the Foundation to Health Quest under the terms of the Agreement, and that the medical services that were committed to by Health Quest in the CON are supplied to New Sharon Hospital.

By way of background, I am the President of RateFinancials Inc. which was started in 2002. Our company rates the financial reporting, accounting and governance practices of corporations, including health care companies and hospitals – and as such, we are considered financial experts. I am the President of Heritage Capital Corp. – a middle market investment banking company which was started in 1977. I am also the Treasurer and on the Board of The Osborne Association – a non-profit social services agency which works in over 20 prisons in New York State, providing a full range of services including behavioral, court advocacy, job placement, addiction treatment, etc.

The members of The Community Association to Save Sharon Hospital all live in the area served by Sharon Hospital and have organizational standing as we are all impacted and affected by the medical services offered by Sharon Hospital. If Sharon Hospital ceases to exist, we would all be directly adversely affected so therefore we have a meaningful stake in the outcome of the public hearings and what is decided.

We would also ask that the Attorney General also act in these proceedings, since the interests of the public are involved due to the involvement of the Foundation for Community Health and adopt our suggestions for the various changes we have requested.

Thank you for your consideration.

Sincerely,

Victor Germack
Vice President

cc: The Honorable Attorney General George Jepsen
The Honorable Senator Richard Blumenthal
The Honorable Senator Chris Murphy
Deputy Commissioner Ms. Yvonne T. Addo
Assistant Attorney General Gary W. Hawes
Representative Brian Ohler
Charlene LaVoie, Esq.
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FAX SHEET

March 31, 2017

To: Ms. Yvonne T. Addo, MBA
Deputy Commissioner
Office of Health Care Access

Mr. Kevin T. Hansted, Hearing Officer
Mr. Steven Lazarus

Fax Number: 860- 418-7053

From: The Community Association to Save Sharon Hospital

Subject: Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
Certificate of Need: Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON & DOCKET NO. 16-32133-CON

Rebuttal Testimony Submitted by The Community Foundation to Save Sharon Hospital In Response to Prefiled Testimony of Mr. Robert Friedberg
For the Public Hearing to be held by the Department of Public Health Office of Health Care Access on April 5, 2017 at Sharon Town Hall, Sharon, CT.

Copy by email to:
Mr. Gary W. Hawes, Assistant Attorney General
Jennifer Groves Fusco, Esq.
Updike, Kelly & Spellacy

Please Note: For speed of communications, could you please direct all contacts to the email address, fax or phone above. Thank you.

The Community Association to Save Sharon Hospital

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March 31, 2017

Ms. Yvonne T. Addo, MBA
Deputy Commissioner
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capital Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Mr. Kevin T. Hansted, Hearing Officer
Mr. Steven Lazarus

Copy by email to:
Mr. Gary W. Hawes, Assistant Attorney General
Jennifer Groves Fusco, Esq.

Re: Certificate of Need: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut
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DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Rebuttal Testimony Submitted by The Community Association to Save Sharon Hospital In Response to Prefiled Testimony of Mr. Robert Friedberg

For the Public Hearing to be held by the Department of Public Health Office of Health Care Access on April 5, 2017 at Sharon Town Hall, Sharon, CT.

A. Prefiled Testimony of Mr. Friedberg
Mr. Friedberg says that, 1. "We understand that our volume and financial projections show significant growth in Sharon Hospital during Health Quest's first three years of operations. However we believe these projections are consistent with what has been achieved at Sharon Hospital historically and

attainable given Health Quest's resources..." 2. We are projecting a consolidated (Sharon Hospital/Regional Healthcare Associates) margin of 6% by FY 2020. This is consistent with, and in many instances less than, the operating margins achieved by other Connecticut hospitals in FY's 2015 and 2016. Attached, as Exhibit A is a comparison and summary of hospital operating margin data, compiled using audited financial statements and other information collected by OHCA. This data shows that each year there were seven (7) Connecticut hospital with operating margins in excess of 10%"

Our Response: Mr. Friedberg states that these financial and volume projections that Heath Quest makes are consistent with what has been achieved at Sharon Hospital historically. Considering the last several years, this is not correct.

We hope Mr. Friedberg's real skills lay in operating management and not in understanding financial accounting, or the interpretation of financial results. First, as our Exhibit 1 shows (previously submitted in our prior Testimony, and attached here as well), the bulk of the projected incremental revenue and increase in profits come by 2018 - within the first two years after purchase – in fact, 83% of the increase in incremental revenue from FY 2017 through FY 2020 occurs in just two years, by 2018, not by 2020. By 2018, Health Quest is projecting achieving a 6.9% operating profit margin for Sharon Hospital.

Now, Mr. Friedberg is using the OHCA supplied data in his Exhibit A but he's using the wrong information from OHCA. The information contained in his Exhibit A is only the operating results of hospitals. To get the true and correct financial picture for each hospital; you must consolidate that information with physician and group practices/affiliates' financial results that are associated with each operating hospital. These results are shown by OHCA in its FY 2016 Hospital Health System – Statement of Operations Data – which we will call Exhibit 2. OHCA's FY 2015 results are shown as Exhibit 3. Exhibit 2 - the 2016 OHCA results, after the consolidation of the hospitals and their associated physician practices, show much lower financial results than is shown by Mr. Friedberg's testimony. In fact, contrary to Mr. Friedberg's assertion, using Exhibit 2, no hospital achieves a 6% operating margin in Connecticut! Griffin Health Services showed a 5.24% operating profit margin – this was the highest operating profit margin in Connecticut in 2016. 16 hospitals are reported and only 8 hospitals report positive operating profit margins. As we have said in our Testimony, the Health Quest revenue and profit projections and their business plan for Sharon Hospital are just not believable and will not be attained within the projected time period. We would ask that OHCA require Health Quest to furnish a revised realistic business plan and projections so we can see the correct working capital and investment needs to turn Sharon Hospital around. Further, OHCA should require a written commitment from Health Quest regarding the required level of investment and a time commitment to restore our Hospital to health.

B. Prefiled Testimony of Mr. Robert Friedberg

1."Lastly, I will touch on our new partnership with the Foundation for Community Health ("FCH") and why we believe their continue funding and involvement with Sharon Hospital governance going forward will be of great benefit to the Sharon Community"

And

2. "Once the terms of these FCH-nominated Board members expire new members will be nominated by the Sharon Hospital Board in the normal course and approved by Health Quest"

Our Response: We object to these statements because, as we have previously stated in our Testimony, the New Sharon Hospital Board is first, just an advisory board with no fiduciary or governance role; The Foundation for Community Health ('the Foundation") will not have a governance role at Sharon Hospital, secondly, contractually, the Board members' terms don't extend beyond the first six years, third, new members of the Board are to be nominated by the Sharon Hospital Board and not by the Foundation, fourth, the Foundation is not a partner as partners share equitably, and lastly, according to the Grant Agreement, Health Quest retains the right to eliminate all of the advisory boards at their hospitals if they alone decide it is in their interests – see Grant Agreement – 2.7.4 – "For example, if one Other Hospital board would be dissolved, then all of the Other Hospital boards should be dissolved"

C. We still don't understand why Health Quest needs the Foundation's $9 million to purchase and fund Sharon Hospital. Health Quest is a major hospital with sufficient resources to fund this purchase and make the necessary investments. By his own admission, Mr. Friedberg says, "In the last three years alone, Health Quest has committed more than $750 million to improve VBMC, NDH, PHC, and HQMO."

Our Response: The Foundation has only $25 million in assets committed to helping the Community with various worthwhile grants – if they weren't required to fund this purchase and provide working capital, then they would have $9 million more available to make grants, in addition to fund raising they could do on their own. If the Foundation were not required to fund the purchase price and make working capital grants, then I'm sure the Foundation would be happy to lend its counsel, help and advice to Health Quest and Sharon Hospital to make it succeed. The Foundation – could still be a "partner", and it would still work just as hard.

As it is, the Foundation is making a financial commitment, but contractually, not getting what it should.

D. Mr. Friedberg is still somewhat vague on the number of physicians and their specialties and where they will be based or what percentage of their time will be committed to Sharon Hospital.

Our Response: We would like to see the detail of his projected staffing and recruitment. He must have it since there is a business plan and projections provided with the CON.

E. Mr. Friedberg talks about a "conditional Asset Purchase Grant' and a "conditional Working Capital Grant"

Our Response: What does he mean by using the word, "conditional"? There is nothing conditional about this on the part of the Foundation.

F. Mr. Friedberg's statement that, "This will allow FCH to reinvest funds that were originally intended for Sharon Hospital but never achieved due to the Hospital's for-profit tax status. Now, as a tax-exempt organization, the funds can be directly provided in order to enhance the quality and accessibility of healthcare services for the community".

Our Response: His statement is absolutely incorrect. The Foundation had the right of first refusal to repurchase Sharon Hospital for a definite time period if Sharon Hospital were to be sold during that period. That right expired, and the Foundation was under no legal obligation to support the Hospital whether it is for-profit, or not-for-profit. In fact, on its own, the Foundation has been doing terrific work in support of local healthcare groups and needs.

EXHIBIT 1

Combined Sharon Hospital & Regional Healthcare Associates (In $ millions) *

Pro Forma Operating Results

	FY 2015 Act. Results	FY 2016 Act. Results Estimated	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON	FY 2020 Projected W/out CON	FY 2020 Projected Incremental	FY 2020 Projected With CON
Operating Revenue	$54.00	$50.10	$56.80	$5.20	$62.00	$57.30	$17.50	$74.90	$58.20	$20.00	$78.00	$59.00	$21.00	$80.00
Operating Expenses	54.8	55.7	59.2	2.4	61.6	60.1	9.6	69.7	61.2	11.40%	72.6	62.3	12.9	75.2
Operating Income	-0.8	-5.6	-2.4	2.8	0.4	-2.8	7.9	5.2	-3.0	8.6	5.4	-3.3	8.1	4.8
Net Income	-17.7	-5.6	-2.4	2.8	0.4	-2.8	7.9	5.2	-3.0	8.6	5.4	-3.3	8.1	4.8
Operating Margin - %	-1.48%	-11.17%	-4.22%	53.84%	0.65%	-4.88%	45.14%	6.94%	-5.15%	43.00%	6.92%	-5.59%	38.57%	6.00%
Total Margin - %	-32.77%	-11.17%	-4.22%	53.84%	0.65%	-4.88%	45.14%	6.94%	-5.15%	43.00%	6.92%	-5.59%	38.57%	6.00%

* All financial information is taken from the financial worksheets submitted as part of the CON by Sharon Hospital and Regional Healthcare Associates

Worksheet Prepared by Victor Germack - 3/11/17

EXHIBIT 2

FY 2016 HOSPITAL HEALTH SYSTEM - STATEMENT OF OPERATIONS DATA

	FY 2016 NET PATIENT REVENUE	FY 2016 OTHER OPERATING REVENUE	FY 2016 REVENUE FROM OPERATIONS	FY 2016 NET OPERATING EXPENSES	FY 2016 GAIN/(LOSS) FROM OPERATIONS	FY 2016 NON OPERATING REVENUE	FY 2016 REVENUE OVER/(UNDER) EXPENSES	FY 2016 OPERATING MARGIN	FY 2016 NON-OPERATING MARGIN	FY 2016 TOTAL MARGIN
								Gain/(Loss) from Oper / (Revenue from Operations+Non Operating Rev)	Non Oper Revenue / (Revenue from Operations+Non Operating Rev)	Revenue Over/Under Exp / (Revenue from Operations+Non Operating Rev)
PRIVATELY OPERATED										
BRISTOL HOSPITAL & HEALTHCARE GROUP	$169,423,693	$5,919,418	$175,343,111	$176,835,839	[illegible]	$1,304,934	[illegible]	[illegible]	0.74%	[illegible]
CCMC CORPORATION INC.	$358,221,226	$40,148,735	$398,369,961	$397,642,835	$727,126	$12,526,617	$13,253,743	0.18%	3.05%	3.23%
DAY KIMBALL HEALTHCARE INC.	$127,013,156	$7,117,868	$134,131,024	$133,792,367	$338,657	$641,978	$980,635	0.25%	0.48%	0.73%
EASTERN CT HEALTH NETWORK INC.[1]	$0	$0	$0	$0	$0	$0	$0	0.00%	0.00%	0.00%
GREATER WATERBURY HEALTH NETWORK, INC.[1]	$251,626,867	$11,814,048	$263,440,915	$297,005,778	[illegible]	$2,120,231	[illegible]	[illegible]	0.80%	[illegible]
GRIFFIN HEALTH SERVICES CORPORATION	$170,397,927	$18,509,383	$188,907,310	$178,946,749	$9,960,561	$1,309,748	$11,270,309	5.24%	0.69%	5.92%
HARTFORD HEALTHCARE CORPORATION	$2,350,802,000	$313,129,000	$2,663,931,000	$2,528,378,000	$135,553,000	$71,686,000	$207,239,000	4.96%	2.62%	7.56%
C. HUNGERFORD HOSPITAL	$110,242,061	$6,483,839	$116,725,900	$123,502,173	[illegible]	$1,961,328	[illegible]	[illegible]	1.65%	[illegible]
JOHNSON MEMORIAL MEDICAL CTR, INC.[2] (3 months)	$0	$0	$0	$0	$0	$0	$0	0.00%	0.00%	0.00%
LAWRENCE + MEMORIAL CORPORATION[3]	$418,160,496	$18,646,595	$436,807,091	$464,422,293	[illegible]	$2,560,142	[illegible]	[illegible]	0.58%	[illegible]
MIDDLESEX HEALTH SYSTEM, INC.	$403,365,000	$12,659,000	$416,024,000	$397,793,000	$18,231,000	$12,382,000	$30,613,000	4.26%	2.89%	7.15%
MILFORD HEALTH & MEDICAL, INC.	$67,105,682	$6,894,033	$73,999,715	$76,178,411	[illegible]	$1,130,276	[illegible]	[illegible]	1.50%	[illegible]
SAINT MARY'S HEALTH SYSTEM, INC.[4] (10 months)	$0	$0	$0	$0	$0	$0	$0	0.00%	0.00%	0.00%
SAINT VINCENT'S MEDICAL CENTER[5]	$457,103,000	$49,355,000	$506,458,000	$529,342,000	[illegible]	$6,940,000	[illegible]	[illegible]	1.35%	[illegible]
SHARON HOSPITAL HOLDING COMPANY, INC.	$55,199,240	$698,785	$55,898,025	$58,399,946	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
STAMFORD HEALTH INC.	$544,621,000	$18,923,000	$563,544,000	$558,412,000	$5,132,000	$5,470,000	$10,602,000	0.90%	0.96%	1.86%
TRINITY HEALTH - NEW ENGLAND[6]	$962,505,000	$56,981,000	$1,019,486,000	$1,022,859,000	[illegible]	$60,818,000	$57,445,000	[illegible]	5.63%	5.32%
WESTERN CT HEALTH NETWORK, INC.	$1,181,451,000	$38,511,000	$1,219,962,000	$1,211,319,000	$8,643,000	$52,466,000	$61,109,000	0.68%	4.12%	4.80%
YALE-NEW HAVEN HEALTH SERVICES CORP.[7]	$3,579,271,000	$207,633,000	$3,786,904,000	$3,647,566,000	$139,338,000	$320,570,000	$459,908,000	3.39%	7.80%	11.20%
STATE OPERATED										
UNIVERSITY OF CT HEALTH CENTER[8]	$532,676,000	$210,390,000	$743,266,000	$1,053,578,000	[illegible]	$460,111,000	$149,799,000	[illegible]	38.23%	12.45%

Source: FY 2016 Audited Financial Statements. (Some adjustments have been made by OHCA from the original AFS for Other Operating Revenue and Non Operating Revenue to conform to the above presentation for several health systems.)

Net Patient Revenue amount shown is the amount after the provision for bad debts as indicated in the hospital audited financial statements.
Other Operating Revenue includes AFS amounts for items such as Other Operating Revenue and Net Assets Released from Restrictions.
Non-Operating Revenue includes AFS amounts for items such as investment income & losses, changes in the value of investments, profits & losses from joint ventures and donations.

[1]Note #1 - Prospect Medical Holdings acquired Eastern CT Health Network (ECHN) and Greater Waterbury Health Network in October 2016. ECHN was given a time extension to file their audited financial statements.
[2]Note #2 - Johnson Memorial Medical Center (JMMC) will represent activity from October 1, 2015 to December 31, 2016 which was before it affiliated with Trinity Health New England. JMMC was given a time extension to file their audited financial statements
[3]Note #3 - Lawrence & Memorial Corporation represents a full year of activity October 1, 2015 to September 30, 2016. The health system affiliated with YNHHSC in September 2016. The totals include amounts for Westerly Hospital in Rhode Island.
[4]Note #4 - St. Mary's Health System (SMHS) will represent activity from October 1, 2015 to July 31, 2016 which was before it affiliated with Trinity Health New England. SMHS was given a time extension to file their audited financial statements.
[5]Note #5 - On January 1, 2016, Ascension Health became the sole member of St. Vincent's Medical Center (SVMC) and the entities of the former St. Vincent's Health Services Corporation became part of SVMC.
[6]Note #6 - Trinity Health New England acquired St. Francis Care, Inc. in October 2015 followed by Johnson Memorial Medical Center (January 2016) and St. Mary's Health System (August 2016).
[7]Note #7 - Yale-New Haven Health Service Corporation's (YNHHSC) Audited Financial Statements include a $241 million contribution to non-operating income related to the acquisition of L+M Corporation.
[8]Note #8 - UCONN is State operated and its non-operating revenue was primarily the result of State and Capital appropriations of over $464 million.

OHCA will release this document again at a later date after all hospitals have filed their FY 2016 Audited Financial Statements.

EXHIBIT 3

FY 2015 HOSPITAL HEALTH SYSTEM - STATEMENT OF OPERATIONS DATA*

	FY 2015 NET PATIENT REVENUE	FY 2015 OTHER OPERATING REVENUE	FY 2015 REVENUE FROM OPERATIONS	FY 2015 NET OPERATING EXPENSES	FY 2015 GAIN/(LOSS) FROM OPERATIONS	FY 2015 NON OPERATING REVENUE	FY 2015 REVENUE OVER/(UNDER) EXPENSES	FY 2015 OPERATING MARGIN	FY 2015 NON-OPERATING MARGIN	FY 2015 TOTAL MARGIN
								Gain/(Loss) from Oper / (Revenue from Operations+Non Operating Rev)	Non Oper Revenue / (Revenue from Operations+Non Operating Rev)	Revenue Over/Under Exp / (Revenue from Operations+Non Operating Rev)
BRISTOL HOSPITAL & HEALTHCARE GROUP	$168,109,451	$6,317,978	$172,427,428	$172,340,088	$87,341	$997,043	$1,084,384	0.05%	0.57%	0.63%
CCMC CORPORATION INC.	$341,250,390	$39,119,347	$380,369,737	$379,326,166	$1,043,571	$10,376,378	$11,419,949	0.27%	2.66%	2.92%
DAY KIMBALL HEALTHCARE INC.[1]			$0		$0		$0	0.00%	0.00%	0.00%
EASTERN CT HEALTH NETWORK INC.	$297,145,105	$18,422,521	$315,567,626	$315,848,076	($280,450)	($2,235,410)	($2,515,860)	-0.09%	-0.71%	-0.80%
GREATER WATERBURY HEALTH NETWORK, INC.	$233,666,461	$11,401,405	$245,067,866	$268,052,904	($22,985,038)	$597,134	($22,387,904)	-9.36%	0.24%	-9.11%
GRIFFIN HEALTH SERVICES CORPORATION	$151,665,668	$16,916,293	$168,581,961	$167,787,046	$794,915	($626,903)	$168,012	0.47%	-0.37%	0.10%
HARTFORD HEALTHCARE CORPORATION	$2,239,380,000	$207,215,000	$2,446,595,000	$2,416,588,000	$30,007,000	($13,368,000)	$16,639,000	1.23%	-0.55%	0.68%
C. HUNGERFORD HOSPITAL	$113,735,730	$6,810,204	$120,545,934	$121,979,246	($1,433,312)	$2,960,711	$1,527,399	-1.16%	2.40%	1.24%
JOHNSON MEMORIAL MEDICAL CENTER, INC.[2]			$0		$0		$0	0.00%	0.00%	0.00%
LAWRENCE + MEMORIAL CORPORATION[3]	$438,782,346	$21,207,462	$459,989,808	$470,286,412	($10,296,604)	$11,832,973	$1,536,369	-2.15%	2.51%	0.33%
MIDDLESEX HEALTH SYSTEM, INC.	$377,006,000	$14,648,000	$391,654,000	$390,600,000	$1,054,000	$7,195,000	$8,249,000	0.26%	1.80%	2.07%
MILFORD HEALTH & MEDICAL, INC.	$64,899,709	$4,647,727	$69,547,436	$77,415,816	($7,868,380)	$1,211,823	($6,656,557)	-11.12%	1.71%	-9.41%
SAINT FRANCIS CARE, INC.	$772,752,000	$49,214,000	$821,966,000	$818,524,000	$3,442,000	($17,533,000)	($14,091,000)	0.43%	-2.19%	-1.75%
SAINT MARY'S HEALTH SYSTEM, INC.	$285,389,000	$10,072,000	$295,461,000	$293,300,000	$2,161,000	$2,528,000	$4,689,000	0.73%	0.85%	1.57%
SAINT VINCENT'S HEALTH SERVICES CORP.	$442,387,000	$46,108,000	$488,495,000	$508,201,000	($19,706,000)	($13,177,000)	($32,883,000)	-4.15%	-2.77%	-6.92%
SHARON HOSPITAL HOLDING COMPANY, INC.[4]			$0		$0		$0	0.00%	0.00%	0.00%
STAMFORD HEALTH INC.	$521,111,000	$19,320,000	$540,431,000	$525,446,000	$14,985,000	($2,579,000)	$12,407,000	2.79%	-0.48%	2.31%
WESTERN CT HEALTH NETWORK, INC.	$1,123,622,000	$33,617,000	$1,157,439,000	$1,144,647,000	$12,792,000	$18,590,000	$31,382,000	1.09%	1.58%	2.67%
UNIVERSITY OF CT HEALTH CENTER	$512,950,000	$208,200,000	$721,168,000	$1,007,042,000	($285,874,000)	$440,084,000	$154,210,000	-24.62%	37.90%	13.28%
YALE-NEW HAVEN HEALTH SERVICES CORP.	$3,492,685,000	$109,595,000	$3,602,280,000	$3,442,624,000	$159,656,000	($15,565,000)	$144,091,000	4.45%	-0.43%	4.02%

Source: FY 2015 Audited Financial Statements. (Some adjustments have been made by OHCA from the original AFS for Other Operating Revenue and Non Operating Revenue to conform to the above presentation for several health systems.)
Notes: The Net Patient Revenue (NPR) amount shown is the amount after the provision for bad debts as indicated in the health systems' audited financial statements.
[1]Note - Day Kimball Healthcare was given a time extension until March 30, 2016 to file their audited financial statements.
[2]Note - Johnson Memorial Medical Center was given a time extension to file it's audited financial statements until March 31, 2016.
[3]Note - L+M Corporation includes amounts for Westerly Hospital in Rhode Island.
[4]Note - Sharon Hospital Holding Company was given a time extension to file it's audited financial statements until May 1, 2016.

*OHCA will release this document again at a later date after all hospitals have filed their FY 2015 Audited Financial Statements.

Roberta B. Willis
P.O. Box 1733
Lakeville, CT 06039
Roberta.willisct@gmail.com

April 6, 2017

Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc.

Docket No. 16-32132-CON

Testimony for Public Hearing

Good afternoon. Thank you for the opportunity to testify. For the record, I am Roberta Willis, the former State Representative representing nine towns in NW Connecticut. I also have served on the Advisory Board of Sharon Hospital since it was acquired by Essent Healthcare in 2002. The formation of the Advisory Board and my membership were a condition of the original decision by the Attorney General, Richard Blumenthal. As a public official, I have been involved with the hospital for sixteen years and worked with the Office of Health Care Access and the Attorney General Blumenthal on developing the conditions and obligations of Essent Health Care in the original sale of the hospital.

I am here to support Sharon Hospital's application for a Certificate of Need that is required for the hospital to once again become a community non-profit full service acute care health center.

Like many families in this area, Sharon Hospital has been providing health services for me and my family over many generations. My mother was born there. My children were born there. My grandchildren were born there. Our family continues to receive medical care including inpatient services there. Therefore, as consumers of the services they provide, we are pleased that we will continue to have access to the services we presently receive and welcome the prospect of having increased access to a greater network of professional providers. We look forward to the added opportunity for expanded services when Sharon joins Health Quest hospitals.

Since the acquisition of Sharon Hospital by Essent Healthcare, the healthcare landscape in Connecticut has be changed in several ways. Many of those changes have made it increasingly difficult for our hospitals, especially our small community hospitals to sustain themselves. Already, three-quarters of Connecticut's 28 general hospitals are either part of larger health systems that operate multiple hospitals, or are in talks to join one. With the proposal for our closest independent hospital, Charlotte Hungerford, and Hartford Hospital,

Sharon becomes one of the few hospitals in Connecticut that does not have an affiliation, which puts this small rural hospital at a tremendous disadvantage. As CT's sole for profit hospital, and a small rural community hospital, partnerships or affiliations with larger networks were really impossible. Health Quest is a natural fit for Sharon. It is the nearest tertiary care facility to Sharon. To survive in the present healthcare landscape, the state's small hospital requires a sustainable framework. This partnership will help position our hospital to remain a financially viable health care resource for our area.

The FCH was initially funded with the net proceeds of the sale of the hospital. As a condition required by the State, the FCH had the 'right of first refusal', if Essent decided to sell during the first five years. While that did not occur, it is worth remembering that provision as part of their original charge.

I would like to publicly express my thanks and gratitude to the board members of the Foundation for Community Health(FCH) and their executive director, Nancy Heaton for their service and dedication to this community over their many years of work as the stewards of this community's funds. They have been dedicated to determining our needs with the aim of promoting and insuring that there is access to quality healthcare. We are particularly fortunate to have them at this time. They are well respected and knowledgeable community members, who have taken their charge to the utmost degree. They come from varied backgrounds in healthcare and business, making them ably qualified to review this proposal. They have always represented the best interests of community. I would like to express my complete confidence in their due diligence during this process. This is a complex process. They insured that it was thorough, professional, fair and in the best interests of all of us.

The sale of the hospital in 2002 was a real leap of faith, and was viewed with much skepticism. Thankfully, Essent and Regional Partners kept the hospital doors opened and it continued to operate as an acute care health center. It would be safe to say, otherwise there may not have been a hospital today for Health Quest to acquire. I do not think anyone involved over 15 years ago, would have ever predicted that Sharon Hospital would return to its original non-profit status.

Thank you for considering the Certificate of Need application being submitted by Sharon Hospital. I think I can say with confidence, the community is hopeful that this application is approved as expeditiously as possible.

Thank you for your attention to this important matter for our communities. I would be pleased to answer questions you might have on this proposal.

Arthur Eugene Chin, MD
59 Old Asylum Road
Lakeville, CT 06039
H: 860-435-9939
C: 860-318-5238

April 4, 2017

Ms Yvonne T. Addo, MBA
Deputy Commissioner
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
MS # 13HCA
Hartford, CT 06134-0308

Dear Ms. Addo,

I am writing this letter in support of the sale of Sharon Hospital to Health Quest.

I live in Lakeville CT with my wife and 3 children and have an understanding of Sharon Hospital and the proposed sale of Sharon Hospital to Health Quest from several perspectives.

- I am an Emergency Physician in the Sharon Hospital Emergency Department (full-time 1999-2015, part-time 2015-present). During my career at Sharon Hospital, I have transferred many patients from the Emergency Department directly to Vasser Hospital for more advanced care than we could provide at Sharon. My professional interactions with the physicians at Vasser Hospital (most notably in the ED and cardiology) and with Health Quest community physicians have been excellent.

- I serve on the Board of The Foundation for Community Health (FCH). As such, I have a clear understanding of how this sale will affect FCH and our mission to improve the health of our community. Additionally, and as part of the due diligence regarding this transaction, I have met with physicians and Health Quest administrators, and have reviewed clinical quality data from the 3 Health Quest hospitals.

- My family and I have lived in Lakeville CT for 18 years. Our youngest child was born at Sharon Hospital and over the years we have used a spectrum of services at the hospital including the Emergency Department, Occupational Therapy, Inpatient Surgery, Radiology, and Laboratory Services, to name a few.

Sharon Hospital is a critical part of this community. The hospital provides crucial access to health care that would otherwise necessitate a 45 minute drive in any direction, including for Emergency Department services. As an Emergency Physician, I am well aware that any delay in emergency care of conditions such as stroke, heart attack, trauma, and sepsis could be devastating for a patient. The hospital also plays a key role in this community beyond direct clinical care. Sharon Hospital provides jobs and opportunities for

professional advancement, and is an important provider of outpatient community healthcare. For many people, the presence of a high quality community hospital like Sharon Hospital is an important part of the decision to live in the area.

I believe that Health Quest represents the best available solution for the current financial and clinical challenges facing Sharon Hospital today. Health Quest has demonstrated at their existing facilities that they will expand services, increase and streamline access to care in our community, and enhance the services at Sharon Hospital. Many patients in our community must now travel to other hospitals to receive care that Health Quest proposes to enhance locally (such as oncology and cardiology).

The proposed acquisition plan will also allow the Foundation of Community Health to continue our current program funding levels for at least the next decade. As an FCH board member, I look forward to a closer working relationship with Sharon Hospital so we can achieve a common goal of improving the overall health of our community.

For all these reasons, I urge you to approve the sale of Sharon Hospital to Health Quest.

Sincerely,

Arthur Eugene Chin, MD
Board Member
The Foundation for Community Health

Statement of Robert Kuhbach
In support of the
Transfer of Ownership of Sharon Hospital to Health Quest
Public Hearing
Sharon Town Hall
April 5, 2017

Good afternoon.
My name is Robert Kuhbach and I am a full time resident in the Town of North East, New York, living in the Coleman Station Historic District, just west of the Sharon Hospital. I have had a home in this area since 1981.
I am a director of the Foundation for Community Health, having joined the Board in the summer of 2015. I am currently Secretary, and a member of the Finance and Executive Committees. I also served as a member of the special Board Committee charged with the responsibility of evaluating and recommending to the full Board any arrangement involving use of Foundation resources to facilitate the transition of Sharon Hospital from "for profit" status to "not-for-profit" status.
Professionally, I retired from full-time employment in 2012 at age 65, having served as General Counsel and Chief Financial Officer at four public companies for nearly 30 years.

As a long time resident of the Millerton, New York area, I am familiar with the critical role which Sharon Hospital plays in providing quality, accessible health care to this area. At various times over the years, I have personally been treated at Sharon Hospital, as has my wife, and other family members. In all cases, the service was very professional, timely and effective.

I fully support this proposed transaction for two key reasons. First, Sharon Hospital supplies vital health care services in a rural area of northwest Connecticut and eastern Dutchess and Columbia Counties. If Sharon Hospital were to close, it would have a devastating impact on the lives of the residents of this area, who depend on the continued operation of this hospital. This is particularly important for those of us more senior in age, where chronic health issues and convenient access to high quality care is

more compelling. Health Quest's plans to increase services like oncology and cardiology is of particular interest to the aging population, which has been expanding in this area.

My second reason for supporting this transaction, and in particular, the Foundation's grant commitments, is based on a thorough assessment of the alternatives and the fact that the Foundation's support is fully consistent with its mission. The Foundation's special Board committee, consisting of experienced medical service providers and senior business executives spent over a year and a lot of time analyzing the situation, and potential solutions. Consistent with my business experience, we evaluated Health Quest's capabilities and track record, considered alternatives, assessed the risks and concluded that focusing on having a local, successful hospital operator become Sharon Hospital's new owner made the most sense. Having reached that tentative conclusion, our committee negotiated hard to get the best deal for the community, using the Foundation's resources. At the end of the day, I am fully satisfied that the transaction as currently structured, provides the community and the Foundation with the best opportunity to successfully stabilize and revitalize Sharon Hospital for the greater public good.

In conclusion, I would ask that the OHCA approve the sale of Sharon Hospital to Health Quest so as to ensure continued access to high quality hospital and physician services to the greater northwest Connecticut and eastern Dutchess County and Columbia County region.

Thank you for your time.

User, OHCA

From: Lazarus, Steven
Sent: Tuesday, April 04, 2017 1:53 PM
To: Jennifer Groves Fusco (jfusco@uks.com); victorger@pipeline.com
Cc: User, OHCA; Olejarz, Barbara; Martone, Kim; Hansted, Kevin; Riggott, Kaila; Foster, Tillman; Schaeffer-Helmecki, Jessica; Fernandes, David; Greer, Leslie
Subject: Tentative Agenda and Table of the Records for April 5th Hearing, DNs: 32132 & 32133
Attachments: 16-32132 16-32133 Combined Agenda.doc; 32132 table.doc; 32133 table.doc

Please see the attached Tentative Agenda and Table of the Records for tomorrow' s public hearing under DNs: 16-32132 &16-32133. If you have any questions regarding anything in the material, please do not hesitate to contact me.

Thank you,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

Docket Number: 16-32132-CON Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

And

Docket Number: 16-32133-CON Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

April 5, 2017 at 4:00 p.m.

I. Convening of the Public Hearing

II. Public Comment

III. Docket Number: 16-32132-CON

- **A. Applicants' Direct Testimony**
- **B. Intervenor's Direct Testimony**
- **C. Applicants' cross-examination of Intervenor**

IV. Docket Number: 16-32133-CON

- **A. Applicants' Direct Testimony**
- **B. Intervenor's Direct Testimony**
- **C. Applicants' cross-examination of Intervenor**

V. OHCA's Questions of both Applicants

VI. Public Comment

VII. Closing Remarks

VII. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc**

DOCKET NUMBER: **16-32132-CON**

PUBLIC HEARING: **April 5, 2017 at 4:00 pm**

PLACE: **Sharon Town Hall**
63 Main Street
Sharon, CT 06069

EXHIBIT	DESCRIPTION
A	Letter from Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc (Applicants) dated November 3, 2016 enclosing the Certificate of Need (CON) application for the Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc. under Docket Number 16-32132, received by OHCA on November 3, 2016. (639 Pages)
B	Letters from the public in the matter of the CON application filed under Docket Number 16-32132. (7 pages)
C	Letter to OHCA from Representative Roberta B. Willis dated November 7, 2016, received November 21, 2016 and OHCA's response dated December 2, 2016 in the matter of the CON application under Docket Number 16-32132. (2 pages)
D	OHCA's letter to the Applicants dated December 2, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32132.(8 Pages)
E	Applicants responses to OHCA's letter of December 2, 2016, dated January 17, 2017 in the matter of the CON application under Docket Number 16-32132, received by OHCA on January 17, 2017. (241 Pages)
F	OHCA's letter to the Applicants dated February 16, 2017 requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32132.(2 Pages)

G	Applicants responses to OHCA's letter of February 16, 2017, dated February 21, 2017 in the matter of the CON application under Docket Number 16-32132, received by OHCA on February 21, 2017. (13 Pages)
H	Designation of Hearing Officer in the in the matter of the CON application under Docket Number 16-32132, dated March 3, 2017. (1 page)
I	OHCA's letter to the Applicants dated March 3, 2017 enclosing order consolidating this hearing with Docket Number 16-32133 for hearing purposes in the matter of the CON application under Docket Number 16-32132 (1 page)
J	OHCA's letter to the Applicants dated March 3, 2017 deeming the application complete in the matter of the CON application filed under Docket Number 16-32132. (1 page)
K	OHCA's request for legal notification in *Republican American* and OHCA's Notice to the Applicants of the public hearing scheduled for April 5, 2017 and in the matter of the CON application under Docket Number 16-32132, dated March 7, 2017. (5 pages)
L	OHCA's letter to the Applicants dated March 17, 2017 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 16-32132. (3 pages)
M	Letter from the Community Association to Save Sharon Hospital ("Petitioner") to OHCA dated March 23, 2017 requesting intervenor status in the in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 23, 2017. (3 pages)
N	Letter from the Applicant to OHCA dated March 24, 2017 Objecting to the request for intervenor status in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 24, 2017.(5pages)
O	OHCA's Ruling on a Petition filed by Community Association to Save Sharon Hospital to be designated as an Intervenor with Limited Rights in the matter of the CON application under Docket Number 16-32132,dated March 24, 2017. (1page)
P	Letter of Support received from Senator Miner and Representative Ohler dated March 27, 2017 in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 27, 2017. (1page)
Q	Intervenors letter dated March 27, 2017 enclosing a copy of their letter to the Attorney General's Office date dMarch 27, 2017 in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 27, 2017 (7 pages)
R	Letter from the Intervenor dated March 29, 2017 enclosing testimony in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 29, 2017 (8 pages)

S	DPH response to Senator Miner and Representative Ohler dated March 29, 2017 in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 27, 2017. (2 pages)
T	Applicants letter dated March 29, 2017 enclosing Notice of Appearance, responses to issues and prefile testimonies in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 29, 2017. (151 pages)
U	Letter from the Intervenor dated March 29, 2017 enclosing revised testimony in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 29, 2017. (151 pages)
V	Letter from the Intervenor dated March 31, 2017 enclosing rebuttal testimony in the matter of the CON application under Docket Number 16-32132, received by OHCA on March 31, 2017. (8 pages)

Administrative Notice:

- Administrative notice is take of Docket Number: 16-32133-CON, Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.**

DOCKET NUMBER: **16-32133-CON**

PUBLIC HEARING: **April 5, 2017 at 4:00 pm**

PLACE: **Sharon Town Hall**
63 Main Street
Sharon, CT 06069

EXHIBIT	DESCRIPTION
A	Letter from Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. (Applicants) dated November 3, 2016 enclosing the Certificate of Need (CON) application for the Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.under Docket Number 16-32133, received by OHCA on November 3, 2016. (562Pages)
B	OHCA's letter to the Applicants dated December 2, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 16-32133.(5 Pages)
C	Applicants responses to OHCA's letter of December 2, 2016, dated January 17, 2017 in the matter of the CON application under Docket Number 16-32133, received by OHCA on January 17, 2017. (63 Pages)
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M	OHCA's Ruling on a Petition filed by Community Association to Save Sharon Hospital to be designated as an Intervenor with Limited Rights in the matter of the CON application under Docket Number 16-32133,dated March 24, 2017. (1page)
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Q	Letter from the Intervenor dated March 29, 2017 enclosing revised testimony in the matter of the CON application under Docket Number 16-32133, received by OHCA on March 29, 2017. (151 pages)

R	Letter from the Intervenor dated March 31, 2017 enclosing rebuttal testimony in the matter of the CON application under Docket Number 16-32133, received by OHCA on March 31, 2017. (8 pages)

Administrative Notice:

Administrative notice is take of Docket Number: 16-32132-CON, Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

Office of Health Care Access

APPLICANT

(Only persons speaking on behalf of Applicants must sign in)

PUBLIC HEARING-SIGN UP SHEET

April 5, 2017

4:00 pm

Docket Number: 16-32133-CON

Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.

PRINT NAME	Phone	Email	Title
Christian Bergeron	860 364 4084	christian.bergeron@sharonhospital.com	Sharon CFO
Gary Zmrhal	845 475 9538	[redacted]@health-quest.org	Health Quest CFO
Peter Cordeau	860-806-4212	peter.cordeau@sharonhospital.com	Peter R. Cordeau
Jennifer Fusco	203-786-8316	jfusco@cuts.com	Attorney for Applicants
Nancy L Heaton	(860)364-5157	nancy@fchealth.org	FCH CEO

Docket Number: 16-32133-CON
Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

PRINT NAME	Phone	Email	Title
Michael Brower	615/483-4311	mike.brower@rhcnashville.com	Executive Vice President & CFO

Applicant Sign up-*Only persons speaking behalf of the Applicant may put their names on this sheet*

Docket Number: 16-32133-CON
Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.

Print Name	Phone	Email	Title

Applicant Sign up-*Only persons speaking behalf of the Applicant may put their names on this sheet*

Office of Health Care Access

GENERAL PUBLIC

(Only persons speaking as general public must put their names on this list)

PUBLIC HEARING-SIGN UP SHEET

April 5, 2017
4:00pm

Docket Number: 16-32132-CON Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc Transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.	Docket Number: 16-32133-CON Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. Transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.
PRINT NAME	**Representing Organization (If applicable) or Self**
* JOEL W. JONES	SELF
✓ Roberta Willis	self
✓ Rob Kuhbach	FCH
✓ Victor GERMACK	CASSH

Docket Number: 16-32132-CON Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc	Docket Number: 16-32133-CON Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
PRINT NAME	**Representing Organization (If applicable) or Self**
✓ BARBARA PRINDLE	SELF
✓ * Dale C. Jones	Self - board of Selectmen
✓ EDWARD MURRAY	NDP EMS
[illegible]	Self
Cynthia Hoffsnyder	Lakeville Journal
Andre Williams	" "
LORI SITEPARO	Self
Lorna Brodtkorb	
✓* JESSICA FOWLER	BOS
✓ * Malcolm Brown	Former 1st Selectman

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

General Public

Docket Number: 16-32132-CON Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc	Docket Number: 16-32133-CON Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
PRINT NAME	**Representing Organization (If applicable) or Self**
Sharon Daniel Kroeger	self
Pari Forood	self

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

Docket Number: 16-32132-CON Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc	Docket Number: 16-32133-CON Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc.
PRINT NAME	**Representing Organization (If applicable) or Self**
William Heller	Self
Tara O'Neill	self
Brent Colley	Town of Sharon

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, April 11, 2017 12:21 PM
To: Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Schaeffer-Helmecki, Jessica; Fernandes, David
Cc: Ping, David; User, OHCA; victorger@pipeline.com
Subject: Sharon Hospital-RHA -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: DOCS-#1534067-v1-HEALTH_QUEST_SHARON_LATE_FILE_(FINAL).pdf

All:

Attached please find Applicants' Late File Nos. 1 and 2, as requested at the April 5th public hearing. Please let me know if you have any questions or if you require additional information.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
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April 11, 2017

VIA ELECTRONIC MAIL

Kevin T. Hansted
Hearing Officer
State of Connecticut Department of Public Health
Office of Health Care Access Division
410 Capitol Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc.
Docket No. 16-32132-CON &
Transfer of Ownership of Regional Healthcare Associates, LLC to a Subsidiary of Vassar Health Connecticut, Inc.

Dear Hearing Officer Hansted:

This office represents Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, Sharon Hospital Holding Company, Regional Healthcare Associates, LLC, Health Quest Systems, Inc. ("Health Quest"), and Vassar Health Connecticut, Inc. (collectively the "Applicants") in connection with the above-referenced dockets.

For your review, the Applicants enclose Late File Nos. 1 and 2, as requested at the joint public hearing held on April 5, 2017. Late File No. 1 is a copy of the Medical Staff Development Plan that Health Quest had completed for Sharon Hospital and the Sharon service area. Late File No. 2 is a chart that includes volume and financial data for Northern Dutchess Hospital ("NDH") from 2000 through 2016.

Regarding Late File No. 1, in early 2017 Health Quest retained Veralon, a firm specializing in physician needs for organizations such as Sharon Hospital, including the types of physicians relative to the existing service areas (primary and secondary), to prepare a Medical Staff Development Plan. The Veralon study looked at the area demographics, developed a list of physicians in the area by specialty and age, and then, based on that analysis and ratios of physician need to population, determined the approximate number of physicians required in the Sharon service area. Health Quest intends to utilize this study in helping to determine how many physicians should be recruited to the area and the priority for recruiting those physicians.

Primary care physicians – specifically internal medicine and family practice physicians represent the largest deficit identified by Veralon. This is Health Quest's highest priority at the current moment for recruitment. Obstetrics and surgical specialties (including general surgery) also have shortages and are priority recruitments. Cardiology also shows a large deficit and it should be

noted that Health Quest has three cardiologists – the number that the service area is short – who are obtaining their Connecticut licenses and will be practicing at Sharon Hospital. While oncology does not show a physician shortage, this is somewhat misleading. The numbers in essence are overstated as the oncologists shown in the area are not permanent, but rather reflective of a transient basis since they are "travelers" or on the edges of the service area. As such, this does not reflect the true need for oncologists in the area and Health Quest will recruit this specialty on a high priority basis as well.

Regarding Late File No. 2, the data provided for NDH begins in 2000, which is the first full year of operation following the 1999 merger of NDH and Vassar Brothers Medical Center ("VBMC") to form Health Quest. NDH was a distressed hospital at the time of the merger, and had been losing money for several years prior to the merger. As illustrated, there has been substantial improvement in all the categories since the acquisition. However, in particular, the following should be noted:

- In the first full four (4) years of operation (2000-2004) as part of Health Quest, NDH experienced a significant turnaround. Inpatient discharges grew by approximately 25 percent during that time. The operating margin went from a -6.7% to a +4.3%, a turnaround of over $3.3 million. Of note, this was done at a time prior to Health Quest forming Health Quest Medical Practice ("HQMP"). HQMP was formed in 2008, and Health Quest did not have a good platform for recruiting physicians until the formation of HQMP. It is clear from the chart that once HQMP was formed, and along with the management change in 2014, NDH experienced record growth in both volumes and financial success.

- Effective January 1, 2014, Health Quest engaged new leadership, initially at the corporate level and eventually at two of its three hospitals (including NDH). In comparing 2013, the last year under the previous management team, to the following years, there has been steady, consistent growth in discharges, as well as NDH's operating and EBIDA (Earnings Before Interest, Depreciation and Amortization) margins.

- As noted in the CON filings and at the public hearing, Health Quest has continually invested in its facilities. This too occurred at NDH where Health Quest expended $47 million for a new patient tower (Sosnoff Pavilion), which opened in February of 2016. This new facility had a resounding impact, not only on admissions and discharges, but financially as well. NDH recorded a historic $16,374,148 of Net Operating Income with a 14.9% operating margin in 2016.

In summary, as clearly noted at the hearings, while Health Quest sets aggressive growth targets, they have been consistently achieved. NDH is just one example of this. Sharon Hospital has advantages that NDH did not have in its early years with Health Quest. First, Health Quest was just forming when NDH joined the system. Health Quest was developing the system and incorporating NDH simultaneously. Second, HQMP did not exist until 2008, and there was little infrastructure for physician recruitment and retention until HQMP was formed. Finally, the new Health Quest management team, which has been in place since 2014, is committed to top-decile performance and

has been successful at achieving this. Sharon Hospital benefits from not only these three factors but many others and has the potential to achieve levels of growth similar to NDH and perhaps more readily because of the mature status of Health Quest.

Thanks you for your consideration of this Late File information. Please let me know if you require anything further for your review.

Very truly yours,

Jennifer Groves Fusco

Enclosures

cc: David Ping *(w/enc)*
Michael W. Browder *(w/enc)*
Victor Germack *(w/enc)*

LATE FILE NO. 1

SH000975
PP000689
04/11/2017

Sharon Hospital

Medical Staff Development Plan

January 25, 2017

Table of Contents

Introduction

Engagement Context and Overview

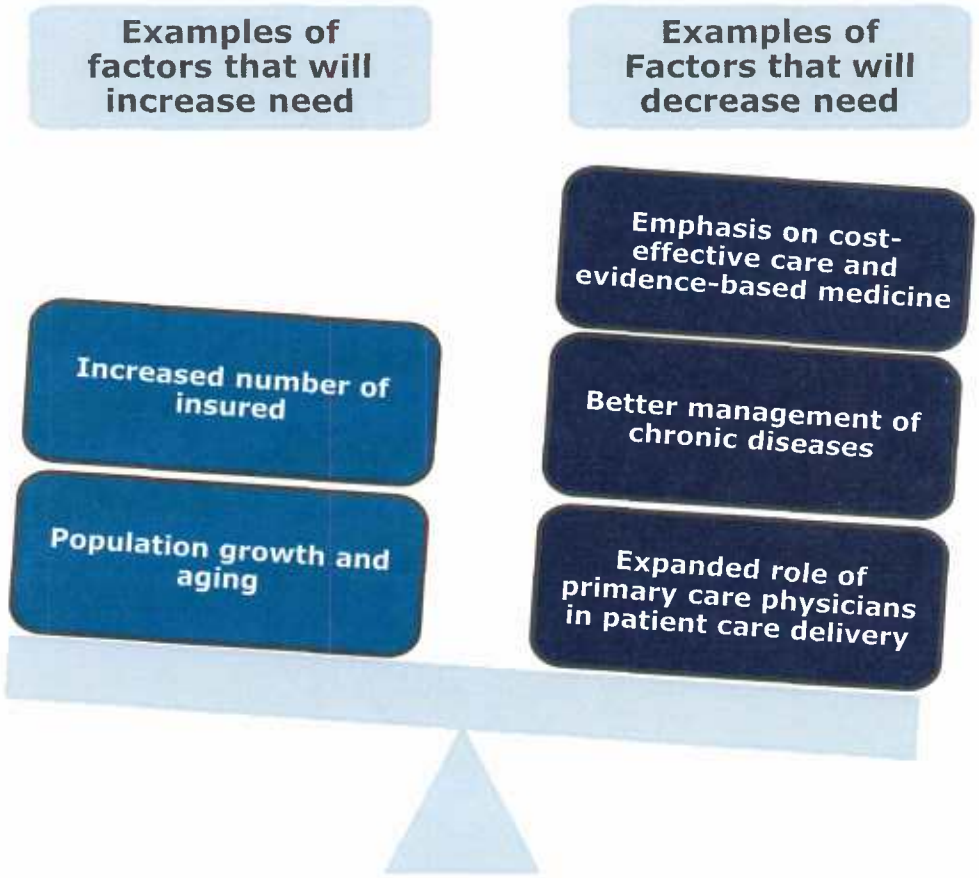
- HealthQuest is acquiring Sharon Hospital ("Sharon") and therefore must understand the Sharon Hospital service area's need for physicians
- HealthQuest engaged Veralon to assist with medical staff planning for Sharon
- Veralon prepared this draft report based on analysis of medical staff data and other physician information

Engagement Objectives

- ☑ Determine the current and future mix of physicians required to meet the community need
- ☑ Provide support and documentation for Sharon's physician recruitment and other practice activities

Factors Affecting Future Physician Need

Physicians

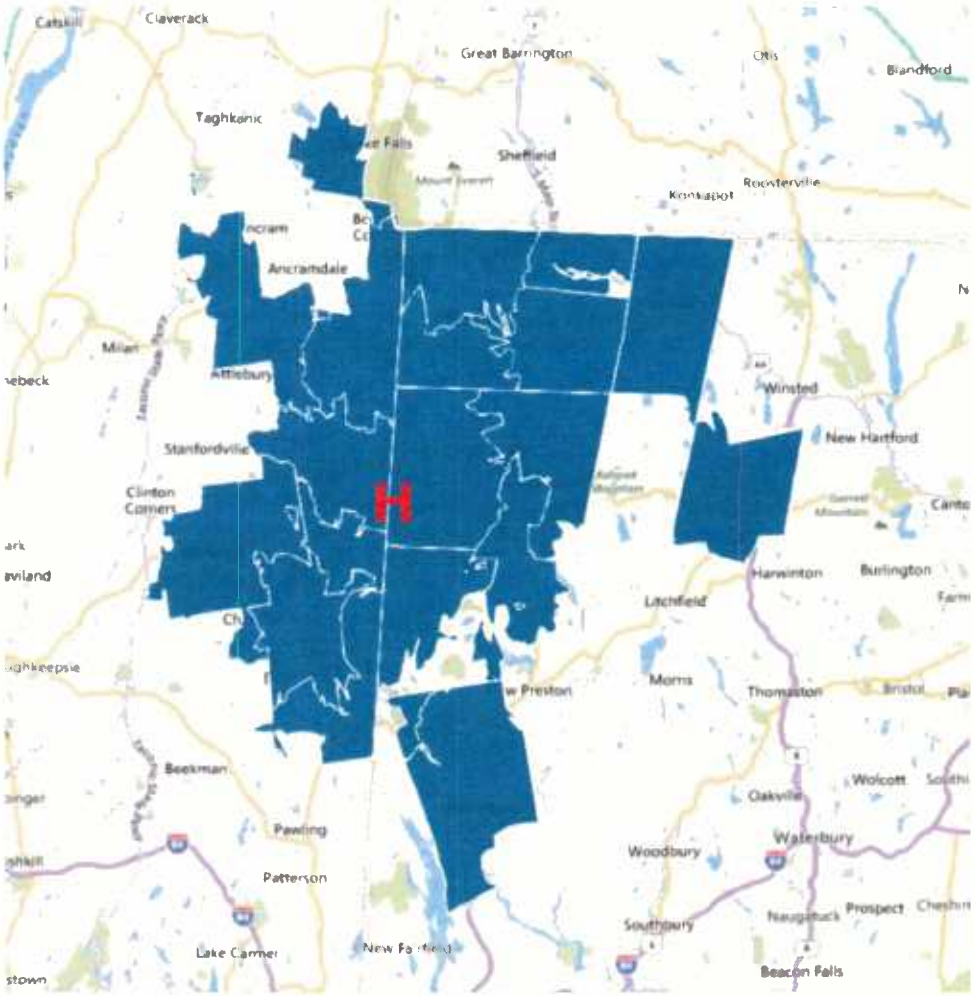


SH000980
PP000694
04/11/2017

HEALTHQUEST Sharon HOSPITAL VERALON

Service Area Overview

Sharon Service Area



Zip Code	City
06018	Canaan
06024	East Canaan
06031	Canaan (Falls Village)
06039	Lakeville
06068	Salisbury
06069	Sharon
06754	Cornwall Bridge
06755	Gaylordsville
06757	Kent
06776	New Milford
06790	Torrington
06796	West Cornwall
12501	Amenia
12516	Copake
12522	Dover Plains
12545	Millbrook
12546	Millerton
12567	Pine Plains
12592	Wassaic
12594	Wingdale
06058	Norfolk

SH000982
PP000696
04/11/2017

Based on 2016 Sharon inpatient discharge data. Service area includes the top towns comprising 75% of total discharges

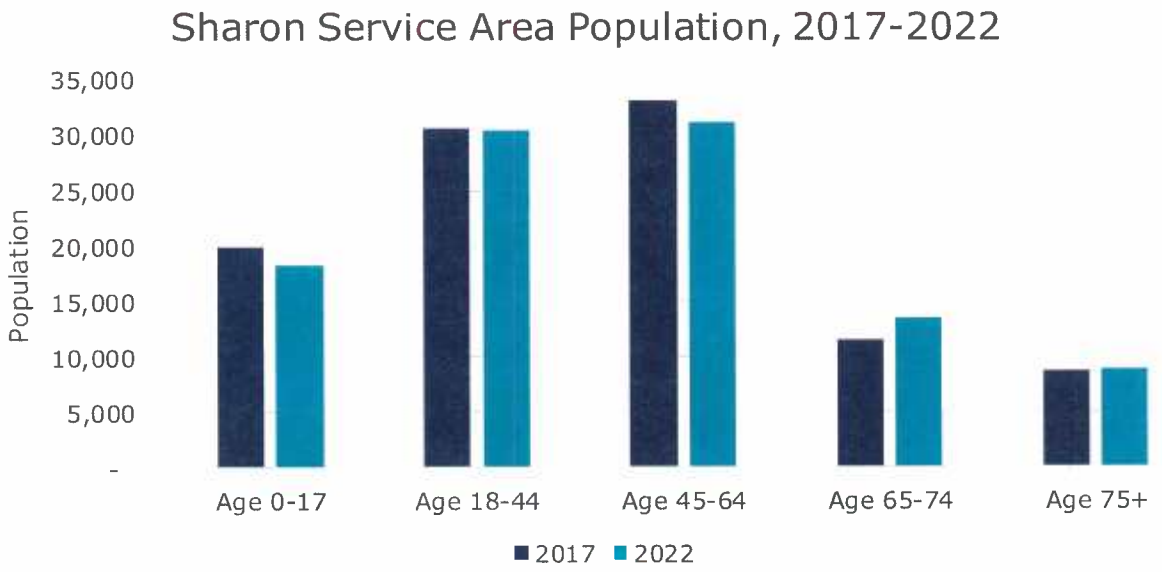
H- *Sharon Hospital*

HEALTHQUEST Sharon HOSPITAL VERALON

Sharon Service Area Population

Demographics

- The population in Sharon's Service Area is projected to decrease slightly (1.6%) by 2022; however, the population aged 65+ is projected to increase by 11%



Sharon Hospital
Service Area Population by Age Cohort

	Total Population			Population Age 65+		
	2017	2022	% Change	2017	2022	Change
Sharon Service Area	104,036	102,362	-1.6%	20,211	22,460	11.1%

[1] Population statistics from Nielsen Pop-Facts Premier, 2016.

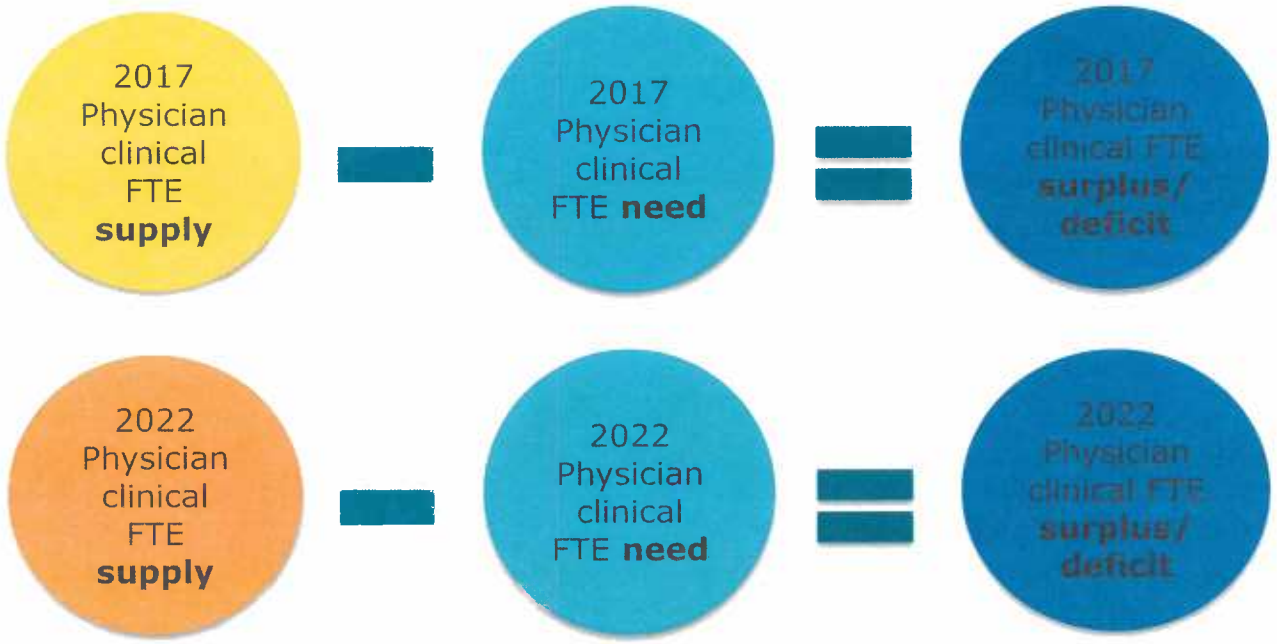
SH000983
PP000697
04/11/2017

HEALTHQUEST Sharon HOSPITAL VERALON

Community Needs Assessment

Community Need Methodology

Determining service area physician requirements (surplus/deficit):



- **Physician Supply:** compiled from Sharon's medical staff roster, insurance provider directories, area hospital websites, and other sources
- **Physician Need (Demand):** determined for each major medical and surgical specialty based on market specific physician-to-population ratios, which are age-adjusted for service area demographics
- **Surplus/Deficit:** determined for the community served by Sharon

SH000985
PP000699
04/11/2017

HEALTHQUEST Sharon HOSPITAL VERALON

FTE Adjustment Guidelines

Adjustments

Age Adjustment

Physicians aged **65-69** are considered "ramping down": **0.5 FTE**

Physicians aged **70 and over** are considered retired: **0.0 FTE**

Office and Service Area Adjustment

For physicians with two or more offices, assumed time split equally among all locations

Locations out of service area are not counted toward service area FTEs

Example Provider

Dr. Smith:
Age: 67 years old
Age Adjustment:
0.5 FTE

Total Office locations: 3
2 within SA
1 outside of SA
Location adjustment:
0.66 FTE

Adjusted FTE:
0.33 FTE

SH000986
PP000700
04/11/2017

HEALTHQUEST Sharon HOSPITAL VERALON

Service Area Physician Supply (2017 & 2022)

Specialty Mix

- Primary Care physicians represent approximately 42% of the 146 physician FTEs in Sharon's service area.
- This is higher than the national PCP prevalence figure of 37%

Physician Attrition

- With no replenishment of physicians to the service area, physician supply is projected to decrease by approximately 21 FTEs by 2022 due to retirement
  - These decreases are spread evenly across primary care and medical specialties, at 14% and 13% respectively.
  - The decrease among surgical specialties is larger, at approximately 17%

Sharon Hospital
Summary of Physician Supply by Specialty:

Specialty	2017 Estimated FTE Level[1]	2022 Estimated FTE Level[1]
Primary Care		
Family Practice	20.1	14.4
Internal Medicine	25.6	23.3
Pediatrics	16.2	15.7
Primary Care Total	**61.9**	**53.3**
Medical Specialties		
Allergy/Immunology	2.4	1.9
Cardiology	5.0	4.8
Dermatology	2.4	1.5
Endocrinology	0.9	0.9
Gastroenterology	3.1	1.2
Hematology/Oncology	5.0	4.5
Infectious Disease	1.2	1.2
Nephrology	1.5	1.0
Neurology	0.7	0.7
Physical Medicine & Rehabilitation	2.5	2.5
Psychiatry	7.6	7.4
Pulmonology	5.0	4.8
Rheumatology	2.4	2.4
Medical Specialties Total	**39.6**	**34.5**
Surgical Specialties		
Cardiovascular/Cardiothoracic Surgery	-	-
Colo-Rectal Surgery	0.5	0.5
General Surgery	8.3	6.3
Neurosurgery	-	-
Obstetrics/Gynecology	11.4	9.3
Ophthalmology	6.0	4.8
Orthopedics	12.4	10.8
Otolaryngology	2.4	2.0
Plastic Surgery	1.3	1.2
Urology	2.7	2.5
Vascular Surgery	-	-
Surgical Specialties Total	**44.9**	**37.3**
Grand Total	**146.4**	**125.0**

SH000987
PP000701
04/11/2017

Sharon Service Area Surplus/Deficit Analysis: 2017 & 2022

Sharon Hospital: Summary of Physician Surpluses and Deficits

Category	2017 SA Supply (Adj FTE)	2017 SA Need	2017 FTE Surplus/ Deficit	2022 SA Supply (Adj FTE)	2022 SA Need	2022 FTE Surplus/ Deficit
Primary Care						
Family Practice	20.1	29.8	(9.7)	14.4	31.6	(17.3)
Internal Medicine	25.6	35.6	(10.0)	23.3	38.5	(15.2)
Pediatrics	16.2	10.8	5.4	15.7	10.4	5.3
Primary Care Total	**61.9**	**76.2**	**(14.3)**	**53.3**	**80.5**	**(27.2)**
Medical Specialties						
Allergy/Immunology	2.4	1.4	1.0	1.9	1.4	0.5
Cardiology	5.0	8.1	(3.1)	4.8	7.9	(3.2)
Dermatology	2.4	3.4	(1.0)	1.5	3.3	(1.8)
Endocrinology	0.9	1.8	(0.9)	0.9	1.7	(0.8)
Gastroenterology	3.1	4.3	(1.3)	1.2	4.2	(3.0)
Hematology/Oncology	5.0	3.8	1.2	4.5	3.6	0.9
Infectious Disease	1.2	1.8	(0.6)	1.2	1.7	(0.5)
Nephrology	1.5	2.5	(1.0)	1.0	2.4	(1.4)
Neurology	0.7	4.2	(3.5)	0.7	4.0	(3.3)
Physical Medicine & Rehabilitation	2.5	2.5	0.0	2.5	2.3	0.2
Psychiatry	7.6	11.2	(3.6)	7.4	10.7	(3.3)
Pulmonology	5.0	7.2	(2.2)	4.8	7.0	(2.3)
Rheumatology	2.4	1.4	0.9	2.4	1.4	1.0
Medical Total	**39.6**	**53.5**	**(13.9)**	**34.5**	**51.6**	**(17.1)**
Surgical Specialties						
Cardiovascular/Cardiothoracic Surgery	-	2.0	(2.0)	-	1.9	(1.9)
Colo-Rectal Surgery	0.5	0.6	(0.2)	0.5	0.6	(0.2)
General Surgery	8.3	7.5	0.8	6.3	7.2	(0.9)
Neurosurgery	-	1.7	(1.7)	-	1.6	(1.6)
Obstetrics/Gynecology	11.4	10.8	0.5	9.3	10.0	(0.7)
Ophthalmology	6.0	6.2	(0.2)	4.8	6.0	(1.2)
Orthopedics	12.4	7.9	4.6	10.8	7.5	3.3
Otolaryngology	2.4	3.0	(0.6)	2.0	2.8	(0.8)
Plastic Surgery	1.3	2.3	(1.0)	1.2	2.2	(1.0)
Urology	2.7	3.6	(0.9)	2.5	3.4	(0.9)
Vascular Surgery	-	1.4	(1.4)	-	1.3	(1.3)
Surgical Total	**44.9**	**47.0**	**(2.1)**	**37.3**	**44.6**	**(7.3)**
Grand Total	**146.4**	**176.8**	**(30.4)**	**125.0**	**176.6**	**(51.6)**

LATE FILE NO. 2

SH000989
PP000703
04/11/2017

Northern Dutchess Hospital: Growth from 2000 – 2016
Docket Nos. 16-32132-CON & 16-32133-CON – Late File #2

Year	Discharges	Operating Margin	EBIDA Margin	
2000	2,916	-6.7%	2.2%	First year operation post merger
2001	3,043	-2.8%	5.7%	
2002	3,361	1.9%	7.0%	
2003	3,621	1.4%	7.0%	
2004	3,605	4.3%	9.5%	
2005	3,564	1.7%	7.8%	
2006	3,866	3.5%	11.5%	Rosenthal Pavilion Opens
2007	4,067	0.6%	10.0%	Full depreciation and interest
2008	4,156	2.7%	10.0%	Recession
2009	4,189	5.6%	12.0%	HQMP recruits IM, General Surgery and OB
2010	4,176	7.0%	14.0%	
2011	4,205	12.6%	19.2%	
2012	4,199	8.7%	15.0%	
2013	4,487	12.3%	17.9%	
2014	4,678	14.0%	19.3%	Full year of new management team
2015	5,130	13.4%	19.6%	
2016	5,417	14.9%	22.2%	Sosnoff Pavilion opens

SH000990
PP000704
04/11/2017

User, OHCA

From: victorger@pipeline.com
Sent: Thursday, April 13, 2017 10:12 PM
To: Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Schaeffer-Helmecki, Jessica; Fernandes, David
Cc: Ping,David; User, OHCA; Jennifer Groves Fusco
Subject: Re: Sharon Hospital-RHA -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: 4-13-17 Response to Late File Nos. 1 and 2-The Community Association to Save Sharon Hospital.docx

To All:

Attached please find The Community Foundation to Save Sharon Hospital's response to Applicants' Late File Nos. 1 and 2.

Thank you,

Victor Germack
Vice President

The Community Association to Save Sharon Hospital

P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

VIA FAX & ELECTRONIC MAIL

April 13, 2017

Mr. Kevin T. Hansted
Hearing Officer
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capital Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Re: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc. & Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Response by The Community Association to Save Sharon Hospital to Late File Nos. 1 and 2 Filed by the Applicants – Essent Healthcare of Connecticut, Inc. Health Quest Systems, Inc., and Vassar Health Connecticut, Inc.

A. Regarding Late File No. 1

At the April 5th. Hearing, the Hearing Officer requested that the Applicants furnish their physician manpower needs assessment study which the Applicants stated was used as the basis for their staffing projections as outlined in their CON Application. In our Prefiled Testimony, we maintained that the Applicants did not specify a medical staffing plan in their CON. Therefore, we listened very carefully to the OHCA questions and the Applicant's responses at the Hearing, to determine what physicians and what specialists would be added and when, where they would be located, and how their time would be divided between Sharon Hospital and the other Health Quest hospitals. Unfortunately, none of this critical information was provided in the CON or at the Hearing. The Applicants' answers at the Hearing on this

critical subject were vague and incomplete. We heard the Applicants make statements like "22 FTEs would be added", and "still deciding what physicians and what types", among other answers from the Applicants. The Veralon study that was furnished by the Applicants – as Late File No.1, doesn't provide any definite answers to the Sharon Hospital staffing questions. In fact, the Veralon study talks about a physician deficit today of 30.4 FTEs, and a physician deficit of 51.6 FTEs by 2022. While primary care physicians are the most critical need now and in 2022, it also mentioned needs for psychiatry and pulmonology which had not been previously discussed by the Applicants.

We still don't understand how you can provide a CON, which contains a business plan with detailed financial projections, supposedly based on physician staffing, and yet there is no detail given for what the healthcare services or medical staffing will be. We again ask that Health Quest tell us what medical services and staffing Sharon Hospital will provide to the Community. How can we hold Sharon Hospital and Health Quest accountable if we don't know what they intend to provide?

Our major objection which still remains is that the current financial projections and business plan for Sharon Hospital, contained in the CON, are unrealistic and must be resubmitted together with a stated medical service plan that is believable. On behalf of the public, it makes no sense for OHCA to approve a hospital's health service plan that is unrealistic and with no stated guarantees of financial support or service.

B. <u>Regarding Late File No. 2</u>

The Applicants were asked to provide supporting data for their statements that Northern Dutchess Hospital ("NDH"), which Health Quest acquired in 1999, has had very good growth and "went from a negative margin to a 13.5% operating margin". The Late File #2 shows the discharges, operating margin and EBITDA margin from 2000 through 2016 for NDH. It shows an operating margin of 13.4% in 2015 and 14.9% in 2016.

Unfortunately, the information contained in Late File No. 2 is misleading, as it's just the operating results for Northern Dutchess Hospital without its associated physician costs. To get the correct financial picture for each hospital, you must consolidate their operating revenue and expenses with its associated physician and group practices/affiliates' costs. This is the same mistake that Mr. Friedberg made in his Prefiled Testimony, which we pointed out in our Rebuttal to his Testimony.

To get the correct operating profit margin for Northern Dutchess Hospital, you must allocate a proportionate share of the total physician and group medical practice costs, which appear to be from: HQ Med Practice, HV Cardio

Practice and HQUMCP (See Consolidating Statement of Operations - page 41 of the 2015 Health Quest Systems Audited Financial Statement) to NDH.

For the purpose of the physician cost allocation, we would assume that NDH should share a proportionate share of the total physician and group practice medical expense of $36.0 million based on their share of revenue as a percentage of the total revenue of the three hospitals. Doing this would reduce NDH's operating profit from $12.4 million (See page 42 of the 2015 Health Quest audited statements) to $8.2 million, And on a revenue base of $92.6 million, NDH would show an operating profit margin of 8.8% in 2015 not 13.4%! In addition, Connecticut has a 6% provider tax which New York State does not have – but if it did, (and we know Sharon Hospital will have the 6% provider tax) NCH's profit margins would be significantly reduced and their results would be more in line with most of the Connecticut hospitals' financial results.

C. US Department of Justice Investigations

Note 15 of the Health Quest Systems Audited Financial Statements for 2015 discloses two outstanding 2016 United States Department of Justice investigations into two matters that relate to self-disclosure efforts by Health Quest into contracts entered into between VBMC and PHC and two separate physician groups. While Health Quest has reserved an estimated liability for these matters, it says, "It is reasonably possible that a change in these estimates will occur in the future and the change could be material to the consolidated financial statements". Because the change could be material, OHCA must ascertain the nature and extent of these investigations as they could have a significant impact on Health Quest's future operations and that of Sharon Hospital going forward.

Thank you for your consideration.

Sincerely,

Victor Germack
Vice President

cc: Jennifer Groves Fusco, Esq.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

SHARON HOSPITAL HOLDING COMPANY AND THE SHARON HOSPITAL AND HEALTH QUEST SYSTEMS, INC. AND VASSAR HEALTH CONNECTICUT, INC.
TRANSFER OWNERSHIP OF THE SHARON HOSPITAL TO VASSAR HEALTH CONNECTICUT, INC.
A SUBSIDIARY OF HEALTH QUEST SYSTEMS, INC.

DOCKET NO. 16-32132-CON

AND

REGIONAL HEALTHCARE ASSOCIATES, LLC AND HEALTH QUEST SYSTEMS, INC. AND VASSAR HEALTH CONNECTICUT, INC.
TRANSFER OWNERSHIP INTEREST OF REGIONAL HEALTHCARE ASSOCIATES, LLC TO VASSAR HEALTH CONNECTICUT, INC.
A SUBSIDIARY OF HEALTH QUEST SYSTEMS, INC.

DOCKET NO. 16-32133-CON

APRIL 5, 2017

4:00 P.M.

SHARON TOWN HALL
63 MAIN STREET
SHARON, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Sharon Hospital Holding Company and The Sharon Hospital and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. transfer ownership of The Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc. and Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. transfer ownership interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc., held at the Sharon Town Hall, 63 Main Street, Sharon, Connecticut, on April 5, 2017 at 4:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. This public hearing before the Office of Health Care Access is being held on April 5, 2017 to consider two applications, one by Essent Healthcare of Connecticut, Inc., DBA: Sharon Hospital, and Sharon Hospital Holding Company and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc., for

the transfer of ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc., and they're in Docket No. 16-32132-CON. Boy, that was a mouthful.

And the second application, bearing Docket No. 16-32133-CON, is Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. for the transfer of ownership of interest of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., as subsidiary of Health Quest Systems, Inc.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a(f)2, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I have been designated as the Hearing Officer for both of these matters this evening.

The staff members assigned to assist me in this case are Kaila Riggott, Steven Lazarus, Jessica Schaeffer-Helmecki and David Fernandes, and the hearing is being recorded by Post Reporting Services.

In making its decision on both of these

matters, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Specifically, OHCA will consider the following; whether there is a clear public need for the proposed transaction, whether the Applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the healthcare system in Connecticut, or that the proposal is financially-feasible for the Applicant; whether the Applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of healthcare delivery in the region; and whether the Applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of healthcare providers and patient choice in the region.

Essent Healthcare of Connecticut, Inc., DBA: Sharon Hospital, Sharon Hospital Holding Company, Health Quest Systems, Inc. and Vassar Health Connecticut, Inc. have been made parties to this transaction, as well as Regional Healthcare Associates, LLC and Health Quest Systems, Inc. and Vassar Health Connecticut under their respective Docket numbers.

Community Association to Save Sharon

Hospital has been designated as an Intervenor, with limited rights in both dockets, and what that means, for those of you in the audience, is that Community Association to Save Sharon Hospital has the right to present testimony, however, they do not have the right to Cross-Examine the Applicant.

The Applicant, if they choose to do so, may Cross-Examine Connecticut Association to Save Sharon Hospital.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's Table of the Record in both of these matters.

All documents have been identified in the Table of the Record for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus, staff at the Office of Health Care Access, Department of Public Health.

We have two dockets for the record today. The first one is Docket No. 16-32132, and that includes Exhibits A through V and, also, it's taking administrative notice of Docket No. 16-32133.

The other Docket that we're taking notice today are the Exhibits A through R, and that's for Docket No. 16-32133.

And we also want to note that we received three letters of support for these applications, and they're from Robert Kuhbach, Roberta Willis and Arthur Chin(phonetic). These will be added to the record.

HEARING OFFICER HANSTED: Thank you, Mr. Lazarus. Counsel, do you have any objection?

MS. JENNIFER FUSCO: No. Jennifer Fusco, counsel for the Applicants. We have no objection to the record.

HEARING OFFICER HANSTED: Okay, thank you. And the way that we're going to proceed this evening or this afternoon is that we're going to first hear public comment from anyone, who has signed up to give public comment.

For those of you in the audience, if you wish to give public comment, please sign up on the sheet at the back of the room in the hallway. That way, we know who to call to give public comment. We will take you in the order that you signed up.

After we've heard public comment, we will hear the opening presentation from the Applicants, as well as their Direct testimony, then we will move to the Intervenor for his Direct testimony.

If there's any Cross-Examination by the

Applicant, they will proceed with that at that time, then we will have questions for the Applicant and possibly the Intervenor. I don't think we have any for the Intervenor today, just the Applicant, then we will hear more public comment, and then we will close the hearing.

Okay. At this point, we're going to start with the public comment. As always at the hearings, we defer to any elected officials. Are there any elected officials, who would like to give testimony here or public comment?

I know we have one signed up. I saw two hands. Three hands. If you could please sign up with Leslie, she can take the names.

MS. LESLIE GREER: First, we'll have Dale Jones, then we'll have Jessica Fowler, and then Mr. Brown, the three people right up here.

MR. DALE JONES: Okay to begin?

HEARING OFFICER HANSTED: You may.

MR. JONES: Thank you. Good afternoon. My name is Dale Jones. I'm a Selectman here in Sharon. Thank you, guys, for coming out today and hearing us.

I was, in fact, born at Sharon Hospital way back in 1961. I'm here in support of the transfer of ownership of Sharon Hospital to Vassar Health

Connecticut, also known as Health Quest.

My wife and I raised our children here in Sharon, and, like most parents, we spent our share of time at the emergency room here at our local hospital and for follow-ups.

As you've no doubt noticed, it's a different world out here from most of Connecticut. Everything is a drive. We're fond of saying that, when people, who come from more populated areas of Connecticut, when they refer to the Northwest Corner and Sharon, the last two words that they always end with are out there, as in it's beautiful out there. What do you do for a living out there?

So, yeah, everything is a drive to get out here, and that is a good place to start, as far as the need for Sharon Hospital to continue here as a community hospital.

Having a viable, successful, full-service local hospital, not only for our Town of Sharon, but for the surrounding towns here and across the border, is critical to living out here, and not just for families raising children, as I've testified, but, also, for our substantial senior community out here, as well.

Without Sharon Hospital, the nearest

hospital of any similar caliber is in Torrington. It's a good 40 miles east of here, or 40 minutes, I should say. Hudson, New York, Great Barrington, Massachusetts to the north, both nearly an hour, sometimes more, or to Poughkeepsie to the southwest, a good 45 minutes.

We need and we deserve accessible health care that is a reasonable distance. Sharon Hospital has served that need for us for so long.

Health care is in a very transformative place everywhere. I'm sure I don't have to tell you folks that. And, like many other industries, it's economy of scale and sharing of resources. That's the key to survival, and I believe this transfer is necessary to save this hospital.

I believe the non-profit business model is a better one for small community hospitals. Sharon's Foundation for Community Health Partnership, which has been proposed, should this transfer be approved, will bring some badly-needed resources back to Sharon Hospital and back to these communities.

And there's also value in having a partner like Health Quest acquiring Sharon Hospital. It's regional. It's already part of the community, so it's already keyed into the needs of the residents personally.

Now not to denigrate the private concern, Essent, that has owned the hospital these past several years, but they're based in the middle part of the country, not on the ground here delivering the care, like Vassar and Health Quest have been doing. Those folks are already here. They already know the community. We think, or I think it makes them a better partner.

And, finally, putting my Selectman's hat on, a successful, thriving, vibrant Sharon Hospital, providing local jobs, is no doubt a huge economic asset to the Town of Sharon.

I urge you to approve the sale of Sharon Hospital to Health Quest. Thank you.

HEARING OFFICER HANSTED: Thank you.

(APPLAUSE)

MS. JESSICA FOWLER: Hi. I'm Jessica Fowler, and I wish we can get this many people at a budget hearing.

HEARING OFFICER HANSTED: Ms. Fowler, before you proceed, I just want to, I should mention, for those that are going to give presentations, the little alien-looking eye that you see in front of you, we're actually making OHCA history this evening, this is the first hearing we are actually webcasting the meeting, so

we're recording it, so we brought a little technology to Sharon, not that you don't have it already.

MS. FOWLER: Thank you for the added pressure.

(LAUGHTER)

HEARING OFFICER HANSTED: It was in no way intended that way.

MS. FOWLER: I know.

HEARING OFFICER HANSTED: You may proceed.

MS. FOWLER: Thank you. My voice isn't quite as smooth as Dale's, but I'll give you my perspective as a resident in Sharon and as a Selectman.

As a resident, I've had two children, and, like Dale, I've taken my kids to the hospital, especially my son, with stitches and rips and gashes and fevers, etcetera, etcetera.

I'm always happy with my experience, especially when I would walk in and see somebody I knew. That made a huge difference, especially when my son had a gash in his knee that required 60 stitches. That made even more of a difference, so, as a resident, I'm extremely supportive of this transfer of ownership.

As a Selectman, and I kind of continue with what Dale was just saying, I am deeply concerned

about growth in our town. Both Dale and Brent and myself are concerned, as well as your Board of Finance and your Board of Educations.

We are working together right now on a joint committee to address growth issues. Population is expected to decline in Sharon by over 20 percent between 2015 and 2025. These are projections that the Northwest Hills COG office has provided us.

This is very upsetting. At the 21 towns in the COG region, Sharon has the highest percentage of residents over 64 years of age, so that’s 21 towns in the COG region. We have the highest percentage of that age group.

Our public school enrollment is rapidly declining. That’s just in a freefall. That’s kind of a given.

We know that, out of the 1,000 jobs in Sharon, 60 percent of those are from the healthcare and medical sector, and I’m betting that two-thirds of that 60 percent is Sharon Hospital.

The hospital is an absolute anchor for our town. We have no private schools. We have no light industry. We have nothing else here. We have wonderful people, wonderful residents, an absolutely stellar part-

time community, but we need this hospital on so many levels.

Dale was great about outlining why we needed it, in terms of accessibility, in terms of location. We need it for this town, so I would urge you to support this transfer. Thank you.

(APPLAUSE)

(Whereupon, public testimony was heard.)

HEARING OFFICER HANSTED: At this point, I'd like everyone, who is going to testify here this evening, to please stand, raise your right hand and be sworn in by the court reporter.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay. Would everyone that was just sworn in just please identify yourselves one at a time?

MR. GARY ZMRHAL: Gary Zmrhal, Chief Financial Officer, Health Quest.

MR. CHRISTIAN BERGERON: Christian Bergeron, Chief Financial Officer, Sharon Hospital.

MR. GLENN LOOMIS: Glenn Loomis, Chief Medical Officer, Health Quest.

MS. NANCY HEATON: Nancy Heaton,

Foundation for Community Health.

MR. PETER CORDEAU: Peter Cordeau, CEO, Sharon Hospital.

MR. MICHAEL BROWDER: Mike Browder, Executive Vice President, Chief Financial Officer, RCCH, HealthCare Partners.

MR. ROBERT FRIEDBERG: Robert Friedberg, President and CEO of Health Quest.

MR. DAVE PING: Dave Ping, Senior Vice President of Strategic Planning for Health Quest.

MR. VICTOR GERMACK: I'm Victor Germack, Community to Save Sharon Hospital.

MR. CHRIS MILLER: Chris Miller, Director of Physician Services with Sharon Hospital.

HEARING OFFICER HANSTED: Okay, thank you, everyone. And just a reminder, for those of you, who have submitted written testimony, before you testify before me this evening, please just adopt your testimony for the record and state your full name again. And, Ms. Fusco, you can --

MS. FUSCO: We'll begin our presentation with Mr. Cordeau, who is the CEO of Sharon Hospital.

HEARING OFFICER HANSTED: Okay. Can everyone hear back there?

VOICES: No.

MS. FUSCO: Do we want to use the amplifying?

HEARING OFFICER HANSTED: Yes. Everyone can hear me okay, correct?

VOICES: Yes.

HEARING OFFICER HANSTED: Okay.

MR. CORDEAU: Good afternoon. My name is Peter Cordeau, and I'm the Chief Executive Officer at Sharon Hospital.

I've been with Sharon Hospital for three and a half years, and I've had the privilege to serve as their Chief Executive Officer for the past year and a half, and I would like to adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. CORDEAU: I would like to introduce Mike Browder, Executive Vice President and CFO of RCCH. At the end of the table, Robert Friedberg, President and CEO of Health Quest, and Nancy Heaton, CEO of the Foundation for Community Health.

I'd like to thank OHCA for the opportunity to speak in support of the CON to sell Sharon Hospital to Health Quest, a non-profit healthcare system based in the mid-Hudson Valley Region of New York.

Mr. Friedberg will tell you more about the Health Quest system, which includes notably both tertiary and community hospitals and a physicians' practice of nearly 300 providers covering 25 medical specialties at 20 office locations.

Sharon, as you know, is one of the smallest acute care hospitals in the State of Connecticut, with only 78 licensed beds.

Located 30 miles from the nearest hospital, we strive to provide the community with a full complement of hospital and physician services, but, as you will hear today, there have been challenges in this regard that have adversely impacted the hospital's financial performance and put our survival in jeopardy.

By way of background, Sharon has unique demographics among Connecticut hospitals. Sixty percent of our service area population resides in the State of New York. In the last year, 42 percent of our inpatient discharges were of New York residents.

Sharon is also an aging community, with 40 percent of our service area population projected to be over the age of 55 within the next five years, and Medicare is our primary payer.

As you also know, Sharon Hospital was the

first hospital in Connecticut to operate as a for-profit. We were acquired by Essent Healthcare in 2002, and Mr. Browder here will tell you more about what Essent was able to accomplish in the past 15 years, including significant renovation projects that provided much needed modernization to our Labor and Delivery Unit and our Emergency Department.

He will also explain how changes to the healthcare delivery system, cuts to reimbursement, provider taxes and other issues have combined to bring about the financial issues facing the hospital today.

You will also hear from Mr. Friedberg why Health Quest has chosen to acquire Sharon Hospital, how we fit within the healthcare system, and what their plans are for capital investments, physician recruitment and service expansion.

We have been working with Health Quest for several months and are excited to learn about their plans to upgrade our electronic medical record and to expand our incredibly well-utilized Senior Behavioral Health Unit and add primary and specialty physician services and facilities, including medical oncology and infusion and cardiology, just to name a few.

Lastly, you'll hear from Ms. Heaton about

the role the Foundation for Community Health is playing in funding the return of Sharon Hospital to a non-profit community asset and Health Quest's strategic investment in both the hospital and the associated physician practices.

As I mentioned in my testimony, I've spent several hours speaking with members of this community regarding issues related to Sharon Hospital.

We sat down one-on-one with individuals to discuss this transaction and our expectations for a new Sharon Hospital under Health Quest ownership.

We held a well-attended community forum right here in this very room, where Mr. Friedberg and Mr. Browder spent several hours answering questions and addressing concerns about the future of Sharon Hospital.

We hope that our presentation today will give OHCA and those present even more insight into a transaction that we believe presents great opportunities for our community hospital.

I'm personally excited to move forward with Sharon Hospital under Health Quest ownership, and, in my recent dealings with Health Quest, I'm assured of their commitment to this community and to our hospital.

With that, I'd like to introduce Mike

Browder, Executive Vice President and CFO of RCCH, for his remarks. Thank you.

MR. BROWDER: Thank you, Peter. I'm Mike Browder, Executive Vice President and Chief Financial Officer of RCCH HealthCare Partners, the successor and the parent company of Essent Healthcare.

I'd like to refer to and adopt my pre-filed testimony.

Thanks to the OHCA staff for their review of the CON and its thoughtful consideration of a new path for Sharon Hospital. I'm greatly appreciative for that on behalf of my company and personally.

I would like to reiterate something that Peter said. I'm in a unique position today, I think, in this process, in that I was CFO of Essent Healthcare in 2002, and our company then acquired Sharon, making it the second hospital to join the company of the first for-profit hospital in Connecticut, so, if you'll allow me, I'll be a bit of a historian here as we get to what led us to today.

As Peter said, Essent made many commitments to the Sharon community, and I believe we've delivered on all of them.

Among other things, we brought in

professional, experienced hospital leadership. Those of you, who may have been involved or around in 2002, remember just how broken operationally the hospital was. Stacks of bills taller than I am were stacked around the business office, where patients were not being billed and collections were not being made.

We stabilized and repaired all the broken operations. We completed a 16-and-a-half-million-dollar renovation to three of the most important areas of the facility that Peter alluded to; Obstetrics, ER and Imaging, particularly the MRI.

We're also very proud of things that are not often enough discussed, and that is improvements that were made over the years in patient safety and patient satisfaction.

I've actually been personally invited on more than one occasion, of course, I've never had the opportunity to do it, but to represent Sharon Hospital on a national discussion on how positive our ED and our outpatient services are viewed at Sharon Hospital as one of the top-performing community hospitals in the country.

While making these investments, the company and Sharon Hospital grew together and prospered. We were able to achieve a consolidated operating margin

of seven percent, which I think, as some of the earlier folks have commented on, placed us in the very, very upper tier of Connecticut hospitals for several years, not necessarily on an absolute dollar basis, but, certainly, on a relative basis, and I want to point out this was as recent as 2011.

The reason I wanted to emphasize that is that this performance, frankly, which was just a couple of years ago, five years ago, is quite comparable to projections in the future that Health Quest made in its section of the CON.

As an old baseball coach of mine said, if you demonstrate a skill, you own it. That was his way of saying you better do it again, and, in that regard, I believe Health Quest's views of the future make perfect sense to me, in that we have demonstrated that Sharon can do it. In 2013, we had over 3,000 inpatient discharges, as well.

So let me talk a little bit about why things worked so well from 2002 for many years and what's changed over the past five or so.

Our original idea, as a company back in 2002, was to own and operate standalone community hospitals, standalone community hospitals.

It's what I and my colleagues at Essent Healthcare had done our entire careers. It worked for us as a company and for community hospitals by virtue of making it part of a larger family.

You heard some references earlier to economies of scale. We provide management expertise, economies of scale in purchasing ITs, supplies, services, etcetera, as part of a larger group.

Certain processes are lifted off of local management shoulders, like capital structure matters, insurance procurement, legal and audit and those sorts of things.

However, over the years, a number of key changes began occurring in the hospital's base. Hospitals are squarely in the sights of public policy at both the federal and state level today.

In order to balance budgets, hospital payments have been cut directly by reductions in what we were formerly paid for the same service, but, also, indirectly by rule interpretations and changes to arrangements for things like readmissions within 30 days, observation encounters, etcetera, so what worked in the past doesn't necessarily work today.

In Connecticut, on payments, specifically,

a provider tax is introduced by the State, and this hospital and this community are net losers, in that we pay into the pool a lot more than we get back.

Also, it's less material, but, locally, we've experienced a slight shift toward private pay and away from insured service demand, which increases bad debts or other patient bill write-offs, but, mostly, we have entered a new era of hospital physician dynamics.

When I started my career, the way it typically worked was we went into a community, we acquired a poorly-performing standalone community hospital. We recruited physicians to meet demonstrated need in the community.

The physicians came into the community. They setup their own practice. They were their own entity. They ran things their way, and they used the hospital.

When they did that back in the old days, if I may, they were Marcus Welbys. They took call coverage 24/7, darn near 365 days a year. All that has changed over the last generation or so.

Today, physicians that are newly-trained and might be recruited to a community like Sharon would otherwise come, but they have no intention of coming and

setting up their own shop. They want to be employed. Those dynamics are very difficult, very expensive for the hospital. In this state, of course, with the corporate practice of medicine, there are other dynamics that play there, but here's where our experiences and our company operating basis was ultimately challenged.

In communities, like Sharon, where only one or two of a specialty or subspecialty can be supported, if the physicians are no longer going to practice on their own, they want to be affiliated with the hospital, you have a dynamic, where it's very, very difficult for us to recruit those folks to this community when there's only going to be one or two physicians to take that call.

It's not how physicians think and are trained these days. More experienced physicians, perhaps, but even those guys and gals are to the point where they want to think about a different way to practice medicine.

So the company has pivoted toward larger communities, larger populations, larger opportunities, if you will, to partner with our medical staff and recruit medical staff, especially for the specialties and subspecialists, in instances where five, six, seven,

eight man or eight person practices are supported by the population in the community.

And what's really important is, as I went through the cuts in payments and things like that, what I was saying to you is, and I think the first presenter, the Sharon Selectman, used a very important phrase, he talked about economies of scale, and I think we get that by virtue of being part of a large corporation, but he used the phrase sharing of resources.

That's something that we can't bring to this community, because we don't have any other services that are geographically proximate, and it's just too expensive for us to continue to try to recruit physicians in, if they would come, with a smaller population base.

So the sharing of resources, the geographic proximity with Health Quest is the absolute thing that we need to think about as we think about how the hospital turns around from where it is today.

We can, as a company, and are weathering many of the same issues in some of our other communities, but for this physician dynamic.

And since, obviously, we can't change the populations of the underlying advantages in many regards that exist in the Northwest corner of Connecticut, we

began looking for a way to sell the hospital or otherwise save the hospital by solving physician coverage issues.

The prudent thing, then, was for us to explore all strategic outcomes or options for the hospital. I'd like to point out that I've worked in hospitals or for health systems for the vast majority of the past 33 years. I've been responsible for operating approximately 55 hospitals nationwide, and I was actually involved in acquiring most of those 55 before running them.

On the other hand, I've only been involved in exiting a handful of communities over the same time. This is not only a business, but, also, very personal for those of us that would like to get into a business, even if you're not a clinician, as I'm not, when healing is paramount to what we do.

And, so, it's very personal when we decide to sell a hospital or otherwise leave a community. This is a people business, a relationship business with our staff, our physicians in the community, employers, elected officials, everyone in the community, the folks, who have stood up today.

Harder still, though, is a decision to significantly curtail services or to close a hospital

that is an important part of a community like Sharon.

I thought it was interesting that several of the commenters today referenced the potential close of the hospital. That's not something that we've ever had a discussion outside the four walls of our offices in Nashville, Tennessee, but, as much as I hate to say it, I think everyone here understands that those would be alternatives that we would have to consider, had we not found a much better solution; to sell the hospital to Health Quest.

We spent two years exploring options for a new strategic partner for Sharon. We looked at other for-profit systems, some that were rumored to be coming into the state and others that were in the state in some way, shape, or form, but, frankly, they have the same issues that we have today.

So, ultimately, we decided that Health Quest is the best fit for Sharon, in terms of the geographic proximity, the sharing of resources that Robert will talk a little bit about.

They have deep investments in the region, and, frankly, they are someone that shares our vision, and, this is important, they are someone with whom we can get a deal done.

We're highly confident that Health Quest will be able to provide Sharon Hospital with the support and resources necessary to restore this community hospital to a prosperous position that we enjoyed just a few short years ago.

I'll be available to answer any questions you may have. Thanks again for your time and consideration of our CON request. That concludes my remarks.

And now I'd like to introduce Robert Friedberg, President and CEO of Health Quest, to tell OHCA more about Health Quest and its plans for health services in Sharon.

HEARING OFFICER HANSTED: Thank you.

MR. FRIEDBERG: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. FRIEDBERG: Please allow myself to introduce myself. Robert Friedberg, President and CEO of Health Quest, and I adopt my pre-filed testimony.

In my comments today, I really do want to respond to a couple of things that you pointed out that the Board is looking to be able to answer in regards to the need in the community, increasing quality and services for the community and, certainly, the financial

viability of both the Sharon Hospital, itself, and the financial viability of the Health Quest system.

I do want to thank everybody here for giving their time to hear us and process this CON application with the State of Connecticut, and I have to say that there's been -- there certainly has been a lot of great testimony that was given by residents in the community about their feelings about how Sharon has become such an integral part of what goes on in this section of Connecticut, and I think it does speak directly to the need in this community.

This community does need to have access to high-quality healthcare. The distances between this community and other facilities gets to be substantial, and anybody, who has lived in this community for any time, understands that there are conditions on the weather that create even more hardships in being able to access healthcare should the Sharon Hospital not exist.

So let me give you a little bit of a background, then, about Health Quest. So Health Quest is a not-for-profit health system, located in LaGrangeville, New York. Overall, it is about a $1 billion system, and that gives you just a little bit of scale about what the size of the health system is.

It's bigger than most health systems in the region, smaller than a lot of the mega systems either in Yale-New Haven or down in New York City. We comprise three hospitals right now, which is Northern Dutchess Hospital, Vassar Brothers Medical Center and Putnam Hospital Center down in Carmel, New York.

When we were looking at Sharon Hospital, and this project has been going on for quite some time, when we were looking at Sharon Hospital as a possible acquisition to come into the family, we noticed a couple of things that made it stand out to us.

First, I would say that it was already in our service area. We considered the Sharon region and the people in Sharon to be part of the Health Quest service area as a whole, and when we look at where patients were coming into Vassar, coming into Northern, we were able to determine that a lot of them were coming from the very eastern parts of New York, the Eastern Dutchess County, and, also, the Northwestern section of Connecticut.

So when we looked at it, it seemed to be a natural fit, and I would tell you that, when people described this as, you know, looking at Sharon Hospital as part of the Health Quest system and, you know, looking

it as an individual component, I think it does a disservice to what we are trying to bring to this community.

We are trying to bring a solution that allows Sharon to be part of the fabric of a large system, and what that means is that I do not, as the President and CEO of Health Quest, I am not looking at Sharon Hospital in isolation.

I'm looking at Sharon Hospital as a very distinct part of a larger health system and how it fits into that health system and the ability for us to be able to provide services to this community, and that's one of the access points.

And there's a lot of conversation that goes on about how Sharon would fit in, about whether or not this would be something that would be viable. I will tell you that, once it's in the health system, it's just part of the fabric.

Being able to disconnect from that becomes very, very complicated and very difficult and not in concert with the philosophy that we have about how we run our health system.

We run the health system as one integrated program, just like you would look at an individual

hospital and saying one individual part of the hospital may be more profitable or less profitable than the other, but it doesn't work unless the entire thing is in existence.

So when we look at the context of Sharon Hospital and how it fits into the health system, we consider it to be one of those essential elements for this community and for the health system to be able to provide services to the broader geographic region that we serve.

So this venture, this little road that we've been on for about two years now to bring Sharon in, we think, again, it's one of those things that allows patients and the area to get the tertiary care, the academic care, the clinical care that they deserve, and one of the things to point out about how we think about this is, and maybe different than other health systems in the country when they acquire a small hospital and look at a way for just being able to, you know, kind of suck those patients over into the mother ship, we look at this as a way to be able to solve problems for the health system as a whole.

And when I say that, the principal thing that we are interested in doing and the corollary I think

is going to be Northern Dutchess Hospital, the comparison, is to be able to put more resources into the community, so that patients don't have to move. They do not have to go and seek care 40 miles away. Whether or not they're going to Connecticut hospitals, other Connecticut hospitals, or whether they're going to New York hospitals, our role and responsibilities as being the provider of healthcare and the mission that we want to follow is that people should be able to receive exceptional care close to where they live and work.

Secondarily, we want to be able to have the ability to decant. On the New York side, we are extraordinarily busy. Vassar Brothers Medical Center is rather full most days, as is Northern Dutchess Hospital, and we're seeing that, if there's the opportunity to put more resources into Sharon Hospital, more technology, more capabilities, more doctors, then we have the ability to shift volume from the New York side to the Connecticut side and allowing us to look at how we would, then, decant a little bit of the volume on the Vassar and Northern.

So when we get to the discussion a little bit later about economics, we'll have the discussion about what we think we'll be able to do with Sharon

Hospital and the economics of Sharon Hospital, but understand some of that is in the context of being able to have a broader discussion about how we look at the economics of the entire health system.

And I understand, because we are going, you know, kind of across states and we're looking at different things, that we might get focused on the economics in the individual hospital, of Sharon Hospital as an individual hospital, but I have to look at the economics of the health system and how Sharon fits into that and allows us to be viable and continue to be a very thriving health system with the addition of Sharon Hospital into the network.

So our plans are really very simple. We believe that there is opportunities to bring more physicians into the community. We believe that, if we use the power of our large physician group with Health Quest medical practice, which is about 300-and-something providers at the current moment, and we use that resource to be able to recruit and retain and bring doctors to the community, it's going to fill a need, and the need is that there are people in this community, when they're looking for healthcare, their either going to Sharon Hospital now and having to be transferred out for

definitive care, or they recognize that the care doesn't exist in their community and they have to leave anyway, and that doesn't serve anybody any good.

So as we look to bring more doctors in, we believe that that's going to create an environment, where more patients are going to be able to be taken care of at Sharon Hospital, and if they do arrive at the emergency department at Sharon Hospital, they'll be able to be admitted to the hospital with confidence that the physicians and the clinical staff are there to be able to take care of those patients in a very capable manner; safely, effectively and with great outcomes.

Consistent with our mission and vision, we look at how we're going to pursue increasing our quality, and our mantra is very simple. If we can measure it, if we can look at it, if we can understand how we rate, we should be able to perform better than 90 percent of the hospitals in the United States. Top decile performance in everything we do.

And our quality dashboards, our quality statistics, everything that we look at is to move the organizations that are part of our health system towards that concept of top decile performance.

Anything short of that we are not done

with our work, so we will bring a different focus to Sharon Hospital. We will bring this idea that we are going to be relentless in our pursuit of quality, we are going to be relentless in our pursuit of performance and effectiveness, we are going to be relentless in our pursuit of great outcomes.

We're also going to have to do some things that are let's say either capital-intensive or operational-intensive.

One of the advantages that we'll be able to bring to Sharon Hospital is our electronic medical record. This is a shared platform across all of our health system, all of our hospitals.

Patients that do receive care within our health system, they're registered into the system. That patient has one record that goes across the entire health system.

Now most places are like that. Most health systems that's the advantage, that you have an integrated medical record that covers all of your campuses, but what makes it nice when you have a regional area, which you've got a contiguous geographic area, patients that do go to Sharon Hospital and need definitive care that are at a higher level, at a tertiary

level, for example, at Vassar Brothers Medical Center, the instant that the medical record is recorded in Sharon it is immediately available to practitioners at Vassar, so care can be coordinated, care can be started, care can be arranged while that patient is in transit, and that creates a great advantage for patients, who are being able to now get definitive care, knowing that that medical record information is already being reviewed by practitioners.

It's already being viewed by the doctors and nurses that will take care of that patient when they arrive at the Vassar campus, and I think that's a distinct advantage versus being transferred to another facility, in which the electronic medical record now has to be printed, copied, sent, etcetera, etcetera, and then has to be reviewed only upon arrival.

We do also expect to do a lot of expansion and investments in different services, and I'll start, again, with this idea that we're going to be looking at how we're going to employ more doctors into the market.

We've already started the recruitment efforts in preparation for taking on the responsibility for Sharon Hospital.

We expect to bring more cardiology

services to the campus. We expect to restore oncology services to the campus. We expect to be doing more in orthopedics, more in podiatry, more in pain management, more in -- I said orthopedics already. GYN, OBGYN and in GI services.

All of those are in our plans that we've submitted to you about what we think we can bring to the campus, and that's going to translate to more patients being able to get the care at Sharon Hospital, and, so, again, I tie that back to the financial viability of Sharon Hospital and the financial viability of the healthcare system. That's an advantage.

It allows services to be brought locally, and allows people to have their care locally, but also creates a venue in which we are able to add more patients to the Sharon campus and be able to take advantage, as Sharon is very much a fixed cost chassis right now, all right?

The most we can do and the best thing that we can do for the financial side of Sharon Hospital is to add volume and to get it up past its core competency number, its core staffing levels.

So we expect that the innovations that we'll do, whether or not it's upgrades to the Intensive

Care Unit, bringing in telemetry, bringing in AICU capabilities, all the things that we are able to do for the rest of the hospitals in our system, and when we bring those things to Sharon, we expect that that's going to change the environment of Sharon, again, with this idea of being able to make sure that the patients in the community get the type of services that they want and they need.

Our relationship with the Foundation for Community Health really is what made this thing possible. Taking on Sharon Hospital, it is a large project for us. It is an important project for us, but we needed partnerships. We needed to be able to have and know that the community was in on this, that they have skin in the game, that there was a reason for us to come into Connecticut and be a partner of Sharon Hospital.

And our conversations with the Foundation for Community Health led us to believe that we would have great partners in the Connecticut market, and if it wasn't for the fact that the Foundation for Community Health was coming with not only their intellect, their understanding of the community, but, also, with some of the financial resources, this would not be happening, and, very bluntly, we would not be at this table, because

we would not have gone and pursued Sharon Hospital without having the financial support and the intellectual support from the Foundation.

And, lastly, I'll just talk briefly about the financials of Health Quest and the financials of Sharon Hospital, and I would say that most of the health systems in I would say New York and Connecticut we're in the top 10 percent of operating performance.

Last year's operating performance was $68 million of operating income for the health system, $131 million of EBITDA, and a margin of 6.8 percent operating income and then 13-something percent margin in EBITDA, and this is sustained.

We continue to do this year-after-year, and that gives us the ability to be able to take on the responsibility for Sharon Hospital.

We do expect we will improve the operational performance and financial performance of Sharon Hospital. That will take a little time, and I will tell you that we stand by the numbers that are in our CON application.

We believe that that is where we should be going, and we don't see reasons why we can't get there. Having said that, the market is dynamic. There are a lot

of things that are going on in healthcare that are going to have changes that are both positive and negative. There are a lot of changes that are going on in Washington, D.C. that have unknowns for us all, and they will have an effect, both positive and negative, to the operations of Sharon Hospital, but there is a strength to the Health Quest system.

There is a strength that allows us to look at the future and be very bullish, that we can either weather any storms that may be coming, or that we can take advantage of our strength in being able to leverage the market and being able to get better pricing, be able to look at how we're going to get our supply cost down, our pharmaceutical cost down, how we are going to be able to have our systems leverage our capabilities to be able to work efficiently that are sufficient enough for us to be able to continue to operate the health system now with Sharon in it at the same performance level that we've been operating for the last years.

This is a long-term commitment for us. We are not looking to try and understand how we will bring Sharon in for a period of time and then try and understand what the possible exit strategies are for Sharon Hospital. We don't have an exit strategy.

They will be part of our health system, just like Northern Dutchess is, just like Putnam is, just like Vassar is, just like our physician practice is. They will be part of what we do and who we are.

With that, I'll turn it over to Nancy, who is going to talk on behalf of the Foundation for Community Health.

MS. HEATON: Good afternoon. I'm Nancy Heaton, the CEO of the Foundation for Community Health, and I adopt my pre-filed testimony.

I want to thank OHCA for this opportunity to speak in support of the Certificate of Need application for the acquisition of Sharon Hospital by Health Quest and the result and return of the hospital to a not-for-profit status.

I'd like to speak briefly about the Foundation for Community Health, who we are, how we became involved in this transaction and what our role will be with Sharon Hospital moving forward.

So, first, who are we? The Foundation for Community Health, which was originally known as the Sharon Area Community Health Foundation, was established to receive the proceeds of the sale of Sharon Hospital to Essent Healthcare, as well as the restricted and non-

restricted funds and income of the former non-profit hospital.

Our mission is to improve and maintain the health and mental health of the residents in our service area, especially those who are most vulnerable.

Our service area, as you might imagine, matches the traditional service area of Sharon Hospital, covering Eastern Dutchess, Southeastern, Columbia County and the Northwest corner of Connecticut.

FCH is a public charity by its role as a supporting organization under the IRS code. We currently support our three local community foundations; the Berkshire County Community Foundation, the Community Foundation of the Hudson Valley and Northwest Connecticut Community Foundation.

So how did we become involved in this transaction? Well, basically, Roberta Willis, who is sitting right here, introduced us to the Health Quest team.

It was pretty common knowledge at the time, or at least anecdotal stories, that Sharon Hospital was not doing very well financially, and, so, at the Foundation, we were very interested in learning more about Health Quest’s interest in the hospital, as, you

know, we had had the right of first refusal to purchase the hospital for so many years. We were no longer obligated to do that, but it was within our mission to make sure that services were maintained or improved in the community.

It took some time. We met many times, several meetings, conversations with the Health Quest team, and, before we came to the understanding that, if we work together on this endeavor, that we could not only return the hospital back to the community asset that it used to be, but that, as partners, we could better ensure its success.

So using Health Quest's expertise and hospital operations and FCH's expertise regarding the community, its needs, services and knowing the opportunities that exist, it seemed clear to our Board that working together and once we all agreed that partnering would result in a much more likely success for the hospital.

So the Board and staff at FCH also realized that this was probably one of the greatest opportunities that FCH would probably have to positively impact access to healthcare in the Greater Sharon Hospital community, but this investment, we believe,

seeks to bring financial stability and a seamless connection to the resources of a larger system, something which we know in the current healthcare environment is needed, and, Mike, you spoke about this, to keep a small community hospital alive and vibrant.

So FCH conducted an extensive due diligence process regarding Health Quest. We formed a committee of both healthcare and financial expertise. We were fortunate enough to have it on our Board. Together, the committee reviewed years of quality metrics from the other three hospitals, financial records from the other three hospitals.

We met and spoke with clinical, administrative and Board members from the other hospitals, and we met numerous times with the Health Quest management team to discuss why were they interested in Sharon Hospital and what ideas they had regarding its place in their system now and moving forward.

The FCH Board took its obligation to abide by our mission and our fiduciary responsibilities we take these very seriously, but, rest assured, we would not be providing up to $9 million in these two grants to Health Quest if we were not certain of the company’s long-term commitment to Sharon Hospital and its community.

The grants to Health Quest by the Board of FCH, which took over 18 months to finalize in the agreement, are a reflection of our mutual desire to partner on this project.

A primary factor in our decision to partner with Health Quest was that they approached this agreement like us, as a partnership, so they agreed to participate or to put up funds, take the risk of investing into this hospital.

For every fund that we put in, they put in funds, so while we were putting up funds for the purchase, they were also putting up funds for the purchase, and FCH in the agreement will also reimburse Health Quest up to 50 percent for every dollar invested in the hospital up to the $6 million over the next few years.

Those investments will need to be reconciled on an annual basis. It’s our charge to make sure that those investments are in Sharon Hospital, not in necessarily the system or going to Vassar, so it is our responsibility to continue to monitor that going forward.

Lastly, what will our role with Sharon Hospital be going forward? So, first, there’s

governance. FCH, as you already know, has the right to nominate 12 of 15 members of the initial and second class of the Sharon Hospital Board, covering a span of at least six years, including the Chair and Vice Chair position.

This is significant, as the Chair of the Sharon Hospital Board will also sit on the Health Quest system wide Board, and the Vice Chair is expected to follow into the Chairmanship and then have a seat on the Health Quest System Board.

We hope and expect to instill in this Board that -- a culture in this Board of being tied to our community, to be active in assessing local needs, and to continue to think of FCH as a partner in addressing these needs. This is something that has not happened for many years.

We have identified an incredible slate of nominees representing diverse interests and backgrounds and residing throughout the Sharon Hospital service area.

Our bylaws require that we reside in the area, and, so, we follow the same rules in looking for the Sharon Hospital Board.

We have presented these nominees to Health Quest for consideration and expect the Board to be up and running on day one of the new hospital.

Once their second terms expire, we are confident that the Sharon Hospital Board will continue to have significant local membership, as evidenced by the history of the other hospital Boards in the HQ system, whom we have spoken with.

In regards to future investments in infrastructure and services, I've already mentioned the $6 million dollars available in this grant, and, in my written testimony, you'll find a summary of many safeguards written into the grant agreement to protect FCH's investment in the new Sharon Hospital.

Some of these include the requirement of a match, which I've already mentioned, that our obligation to fund this investment is actually only for four years, so if Health Quest chose not to invest, they would not have access to those funds, so the idea is to help and encourage these capital commitments to be as expeditious as possible, and that FCH will be reimbursed for funds given to HQ in the event that Sharon Hospital is sold, closes, or loses its tax-exempt status within the first five years of HQ ownership.

As for future requests from HQ, I'm confident that the staff and Board of FCH will use the same set of parameters and conduct the same due diligence

process it has on this grant, as it has on all of its grants, and will make its decision accordingly.

Lastly, Health Quest has made a commitment to ensure that this large investment does not impact FCH's grant making budget ability to fulfill its mission over the next 10 years.

Health Quest has agreed to fund new and ongoing community programs funded by FCH, or, if appropriate, to provide these services itself.

I am pleased to offer FCH's support for the sale of Sharon Hospital to Health Quest. I am happy to answer any questions you have about our role in this transaction and with the hospital going forward.

Thank you, again, for allowing me to speak. Thank you.

MS. FUSCO: That concludes our presentation in Docket No. 16-32132. We have some brief remarks in 16-32133.

HEARING OFFICER HANSTED: Why don't you just --

MS. FUSCO: -- move forward?

HEARING OFFICER HANSTED: Do you know how long that will be exactly?

MS. FUSCO: Not long. Five to 10 minutes.

HEARING OFFICER HANSTED: Okay, let's go forward.

MS. FUSCO: It's shorter.

MR. CORDEAU: Hello, again. My name is still Peter Cordeau, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MR. CORDEAU: I would like to introduce Dr. Glenn Loomis, Chief Medical Operation Officer of Health Quest and the President of Health Quest Medical Practice that I'll refer to as HQMP.

I'd like to thank OHCA for the opportunity to speak in support of the CON to transfer RHA to a newly-formed non-profit Connecticut Medical Foundation, which will be a subsidiary of Vassar Health Connecticut, the new proposed hospital operating entity.

RHA is a private physician practice that is managed by Sharon Hospital, pursuant to a professional services agreement.

With this transaction, RHA will be brought together under common ownership of the hospital. This will result in a coordinated delivery of physician services in the Sharon Hospital area, access to HQMP's practice management resources and the infusion of capital into RHA that supports such projects as EMR upgrades,

facility renovations to support expanded primary care and specialty services.

By way of background, RHA is a multi-specialty physician practice, with offices in Sharon, Kent and New Milford, Connecticut. Services include primary care, general surgery, orthopedics, hospitalist medicine, OBGYN and urology.

RHA serves more than 15,000 patients in a service area that extends to Northwestern Connecticut and the mid-Hudson Valley Region of New York.

Sharon provides administrative services to RHA, including their recruitment and training of senior management, billing operations, staff recruitment and training, accounting, supply procurement, payroll, human resources, IT, marketing and other general business functions.

This transaction also involves the acquisition of Tri State Women’s Services, which is a local OBGYN practice that is also party to a professional services agreement with Sharon Hospital.

Tri State does not qualify as a large group practice under the OHCA statutes and, therefore, is not part of this CON, however, all of the benefits that we will discuss regarding RHA will be equally applicable

to Tri State.

RHA will be acquired by the newly-formed Connecticut Medical Foundation and will work closely with HQMP, the affiliated physician practice of the Health Quest system.

Dr. Loomis will provide OHCA with more information on HQMP, but, in short, there are nearly 300 providers covering 25 specialties at 20 office locations.

Their administrative resources, most notably physician recruitment, and staffing resources will be a tremendous benefit to the Medical Foundation as it works to expand physician services in Sharon.

As you've heard in testimony earlier today, Sharon's inability to recruit and retain physicians under the RCCH system, along with the increased costs associated with physician staffing within the dynamics of Sharon, had led to the need to terminate services.

This includes the closure of our sleep center in 2015, which closed after our Medical Director relocated out of state, and the closure of Smilow Cancer Center in Sharon after the physicians, who staffed our location, retired.

We're losing patients, because we cannot

offer them the specialty services that they need locally. RHA has seen a significant decline in volume over the years, some 27 percent, as a result of the loss of providers in specialties, including cardiology, pain management, OBGYN, primary care and pediatrics.

We do not have the resources or local network required to staff the physician services that are needed in Sharon. Health Quest does, ready to deploy, which makes their acquisition of the physician practices that we currently manage a logical extension of the acquisition of the hospital.

As I mentioned, Dr. Loomis will provide you with additional background on HQMP and discuss Health Quest's plans for improving the quality and accessibility of physician services in the Sharon community.

I now turn this over to Dr. Loomis. Thank you, again.

DR. LOOMIS: Hi. I'm Glenn Loomis, and I'm the Chief Medical Operations Officer for Health Quest and the President of HQMP. I'd like to adopt my pre-filed testimony.

First of all, I'd like to thank you all for sitting here and spending time with us, we really appreciate, as we review the CON for transfer of RHA and

Tri State Women's Services to the non-profit Connecticut Medical Foundation that will be operated by Health Quest.

I'm really here to talk about the enhancement of physician services. As you heard Mr. Friedberg say, that's a huge part of what we're doing, and I want to tell you a little bit about us and how we can help make that happen.

HQMP is a multi-specialty physician practice that has been operated since 2008 on the New York side of the border.

We have nearly 300 providers, about 25 specialties, 20 office locations, and we did over a quarter million office visits last year.

We have significant overlap with Sharon, in terms of service area. We have practices in Millbrook, etcetera.

In terms of our operation of the Connecticut Medical Foundation, why does this really make sense for Sharon Hospital?

I really want to focus on a couple of things. One is our infrastructure. So HQMP will work hand-in-hand with the Connecticut Medical Foundation to provide back office support and other things, in order to make the Foundation successful.

Initially, recruitment will really be our focus, as well as putting in our EMR and some of those other back office services. The recruitment we're talking about is really primary care, oncology, orthopedics, cardiology, endocrinology, general surgery and OBGYN.

And I want to incorporate some comments that I heard from one of the speakers earlier, asking that we focus on infection control, Lyme Disease and endocrinology, and I just wanted to point out a couple of things.

Number one, we actually just recruited a new infectious disease physician in to HQMP that will be part of what we do, who is an epidemiologist, and half of her time is going to be spent working on epidemiology for our hospitals, because I also oversee all the quality for the hospitals for our system.

In terms of Lyme Disease, we have a large infectious disease group. They have a huge Lyme Disease practice, and it's something that we can also bring to bear in the area.

In terms of endocrinology, we have a growing endocrinology group. We've just added three new endocrinologists on the New York side of the border, and

we very much intend to bring endocrinology services here, as well as diabetes educators.

We are really focusing on a diabetes center type model in all of our practices, and we hope to bring that to the Connecticut area, so, hopefully, that will answer some of the concern that was available earlier.

We really are here to help keep more patients local, especially oncology, cardiology, orthopedics, GYN. I mean those are things we're very much focused on.

You might ask, well, we've had trouble recruiting to the area, why do you think you can do that? So, first of all, we have a number of existing HQMP docs, who are looking, and we will bring those specialty practices over here on a part-time basis fairly immediately, and, so, we are already planning that. We have those plans well ready to be executed as soon as this merger goes through.

The second thing is new and younger docs really want to practice as part of a large group practice. They really don't want to go into private practice anymore, and, so, having them join our large group practice or be associated with our large group

practice is a really important part of what we bring to the table and different than what RHA has been able to bring in the past.

And, finally, we have a really proven record at recruiting physicians. Last year, we recruited 47 physicians, 13 primary care docs, 34 specialists, and that included to rural areas, to Northern Dutchess, to out actually into the Catskills to very small practices.

There's a couple of other things that we bring that's a benefit. We will bring a patient-centered medical home structure to all the primary care practices, so there really would be ability for each of the practices to do much more, in terms of focused patient management, in terms of a patient-centered medical home.

The other thing is we really work to have physician leadership of our practice. We are not in any way an administrator-dominated practice. We are very much a dyad structure, and that really means we operate with a physician and an administrator at all levels, where the physicians really look at being the leader of the practice, in terms of quality and those type of things, and our administrators really are there to make the trains run on time, if you will.

And, so, when we work together like that,

we feel like we provide a much greater -- a great place for physicians to practice. They really feel like it's their practice and that's important.

Other ways we're going to -- HQMP will work with the Connecticut Medical Foundation is in terms of quality, credentialing, finance, etcetera. We have all of those things. We worked very hard to make those all top decile-type performing operations, and we look forward to enhancing access in this region, the quality of care, the numbers of physicians here at Sharon Hospital that are going to be critical to revitalizing this hospital and bringing it to the levels that you've heard about from everybody who has spoken before me.

I'll be available to answer any questions they have. Thank you very much.

HEARING OFFICER HANSTED: Thank you.

MS. FUSCO: That concludes our presentations.

HEARING OFFICER HANSTED: Okay. Mr. Germack, before we get to your presentation, we're going to take a 10-minute break.

(Off the record)

HEARING OFFICER HANSTED: Okay. We're back on the record. Mr. Germack, you can step forward.

MR. GERMACK: Do you want me to sit here?

HEARING OFFICER HANSTED: You may. And the microphone is right there.

MR. GERMACK: Should I use this one?

HEARING OFFICER HANSTED: No, that's not amplifying. It's just recording. That's the one you want. And just a reminder to please adopt your pre-filed testimony for the record.

MR. GERMACK: Good afternoon, Hearing Officer Hansted and members of the OHCA staff. I've submitted my pre-filed testimony. I'd like to adopt that, please.

HEARING OFFICER HANSTED: Thank you.

MR. GERMACK: My name is Victor Germack, and I'm the Vice President of the Community Association to Save Sharon Hospital, which was formed some 17 years ago to prevent the sale of Sharon Hospital to Essent Healthcare.

Sixteen years ago, I testified as the Vice President of the Association at the original CON hearing in Sharon, Connecticut before Attorney General Blumenthal and the Office of Health Care Access concerning the sale of Sharon to Essent, and we think that we were partially responsible for getting some of the stipulations adopted

by Attorney General Blumenthal and OHCA pertaining to cross-corporate borrowing guarantees and the right of first refusal.

Since then, Sharon Hospital has had three corporate notices, its services have deteriorated, patient volume has declined and it is unprofitable.

My testimony today is even more important than it was 16 years ago, as Sharon Hospital today only has one more chance for it to become a viable entity, and we look to you to provide the guidance and the ruling that will set it on its course.

In general, we support non-profit hospitals as a better alternative than the for-profit model. On a preliminary basis, subject to our reservations, we support the planned sale of Sharon Hospital to Health Quest, provided certain additional information not provided in the CON is furnished and certain written assurances are obtained from Health Quest about the extent and amount of their financial commitment to Sharon Hospital.

We agree that the sale is important, it’s crucial, but we’d like to improve the deal. We’d like to improve the structure and I will explain how.

We seek specific changes to the existing

foundation grant agreement, dated September 13, 2016, between the Foundation, Health Quest and Berkshire Taconic Foundation, which will remedy certain shortcomings in the agreement.

We have outlined certain recommendations below that we hope the Office of Health Care Access will adopt, and we have also contacted the Attorney General, asking him to represent the public interest, which is embodied in the Foundation for Community Health, since they are providing the majority of the financing for the purchase, and not to do so would be an abrogation of the Attorney General’s constitutional duties.

We feel that the agreement, as it’s currently written, is not a good deal for the community, is one-sided, and is not fair for those, who have contributed to the Foundation.

We understand the sentiments of the people, who are for the transaction, and we appreciate all the time and effort they have put into it, but we feel it’s unfair and prejudicial to the public interest, to the interest of the Foundation contributors, and to those individuals in the community, who initially contributed to Sharon Hospital prior to its initial conversion in 2002 and, subsequently, from 2002 to the

present.

Those, who contributed to the Foundation between 2002 and the present, were contributing in the expectation and the knowledge that their contributions would be going to the stated purpose of helping fund worthwhile healthcare projects in our community, not that their funds would be committed to buy Sharon Hospital.

Now one of our major problems here is there is no binding commitment by Health Quest to continue to financially support Sharon Hospital for a specific period of time or for a specific amount.

As the financial and operating numbers in the CON show, Sharon Hospital has been in decline for a long period of time; losing quality doctors, cutting staff, poor management by three corporate owners. We probably have had five or six different CEOs at the hospital, perhaps more, over the past 15 or so years, leading to a decline of both in and outpatients.

Since it took such a long time for Sharon Hospital to decline, it will take a long period of time for former patients to return and new ones to approach the hospital. This takes time, staying power and money.

The business plan of financial projection, as set forth in the CON by Health Quest for Sharon

Hospital, are too aggressive and are just not believable.

I'm a businessman, and when I see a business plan submitted by someone potentially seeking funds, I will always look at it and say does it make sense? Is it realistic? Is it doable? We don't believe this plan is doable, in spite of the good will, the commitment, oral commitment by Mr. Friedberg and the rest of the hospital. We just don't feel it's doable.

Exhibit 1 shows Sharon Hospital, which I submitted in my testimony, returning to profitability in two short years, earning $5.2 million by 2018.

In their responses in the CON, they showed incremental growth projections, discharges increasing by 53 percent between 2016 and 2018. They show incremental operating revenue of 17 and a half million dollars in the two-year period and an operating profit margin for Sharon Hospital in 2018 of 6.9 percent on its projected revenue of $74.9 million.

As we had mentioned before, the best possible -- this was in '15, was Yale-New Haven, which reached a 4.5 percent operating margin. In fact, of the 17 hospital systems listed in 2015, just 10 systems showed profitable profit margins, and most did not exceed a one percent operating profit margin.

We would like to see realistic business and operating projections, and we would ask that you ask them to do that in your next round of questions.

What is also missing is a lack of the detailed explanation and the level of support how Health Quest will implement the Sharon Hospital turnaround and make their projected results happen.

So there is no contractual minimal level of financial support that’s set forth by Health Quest in the agreement or in the CON, nor is Health Quest bound to support Sharon Hospital for any minimal period of time.

The Foundation is committing $9 million to Sharon Hospital, which may never be recovered if the hospital fails under Health Quest’s ownership.

What this means in the meantime is the Foundation will have $9 million less to spend on worthy healthcare projects to our community.

In addition, there’s no contractual guarantee contained in the agreement that Health Quest won’t come back to the Foundation and ask for more financial support, so we are looking and we’re asking for financial and operating support for Sharon Hospital for a minimum period of 10 years and commit that they will not ask the Foundation for any additional financial support.

While Mr. Friedberg is talking about skin in the game, any commitments, we'd like to see that in writing.

We have noted in our review of the CON a number of inadequate or incomplete responses to the questions raised by the OHCA staff. I'll just mention a few in the interest of time.

They make a statement that's very puzzling to us. They say, quote, "Vassar Connecticut expects to maintain current services for a period of three years, subject to patient demand and the availability of physicians and other clinical providers and staff." What exactly does that guarantee to our community?

I haven't a clue. Perhaps you all do, and perhaps you should ask Mr. Friedberg and Health Quest exactly what it is they're providing.

We don't know how much working capital is needed to finance the operation at Sharon Hospital until real profitability is achieved. We don't have a business plan and financial projection that is believable and, therefore, no cash flow projection.

In response to a question asked by OHCA to explain 143 percent increase in inpatient discharges or outpatient visits to cover financial incremental expenses

between 2018 and 2019, the answer does not appear to be responsive and is somewhat confusing. We don't understand the answer. We have put it in our response to you, as well.

Another point. How does Health Quest charity or indigent care policy differ from that provided by Sharon Hospital? Will Sharon Hospital's charity care patients be better off or worse off under Health Quest's charity care program and by how much? There is no information in the CON to really detail that answer. We would ask that that be provided.

The CON also talks about capital improvements, costing at least 11 and a half million dollars. In our testimony submitted to you, we understand, upon information and belief, that Sharon Hospital pay for an energy efficiency and savings program energy audit that Trane conducted approximately two to three years ago.

It shows that Sharon Hospital is still burning grade 6 fuel oil, which is not permitted in New York and is terribly dirty, and they must convert the system and make a fuel change to burn cleaner fuel, which is absolutely essential.

We understand that this energy study

showed a complete change. Upgrading the 50-year-old boiler, the burners, etcetera, the tanks would cost approximately $5 million, but would generate savings of approximately 400,000-plus in annual utility savings. Will Health Quest -- are they prepared to make this expenditure?

Health Quest says that Sharon Hospital is projecting to add a total of 18 full-time positions through fiscal year 2020, all of which are non-physician positions. It also says it will add 48 additional full-time employees through 2020, so my question is how many primary care physicians and specialists will be added?

Will Health Quest provide a staffing spreadsheet by timing, specialty and location spelling out the above information?

Also, we'd like to see - it says here, in their response, that Regional Healthcare Associates hasn't filed tax returns in '14 or '15. We'd like to see those returns and understand why they weren't timely filed.

Talking about the Foundation, the Foundation currently has 25 million in assets, which includes the Essent Healthcare purchase price, endowment funds, funds raised since then and interest.

The grant agreement requires that the Foundation restrict $9 million of its funds or 36 percent of its total funds for this transaction. This will negatively and dramatically impact the Foundation's future annual grant making ability to the community, which it has successfully implemented over the past 15 years.

This nine million represents over 56 percent of the 16 million sale amount that the Foundation received from the sale of Sharon Hospital.

In fairness to the many contributors to Sharon Hospital pre-2002 and to the Foundation post-2002, we have urged the Attorney General and the Office of Health Care Access to mandate changes and make this a fairer deal to the community.

The purchase price, the Foundation is committing nine million, which becomes restricted funds, to Health Quest. It pays 60 percent of the Sharon Hospital acquisition purchase price; $3 million and $5 million total purchase price, and, out of the $6 million in investment, up to four years is being committed to Health Quest, which will be matched.

Since the Foundation is not the buyer of Sharon Hospital and is only helping Health Quest finance

the acquisition, why, then, does it have to put in 60 percent of the purchase price?

Skin in the game is a bit too much if you're not getting anything in return for it. We would like to see commitments on the part of Health Quest if they want this type of financial commitment made by the Foundation.

We would suggest that a more suitable purchase investment of only $1 to $2 million by the Foundation would be appropriate, given the limited stated representation that the Foundation will have on the Board of Trustees, the Health Quest Board of Trustees and its lack of ownership, carried interest, or governance role, as it currently stated.

Talking about the working capital grant, we have a problem with that, because it talks about supporting physician expenses.

These are normal operating costs. They should be providing enough working capital to support Sharon Hospital's ongoing operations. We think the grant language pertaining to the working capital grant should be changed to remove any reference to investments and/or paying for direct physician and provider costs.

If Sharon Hospital is sold to a third

party after the first five years of ownership by Health Quest, then the Foundation does not get its asset purchase grant and/or its capital grant return. This is unfair to the public interest and the Foundation.

We would suggest that it should be changed, so if Sharon Hospital is sold to a third party during the first 15 years of ownership by Health Quest, then the Foundation should get its asset purchase grant and working capital grant less all capital campaign funds raised to date by the Foundation returned to it.

Governance, the grant agreement provides that the Foundation can have up to 12 representatives, 80 percent of the total, of the 15 serve on the Sharon Board of Trustees, which is basically a local advisory group, as has been described by Mr. Friedberg.

There are basically three groups of trustees with different terms, but in no event is there a contractual right for the Foundation to have its representatives serve as trustees after the sixth year.

This is unfair, and we would suggest that it be changed, so that, after the sixth year, there will continue to be a majority of the trustees, who will be selected by the Foundation and not by the hospital Board and who will serve on the Sharon Hospital Board of

Trustees, as long as Sharon Hospital is owned by Health Quest and is part of their system.

Governance, the grant agreement states that the Chair of the Board of Trustees of the new Sharon Hospital shall serve ex officio on the Health Quest Board of Trustees.

As I understand ex officio, I would gather that means non-voting. I'd like that changed. In fact, there is not enough Board representation by the Foundation on the Health Quest Board of Trustees given the agreement's current requirement that the Foundation invest $9 million into new Sharon Hospital.

We would suggest that at least three members of the new Sharon Hospital Board of Trustees be named to the current 18-member Health Quest Board of Trustees and they be full voting members, as long as Sharon Hospital is owned by Health Quest.

Annual information reporting to the community, to serve and inform the community on its progress in improving Sharon Hospital, the grant agreement shall be modified to require that the Sharon Hospital Board of Trustees will issue a written annual report to the community no later than March 1st of the following year on the state of Sharon Hospital and what

it has accomplished.

We would also suggest that a monitor be appointed by either the Attorney General or OHCA for the first five years following the purchase of Sharon Hospital by Health Quest to ensure that the terms of the agreement are followed and there is an equitable accounting of the funds given by the Foundation to help Quest under the terms of the agreement and that the medical services that were committed to help buy Health Quest in the CON are supplied to new Sharon Hospital.

I will also make the point, in passing, that we have Health Quest, which is a major hospital institution, healthcare institution, with net assets of close to $500 million. Why do they need our $9 million?

We, at the Foundation, we all will support them in any way. Why do they need our $9 million? This is de minimis to an institution that says they have put $750 million into CAPEX in the last three years that has $450 million in net assets. I just don’t understand and the Foundation doesn’t understand it.

By the way, by way of background, I’m the President of Rate Financials, which was started in 2002. We write the financial reporting, accounting and governance practices of corporations, including

healthcare companies and hospitals.

I'm also the President of Heritage Capital, a middle market investment banking firm. I'm also the Treasurer and on the Board of the Osborne Association, a non-profit social service agency, which works in over 20 prisons in New York State.

The members of the Community Association to Save Sharon Hospital all live in the area served by Sharon Hospital, and, if Sharon Hospital ceased to exist, we would all be directly adversely affected, so, therefore, we have a meaningful stake in the outcome of these public hearings and what is decided.

I thank you very much for your time, for your consideration, and I ask that you carefully consider the changes we have proposed.

HEARING OFFICER HANSTED: Thank you, Mr. Germack.

(APPLAUSE)

HEARING OFFICER HANSTED: Counsel, do you have any Cross-Examination of Mr. Germack?

MS. FUSCO: No, we have no questions.

HEARING OFFICER HANSTED: Okay, thank you. And we're just going to take a brief five-minute break before we get to OHCA's questions. Please try to be back

here in five minutes, just so we can start again. Thank you.

(Off the record)

HEARING OFFICER HANSTED: If everyone can please take a seat, we're going to get started again. Okay, OHCA has some questions for the Applicant. Mr. Lazarus?

MR. LAZARUS: Good afternoon, good evening. With respect to the transfer of ownership of the hospital, it's important to OHCA that specific needs of a local community be met. It's also important to OHCA that needs identified in the Community Needs Health Assessment be reflected in the hospital's community building programs and community benefit activities.

So the following questions pertain to the Community Needs Health Assessment, as well as the community building program and the benefits, building activities.

It was stated in the CON application that once a proposal is finalized, Sharon Hospital is converted to a not-for-profit entity. The Applicants will perform a Community Health Needs Assessment in 2017.

Is Sharon Hospital currently taking any measures to address any needs that were identified in

FCH's 2014 health assessment?

HEARING OFFICER HANSTED: They just need a microphone, whoever has it.

COURT REPORTER: Please state your name for the record.

MR. CORDEAU: My name is Peter Cordeau, and I am the Chief Executive Officer of Sharon Hospital.

There were dental issues, I know, that were addressed in the Community Needs Health Assessment, which really had no relation with the hospital.

The biggest service that we've worked with with the Community Needs Health Assessment, in association with the Foundation, has been transportation, the ability to transport people to Sharon Hospital to work within the City of Northeast, Northeast Transit, in terms of Northeast Dutchess Transit, to get patients to Sharon Hospital to be able to see their physicians and appointments, because access to healthcare is important for us, and transportation is one of the number one issues in the community, in order to access the healthcare in the Sharon Hospital area.

I would say that's the number one, since I've been in this position, area that I've worked closely with the Foundation and the Town of Northeast to provide

to the hospital.

MR. LAZARUS: All right, thank you. Who will be the primary entity responsible for conducting the Community Needs Health Assessment in 2017?

MR. PING: I'm Dave Ping. Health Quest will be doing that analysis. We'll start with the work that the Foundation for Community Health has already done, just like we've done in Dutchess County and in Putnam County, where we work with existing Community Health Needs Assessments in Dutchess County in conjunction with the Dutchess County Department of Health and in Putnam County with the Putnam County Department of Health, and we use those as our starting point for our Community Needs Assessments, conducted a detailed assessment with them and came up with a plan.

MR. LAZARUS: Okay. Does Health Quest incorporate the CDC's 6/18 initiatives in its Community Needs Health Assessment implementation plans at their other hospitals?

MR. PING: So can you repeat, and what's the acronym that you used?

MR. LAZARUS: Does the healthcare, particularly, does Health Quest incorporate CDC's, Center for Diseases?

MR. PING: Yes, we do. We do.

MR. LAZARUS: Okay.

MS. KAILA RIGGOTT: And just as a follow-up to that, do the Applicants plan to incorporate those CDC 6/18 initiatives, if appropriate, in Sharon Hospital's Community Health Needs Assessment?

MR. PING: Absolutely.

MS. RIGGOTT: And, additionally, would there be any concerns with using DPH's Healthy Connecticut State Health Improvement Plan as a starting point for Sharon Hospital's CHMA?

MR. PING: We've done it in New York. New York also has a Healthier Communities Plan that New York State uses, and, so, we use that as our starting point there. I'm guessing it's similar in Connecticut, and we would do the same thing.

MS. RIGGOTT: Thank you.

MR. LAZARUS: How will the Applicants tie the Sharon Hospital Community Needs Health Assessment, the one in 2017, into the hospital's community benefits?

MR. PING: So we'll start by, again, reviewing the work that was done, reviewing what they said were needs in the community at the time, and reviewing if we need to make any adjustments in that,

and, again, just using that as our starting point, how can we continue to meet those needs or meet those needs better?

MR. LAZARUS: Is Sharon Hospital currently providing any type of community building program or community benefits, and, if so, can you provide some sort of examples of those type of programs?

MR. CORDEAU: So, in terms of charity care, so we provide somewhere in the neighborhood of 500-plus thousand dollars of charity care in the community. In terms of what we represent and donate to the Foundation is somewhere in the neighborhood of 40,000 to 50,000 to other community funds and issues to represent and support local non-profits within the Sharon primary and secondary service areas.

MR. LAZARUS: Can you discuss the impact of this proposal on Sharon Hospital's community benefit program and community building activities?

MR. CORDEAU: I'm not sure I understood that. Can you repeat that? Dave?

MR. PING: We believe that we can enhance those significantly. Again, when we look at our charity care policies, we'll, you know, continue those and expand those. Last year, we had about $40 million in charity

care that we had in the community.

We would also, you know, like we have at our hospitals in Dutchess County and Putnam County, continue to support other community organizations, non-government organizations, and we've worked, as an example, in Poughkeepsie with the farm project to provide a farmer's market on wheels that goes to underserved communities in areas of food insecurity in Poughkeepsie.

MR. LAZARUS: Thank you.

MS. RIGGOTT: I think you may have answered sort of my follow-up question, but perhaps you can elaborate a little bit.

I'm just trying to find out a little bit more of the level of community building and community benefits funding that's provided at Health Quest's other hospitals.

I know you just gave me an example of the farmer's market on wheels, so if you can elaborate a little bit on that maybe?

MR. PING: Sure. Again, I can talk about things that we're doing now in our communities.

MS. RIGGOTT: Yes. Right.

MR. PING: And, so, again, we support a number of different organizations; Family Services of

Dutchess County, which is a social services agency, helping victims of domestic abuse, and we also have what we call the Get Fit Hudson Valley, which is part of our fitness program, where we run that twice a year in conjunction with Dutchess County and Putnam County and Ulster County, work with the rail trails in Dutchess and Ulster County and with the Parks Department in Putnam County, and we walk way over the Hudson.

We have this twice-a-year fitness program to help people get in walking programs or fitness programs. We offer dinner with the doctors, where we have heart healthy food available, and cardiologists talk to them about maintaining healthy living activities, so we do that type of thing at Northern Dutchess Hospital.

It is a program for teenagers to help them learn, and their families, learn about how to go to the supermarket and shop for healthy food, and then work with them on healthy cooking, and we have a fitness program for those teenagers, then, at our fitness center at Northern Dutchess Hospital.

A FEMALE VOICE: We can't hear.

MR. PING: I'm sorry. That's usually not a problem with me. So we have a program for teenagers. Is that better?

A FEMALE VOICE: Much.

MR. PING: Okay, thank you. We have a program for teenagers in Northern Dutchess Hospital, where they come to the hospital for it's a 10-week program, and they have fitness classes at our fitness center there.

We bring their parents in. We teach them about healthy shopping and things to shop for and healthy cooking, and then we have follow-ups with them over the next year, so those are just a few of the examples of things that we do.

MS. RIGGOTT: Okay and is there like a quick answer you might have to the level of funding that's provided at your other hospitals for community benefit and community building?

MR. PING: I don't. Gary, do you have the number?

MR. ZMRHAL: Gary Zmrhal, Chief Financial Officer.

COURT REPORTER: I'm sorry. You need to be on a microphone.

MR. ZMRHAL: I'm sorry. Gary Zmrhal. As Dave had indicated, we had $40 million of charity care last year. We also have $28 million of uncollectable bad

debts. In addition to programs that Dave was mentioning, there are other things that we do; teaching people how to do CPR at various other hospitals.

We don't quantify those, because we just run those programs. We would have to go back through our detailed information and take, program-by-program, how much time is spent, but, for all practical purposes, we're providing it, but we just don't quantify it from a dollar perspective.

MS. RIGGOTT: Thank you.

MR. LAZARUS: How are the priorities determined for any of the community benefits and building activities for the following coming year?

MR. PING: So, again, I'll use the examples of what we've done with our other hospitals, so we start with the Community Needs Assessment, we look at that in conjunction with what's at the New York City plan and the Dutchess County plan and the Putnam County plans, then each of the hospitals has a Community Needs Committee that we meet with, where we review the information with them, and, working with that Community Needs Committee from each of the hospitals, we develop the community priorities for the community with their input and have their approval, which then goes to the

local Board, then.

MR. LAZARUS: Thank you. On page 546 of the application, the Applicant stated that Health Quest expects to provide at least $750,000 in financial assistance to the Sharon community by 2020.

Can you elaborate a little bit on what or how these funds will be used?

MS. FUSCO: I'm sorry. Which page?

MR. LAZARUS: 546.

MS. FUSCO: Just let me find it.

MR. FRIEDBERG: So part of it is going to be the charity care. We expect that the volume is going to go up, and, therefore, the amount of charity care that would be given is proportional to the volume increases that we would have, so we would expect that the amount of charity care that we provide to the community will go up with the volume increases.

In addition, when we actually go through the Community Needs Assessment, we expect that those priorities that will come through the CNA process will then allocate the necessary funds to be able to carry those things out and execute.

MR. LAZARUS: Okay, so, we're moving funds for the charity care, the remaining money. There may be

more added, so the $750,000 figure is fluid?

MR. FRIEDBERG: I think it's fluid. The other thing to remember is, because, with the Sharon community, the Sharon planning area does overlap with the planning areas from the New York side, so some of the Community Needs Assessment will overlap, and, so, money that might be allocated towards, let's say for Vassar's CNA program, overlap on the territory and its objectives with Sharon and with Northern Dutchess.

Because of the close proximity of those hospitals in those areas, we do expect that there's going to be some overlap of those programs, as well.

MR. LAZARUS: All right, thank you.

MS. JESSICA SCHAEFFER-HELMECKI: Good evening. So OHCA also considers the solicitation of public input to be a critical part of the CON process.

Health Quest has stated that it will solicit input from the public before finalizing a strategic and its capital plan. When and what type of forum will you be soliciting this input, and what kinds of information will you be looking for?

MR. FRIEDBERG: So I'll handle that question a couple of ways. First of all, because -- I'll start with the more formal methodology, and that is,

because the Board, itself, is comprised of community members, those community members do represent the interests of the community that they are living in and the hospital it's serving, so, in that role, we expect that those community Board trustees are going to be instrumental in being able to provide input into what the strategy should be associated with the hospital.

As we develop our strategies across all of our hospitals, we do that in combination with several things, one of them being our local Boards.

Again, those are our best information sources about what is going on in their communities, because they live there.

The other aspect of it is that we do look again at this Community Needs Assessment, and that also does influence and manage the direction of our strategies, and, as we put those things together, we have a blanket understanding of what the community needs, and then we could use that information to be able to develop our operating and capital budgets.

That, then, flows up to the Health Quest System Board for approval and then a reallocation of funds to each individual area.

We do conduct forums within the

communities on a regular basis, and those tend to be more informal about how we are actually interacting with the communities. They may be small meetings that we're having with Rotary Clubs or with different civil organizations in the region or community breakfasts that we have, where we're telling people what we're up to and then we allow them to have questions and answer, so that there's input and back and forth about what we may or may not be doing in the upcoming year.

That's, again, a lot more informal about how that process works, but that's our process for being able to understand what the community needs, what allocations are necessary for that area, and then shape and develop our strategic plans.

MS. SCHAEFFER-HELMECKI: So at these informal forums, what types of information are you getting from the public?

MR. FRIEDBERG: It's all across the board, right? You can imagine that the interest, and I'll use our markets on the New York side, you imagine that the interest within the City of Poughkeepsie of what they might be interested in talking about and having at the forums that we're doing there versus what might happen in Rhinebeck or even in the Town of Poughkeepsie are going

to be vastly different, so we're looking to understand what is going on in those communities and what we need to do as a healthcare provider to respond to that.

And we do keep it narrow, and we keep it to what's within our world and our ability to be able to execute and act on, so there are things that we are good at, and there are things that are not in our scope.

And, so, as we kind of draw that net of different information across the entire region, we filter it, then, to things that we can actually do something with.

We are not a research institution, so we are not going to be looking to develop bench research on the cures for cancer. On the other hand, if there's a large community need, like, for example, what we've heard in our communication here, is a desperate need to have oncology restored to this community, so we know that that is going to fall into our strategic plans to be able to develop clinical capabilities in oncology in the Sharon community.

MS. SCHAEFFER-HELMECKI: Thank you. Now I'd like to speak about the Foundation a little bit, insomuch as that OHCA is required by statute to consider the financial feasibility of a CON proposal, therefore,

we have the following questions regarding the Foundation for Community Health's contributions with respect to this proposal.

Firstly, how are the amounts of the working capital grant and asset purchase grant determined?

MS. HEATON: So we were in conversation for almost 18 months before we signed the document. It was really --

A FEMALE VOICE: Speak up.

MS. HEATON: Okay. Is that better?

A FEMALE VOICE: Yes.

MS. HEATON: Okay, so, we were in conversation for a year to 18 months, talking about what we would do in partnership with Health Quest, and it was a negotiation. There were two partners at the table. We talked about, you know, what would be a significant, you know, that the investment needed to be significant enough that we felt like we had some impact, so it was our decision that nine million was an appropriate investment in this case.

When it came down to what would it be for, that changed through the negotiations, depending on their negotiations with the other hospital, and that, as the

price, you know, changed, our negotiations were impacted. When they finalized what their deal was, we went to the Board and decided we didn't want all of the funds to go towards purchase.

We wanted most of our funds to be, you know, put here, and then put into investments here, but we also wanted to be good partners, and, so, in the agreement we decided that we would fund the three million, minus the closing costs, and those closing costs would then roll over into the other half, but it may be that it's less than three million after the closing. I don't have any information on that.

It was two people at the table negotiating, and we are very comfortable at the Board and the staff level with the division, and we're comfortable with the three million. That, in itself, it doesn't impact what we can do.

MS. SCHAEFFER-HELMECKI: What is FCH's balance as of 12/31/2016, and we're looking for a division of the restricted versus unrestricted funds and how much of the balance is temporary versus permanent funds?

MS. HEATON: So, by and large, our funds are unrestricted. We have maybe three percent of our

funds are restricted for purpose and/or endowment. Only two million out of all the funds that we have received, 2.2 million, were endowed, so we have to keep the body of the corpus. The rest of it was not endowed, and, so, all of the income that we've made, and we have not actually had many donors, that would be a nice thing, we haven't actually done fundraising, but, you know, all of the funds that we have increased the corpus to 25 million all are unrestricted, so we have very little restricted funds.

There's like three funds that fund a prescription assistance program, and there's only one fund remaining for med ed, medical education. Other than that, all of them are unrestricted for a purpose.

The bulk of the funding that we got was from the value of the sale of the assets. There was a very little amount of money that was donated in name, was named, and purpose attached to it.

MS. SCHAEFFER-HELMECKI: And with FCH have any administrative role in the planning or oversight of the working capital grant?

MS. HEATON: Oversight, in that the expense -- so, first, they have to spend the money, and then, once -- annual to the closing date, we will

reconcile the account, and they will present whatever it is that they've funded up to the limit for each year, some limits per year, and it has to be determined that the funds were spent to improve some capital or service investment in Sharon Hospital, specifically, not something that helps the system, more importantly, in other hospitals, before they get their money.

MS. SCHAEFFER-HELMECKI: In the grant agreement, it states that the working capital grant funds may be used for, among other things, investments in direct physician and provider costs. What exactly does that mean?

MS. HEATON: It could mean that -- so, in some cases, it takes time to build a practice, so they bring in someone that's new to an area, so they need to have their salary covered up until the point where they're generating enough income to support themselves.

This is something we do regularly, and I can give you examples.

MS. SCHAEFFER-HELMECKI: Just a follow-up question. If it is physician salaries, would those physicians be practicing at any hospitals?

MS. HEATON: It would only be for their time at Sharon Hospital. The restriction is that the

money has to be spent to improve Sharon Hospital.

MS. SCHAEFFER-HELMECKI: So they would be full-time Sharon Hospital --

MS. HEATON: Or if it's part-time, but it's only that part of it, so it would be prorated, but it is something that we've done in many other instances, especially in the oral health field, where we've seeded dental practices, just to be able to do what we want to do later on.

MS. SCHAEFFER-HELMECKI: Now the grant agreement also states that there may be a capital campaign to raise funds. Why would a capital campaign be necessary if FCH already has the sufficient funds to cover the working capital grant and --

MS. HEATON: Sure. Well there's two reasons to do fundraising, and one is to raise money. The other is awareness and connectivity to the community, and we are taking that part of our partnership agreement very seriously.

We not only want -- we want Health Quest to be successful in our community, and they can build it, but people have to go to it, so part of the campaign will not only, you know, build and fundraise, local fundraising and hopefully jumpstart that, because we have

more information about people in our community than they do, but it will also be a vehicle to spread awareness amongst people, who may not choose to use services up here, and, so, this is a way to also generate interest, excitement and hopefully use of the services and new services that come into the community, so we see it as a win-win.

MS. SCHAEFFER-HELMECKI: So it wouldn't be soliciting donations from the public to go towards the capital grant?

MS. HEATON: The funds will be solicited to go into a Sharon Hospital restricted fund at Berkshire Taconic, which has already been created.

MS. SCHAEFFER-HELMECKI: So would that be over and above the six million?

MS. HEATON: It could be. It could be. That fund will be -- that fund currently has nine million in it. Once we spend the three million, the amount of money that we're obligated in that fund would be six million.

Within the year, we're going to be earning, because it's still in our pool, so it will be reconciled annually, so that it always is at its cap, you know, so it only needs to have the six million. They're

going to present some expenses that we may choose to fund out of that.

That same fund will also be the recipient of fundraising, should we do it, should it happen. It would also go into that, and that would also be reconciled, so if there's more than the cap in there, that could flow back, you know, along with the interest and anything else to our regular unrestricted account.

MS. SCHAEFFER-HELMECKI: To FCH?

MS. HEATON: Yes.

MS. SCHAEFFER-HELMECKI: To FCH, not to the Sharon Hospital?

MS. HEATON: Our funds would be coming back, so say then they get two million, so now it's down to four million, so we could never get more than whatever is in there. It's a little complicated.

MS. SCHAEFFER-HELMECKI: Okay.

MS. HEATON: But the idea is to use that, and that fund, if it ends up, you know, miraculously ends up making more money than we could imagine, it gets into that fund, its restricted purpose is for Sharon Hospital, only for Sharon Hospital.

The funds raised will always go to Sharon Hospital.

MS. SCHAEFFER-HELMECKI: Sharon Hospital or FCH?

MS. HEATON: Sharon Hospital.

MR. FRIEDBERG: It's FCH for the purposes of Sharon Hospital.

MS. HEATON: Yes.

MS. SCHAEFFER-HELMECKI: Okay. All right.

MS. HEATON: He's making sure that I say that it would -- within the year, before the reconciliation, would reduce our obligation by whatever was raised within that year, but we would never recover more than what we put in there, and that fund is a Sharon Hospital restricted fund under our pool of money. Does that make sense?

MS. SCHAEFFER-HELMECKI: Okay, perfect. Thank you very much for the clarification. Also, you stated the grant funds will be returned to FCH if the hospital is sold or closed within five years or loses the tax-exempt status.

Now that returning of the funds, does that include both the asset purchase, as well as the working capital grant, or just one or the other?

MS. HEATON: The whole thing.

MS. SCHAEFFER-HELMECKI: Okay. The full

nine million comes back?

MS. HEATON: The whole thing.

MS. SCHAEFFER-HELMECKI: And, now, would the funds be returned if the hospital ownership was transferred to another owner without the exchange of actual cash, and can we say sold, but what about if it just transferred, without an actual payment?

MS. HEATON: To a non-profit.

MS. SCHAEFFER-HELMECKI: Transferred, yeah. If it's transferred, say, to a non-profit, would the funds be returned?

MS. HEATON: It would have to be to a non-profit.

MR. FRIEDBERG: The contract with the Foundation calls it -- if we were to transfer the hospital to another not-for-profit, we would have to have assurances and be able to transfer the obligations that we've entered into with the Foundation over to the new entity, otherwise, we would have to refund.

MS. SCHAEFFER-HELMECKI: Okay, thank you. And are there any other situations in which the grant funds would be returned?

MR. FRIEDBERG: I don't believe so.

MS. SCHAEFFER-HELMECKI: Okay, great. I

have a question about the nominations for the Local Governance Board. FCH has stated that it retained outside counsel to identify potential nominees to new Sharon Hospital's Local Governance Board. What criteria did the consultants use to select the nominees?

MS. HEATON: I wouldn't say it was the consultant, who came up with the criteria. It was the Board, our Board committee that worked on this. We worked with a consultant to help us organize ourselves, because I don't know if any of you have ever tried to start a Board from scratch, and, other than our Board, I'm not sure it's been done, especially for a hospital, so we decided -- we created a matrix that talked about geography.

We wanted to make sure New York, Connecticut, different kinds of towns that we're familiar with, we wanted to have a diversity of backgrounds, financial.

Health Quest didn't really need a whole bunch of healthcare experts, but we, you know, people with some healthcare background, people that are just strong community leaders, strong representatives of the community, and we looked at all kinds of demographics, age.

It's not a lot of color, but, you know, we looked at all of that, and then the consultant assisted us by contacting, doing background, whatever was on the internet, and doing an initial survey to find out if people were even remotely interested, and then they were brought into the committee, which the hospital and Peter also participated on that committee, since he would be working closely with that. We wanted his input.

We interviewed candidates once or twice and created, I think, a really outstanding --

MS. SCHAEFFER-HELMECKI: So you have here your nominations set?

MS. HEATON: We've already submitted them to Health Quest.

MS. SCHAEFFER-HELMECKI: Do we know if they've been approved yet?

MR. FRIEDBERG: The governance process associated with Health Quest is that we would take those nominations and we'd take it to the Governance Committee of the Health Quest Board. The Governance Committee meets on April 10th.

Upon favorable recommendation from the Governance Committee, that would go to the Health Quest System Board on the 27th, 28th of April, at which time

those Board members would be, then, seated at the end of April.

MS. SCHAEFFER-HELMECKI: If they're not approved, will you have another opportunity to submit additional nominations?

MS. HEATON: Yes.

MS. SCHAEFFER-HELMECKI: Okay. Thank you. And I think, lastly, will the Sharon Hospital have its own Foundation, separate from that of FCH?

MR. FRIEDBERG: No.

MS. SCHAEFFER-HELMECKI: Okay.

MS. HEATON: And we will not be a hospital foundation.

MS. SCHAEFFER-HELMECKI: Thank you very much.

MR. DAVID FERNANDES: So the volume of the questions will have to do with the Governing Board. So OHCA wants to ensure that the concerns and needs of the local community are adequately represented and that there's a sufficient level of community involvement, so would Connecticut Medical Foundation have representation on the Sharon Board?

MR. FRIEDBERG: The Medical Foundation?

MR. FERNANDES: Yeah.

MR. FRIEDBERG: The employee group or the medical staff?

MR. FERNANDES: Physician practices that will be -- (multiple conversations).

MR. FRIEDBERG: There are physicians that will be on the Board, but there is, by coincidence, one member from the community that is a physician that has been nominated for the Board and, assuming that that goes through the process, would be placed on the Board.

Also, the Vice President of Medical Affairs for Sharon Hospital by ex officio is placed onto the Sharon Board.

MR. FERNANDES: That one physician that you had mentioned, is he or she part of RHA or Tri State Women's?

MR. FRIEDBERG: No.

MR. FERNANDES: Okay.

MR. FRIEDBERG: There's no direct connection between and there's no ex officio positions that come from the physician group to the Sharon Board.

MR. FERNANDES: As a result of the original transfer of ownership application, the Attorney General's Office required the formation of a local Advisory Board, in addition to a local Governing Board.

To clarify, would the 12 FCH nominated Board members be serving on a local Governing Board and not an Advisory Board?

MR. FRIEDBERG: So, for clarification, we did receive a letter from the Attorney General's Office after reviewing all the documents associated with the transaction, including the Foundation for Community Health Grant documents, the Assess Purchase Agreement documents, and we did ask them for relief against those statutes that were imposed and those reliefs were granted.

MS. FUSCO: Does that clarify your question? So the local Governing Board that we're talking about that will have the 12 FCH is the actual hospital Governing Board, and the reason the AG released there was a local Advisory Board put in place, because they wanted to ensure what for-profit hospital was operating the hospital, that there was sufficient community input, so they had a local Governing Board that incidentally was made up of mostly community members, plus the Advisory Board.

The AG is comfortable that now that a not-for-profit is operating the hospital, you don't need that second layer of Board, so the Board we're talking about

is the actual Board.

MR. FERNANDES: Thank you. What authority will those 12 members have, the FCH members?

MR. FRIEDBERG: So, just for clarification, the members that are going to be seated on the Board are community members that are nominated from the Foundation for Community Health. They are Sharon Hospital trustees at that point, so they're independent community members that are then entrusted with the responsibilities that are granted to them from the Health Quest System Board.

Those responsibilities cover several areas, starting with Community Needs Assessment, which we've already addressed, then the second part is to assure that the quality of the medical staff is up to standard, so the credentialing process associated with the medical staff is the responsibility of the local Board, and the other part that is their direct responsibility would be to oversee the quality and process improvement efforts of the hospital, as well.

MR. FERNANDES: How many of those 12 are voting members?

MR. FRIEDBERG: Of those 12 that are from the Foundation nominations?

MR. FERNANDES: Correct.

MR. FRIEDBERG: All members of the Board, including ex officios, are voting.

MR. FERNANDES: Will the FCH or Sharon Board members be represented on the Health Quest Board?

MR. FRIEDBERG: The Chairperson from the Sharon Board is an ex officio and voting member of the Health Quest System Board, and that's consistent with all hospitals within the health system.

MR. FERNANDES: It would be that one person?

MR. FRIEDBERG: Correct, and that's consistent with all hospitals within the health system.

MR. FERNANDES: Okay. The next few questions are going to have to do with the physician recruiting, so OHCA is interested in understanding how physician recruitment will relate to the service plan submitted in response to completeness questions.

The Connecticut Medical Foundation anticipates employing 22 additional FTEs by fiscal year 2020. How many of the 22 FTEs will be physicians?

MR. ZMRHAL: I don't believe any of those 22 FTEs are physicians, actually. I think physicians are in addition to those 22 FTEs, so we have a different plan

for the physician recruitment outside of what was listed on the hospital document, so the answer is zero.

Those FTEs are support staff that are going to be supporting the programs that we're going to be doing within the hospitals, things like the oncology program, etcetera, so the physician FTEs are outside of that.

MR. FERNANDES: The 22 that I'm stating came from the financial worksheet for the Medical Foundation.

MR. ZMRHAL: Sorry. I'm not following where you're at. I'm sorry. I thought you were talking about a different set of FTEs, so this is actually a mixture, but, to be honest, we're still sort of deciding on exactly what physicians and in what mixture, so I can't really give you an exact number on that.

Typically, though, it would be about three FTEs for every full-time physician, so if it's 22 FTEs, it will be about five of those, sorry, six of those will be physicians. I can't do math that quickly on my feet. Six or seven.

MS. SCHAEFFER-HELMECKI: Excuse me. I'm sorry if you already answered this somewhere in your application, but, so, you didn't give us any written

estimate of how many physicians you're anticipating recruiting?

MR. ZMRHAL: We gave you an estimate of the different types of physicians that we were anticipating. At that point, we just actually created a physician manpower look at the area that we do for every hospital area. That was just completed about maybe a month ago, so we didn't know exactly how many we were going to be short of each specific type, so we didn't have exact numbers.

So we put in -- we knew we were going to need at least one OBGYN. We knew we were going to need at least one oncologist, etcetera, so we kind of put in one of each as a placeholder, but it may end up being more than one, to be honest.

MS. RIGGOTT: I thought that I read -- oops.

MR. ZMRHAL: Also, to clarify, it may be one FTE, but it may actually be three physicians part-time coming over and all those kind of things, so, at this point, it's a little bit difficult to handicap it exactly, because we don't know how many people already exist and we're bringing them over versus how many people we're bringing in new.

We're still sort of trying to get that plan into place exactly. What I can tell you, though, is I have two primary care docs lined up to come to Sharon.

We have already purchased the practice in Millerton. I have one OBGYN. So, I mean, these are real plans with real people that already exist. If we consummate the deal, we will -- there's already five FTEs' worth of physicians that I know are coming to the area, so that's what I can tell you actually exists right now, without any further or without including the ones that we would be bringing over here part-time from Poughkeepsie or Northern Dutchess.

HEARING OFFICER HANSTED: The five that you know of right now, are those all primary care physicians?

MR. ZMRHAL: No. They're a mixture, so that's three primary cares, one OBGYN. I'm sorry. Two new cardiologists, so that's actually six. I forgot the cardiologists. I should never forget the cardiologists. I'll get really beat up for that one.

MR. LAZARUS: Do you have a timeline, as to when you're going to complete this plan to figure out how many actual physicians you will be needing?

MR. ZMRHAL: Well, I mean, that will be

ongoing. I mean we iterate that every year, looking at what the volumes are that we have, what the volumes are that we project, what we think the need is, but, you know, I think the overall need for physicians, and I didn't bring a plan with me, the physician manpower needs assessment that we did, but, you know, it's a couple dozen, so, I mean, you know, over time, it's a large number.

MR. LAZARUS: And when is that completed?

(Multiple conversations)

MR. ZMRHAL: I'm sorry?

MR. LAZARUS: Can we get a copy of that as a late file?

MR. ZMRHAL: I don't see any reason why we can't.

MR. LAZARUS: That's the physician manpower.

MR. ZMRHAL: Yeah, so, we do a physician manpower needs assessment. Under CMS guidelines, you have to have that if you're going to support an independent doctor coming in to the area, so we have to have that from a hospital perspective, so we had just done it for all of our other hospitals, so we went ahead and did it as part of our management agreement.

MR. LAZARUS: If we can have that as a late file, that would be terrific.

HEARING OFFICER HANSTED: That will be Late File No. 1.

MS. RIGGOTT: And you said that's done annually or ongoing?

MR. ZMRHAL: It's usually done about every three or four years, the needs assessment. We do, internally within HQMP or within the Medical Foundation, we do it every year to say, okay, well, this doctor is now, you know, working at capacity. We need to add another one, or we need to add another part of one, or we want to add this other new specialty, etcetera, so that's an ongoing yearly plan. What we're recruiting for the next year we usually do that planning the year prior.

MR. LAZARUS: Thank you.

MR. FERNANDES: How did you determine what types of specialists would be recruited?

MR. ZMRHAL: Well we used a -- when we originally did this, we talked to a number of people. We talked to Peter. We talked to the medical staff and asked them what they thought were the needs in the area.

Since then, though, we've corroborated that with the actual manpower needs assessment, but we

know number of patients, people who are patients here, for example, who told us it was terrible when oncology was taken from Sharon Hospital. We'd really like to have that back, and, so, that was something that we put into the plan early on.

MR. FERNANDES: Thank you.

MR. ZMRHAL: In addition, there's a lot of migration data that we use, as well. What's going to other places that could stay here if we had that available?

MS. RIGGOTT: So I just have a follow-up question. I know you gave us some indication of the physicians that would go along with some of the new services or the services you're hoping to gain back, but you had provided on page 883, beginning on page 883, a table that indicates -- it's your service plan for the next three fiscal years, so I guess I'm just following up to see if, at this point, can you provide the number of physicians that would be part of some of these additional services?

I know you gave us primary care, OBGYN, but in terms of the other services, where you're adding services or expanding, at this point, are you able to do that?

MR. ZMRHAL: I think it's premature, to be honest, to do that at this time. Some of them, we could. So, for example, for oncology, you know, we'd probably start with an oncologist coming over one or two days a week and then work up from there, but, for some of them, we're still doing the assessment, as to what that need is really going to be, so it's difficult to give you an exact number at this point.

Like I said, I mean, there's at least six full-time physicians that we already have lined up at this time, so, I mean, that is a known entity already.

MR. FERNANDES: Will the physician practices be located within the Sharon community?

MR. ZMRHAL: It depends on how you define the Sharon community. So if you're defining it as the primary and secondary service area, yes. I mean some of them will be in Sharon. For example, looking to put primary care here.

Some of them we're looking at, you know, is the right place to put them, you know, further out to draw patients in to the Sharon community, but, for the most part, most of them would be working here, but not all.

MR. FERNANDES: Thanks.

MR. ZMRHAL: If you extend it to the secondary service area, however, they would all be within that, you know, that community.

MR. FERNANDES: How long would it take, or how long would you expect it to take a physician to reach a reasonable patient panel size?

MR. ZMRHAL: I mean that totally depends on the specialty. It depends on where we put them. I mean it depends on a lot of things.

On average, I expect a primary care doc to be full by the end of two years. Usually, full by the end of one year. On average, you know, a specialist takes longer, so, you know, on average, they would start to get more busy by nine months and be fully busy by somewhere between two and three years, depending. Especially in a smaller area like this it takes longer.

MR. FERNANDES: Could you detail the additional recruiting enhancements Health Quest can offer over the previous PSA Regional Health Care Associates had?

MR. ZMRHAL: Pete would probably have to answer what there was before. I can tell you what we do. So we have a recruitment director and four FTEs of recruitment staff, who last year, as I said, recruited 47

physicians, and they also recruited another 20-ish non-physician providers or practitioners and PAs.

This year, we have an aggressive plan for closer to 60 physicians, and, so, we have a recruitment process that we work, and, obviously, we're here close and able to recruit people to an area that our recruiters know well. They all live in the area, etcetera, so we recruit to an area that we know well and, also, to a group of physicians with a very physician-led culture that is pretty easy to sell, to be honest.

MR. FERNANDES: Thanks.

MR. ZMRHAL: Do you want to add anything, Pete?

MR. CORDEAU: Sure. I can just add stability, right, so what they add is stability. RHA through RCCH, we could try to find a position. The ability to see the position in this community, given this area and the dynamics, that was really a competitive disadvantage for us, no matter what we did, so the stability of a Health Quest system and a large system.

They've already demonstrated the ability to recruit, so that, in and of itself, is the big game-changer here for any physician that wants to even be in this community and know they're part of a larger system

and have that support.

So, for instance, our general surgeons are now part of a 12 general surgeon practice versus two, and it certainly helps for on-call, it helps for coverage, and it certainly becomes a real kind of advantage for us now.

MR. FERNANDES: Thanks. That pretty much concludes my questions.

MS. SCHAEFFER-HELMECKI: I just have a few questions about some of the volume projections. So OHCA is required by statute to consider the utilization of healthcare services at healthcare facilities as part of its decision-making process.

The following questions pertain to patient volume, both actual and projected. So, firstly, what initiatives will Health Quest take to reverse the decline in outpatient visits outside increasing the number of physicians?

MR. FRIEDBERG: (Multiple conversations) That’s the story.

MS. SCHAEFFER-HELMECKI: Okay, so, the chart on page 650 shows what the expected increase in average daily census would be from improvements to each of the five service lines.

It states that they were derived using Sharon's existing physician line as a proxy. Please elaborate on the underlying assumptions used to arrive at these figures.

MR. BERGERON: Christian Bergeron, Chief Financial Officer, Sharon Hospital.

So what we did was we've used historical data, 2015 data, the activity from physicians, who practice in the those specialties, and evaluated their level of utilization within the hospital, and that was the basis for determining the expectation of the new recruits to Sharon Hospital, which, in many ways we believe, is a conservative few of the possibilities in the new world.

MS. SCHAEFFER-HELMECKI: So you're projecting a total increase in patient volume of approximately 19 percent from fiscal year 2016 through fiscal year 2020, and that table is on page 52.

Please walk us through how you arrived at these figures, and I was going to say beyond physician recruitment, but maybe we won't take away that limitation.

MR. BERGERON: I have to see the exhibit first. I mean I'll answer for now. If Robert wants to

add additional.

I mean, outside of the additional physician activity, I mean, as was mentioned earlier, there was also, you know, by adding the additional services we believe in the future, so reducing the number of transfers that need to leave Sharon Hospital, that plays a role in the future of volumes at the hospital, our ability to keep patients here at the hospital, as opposed to transfer them.

In addition, I think there will be -- what else? EMS, the other things, as Mr. Friedberg mentioned earlier, the decanting of activity in Northern Dutchess and Vassar also presents an opportunity from a volume perspective that we are expecting to realize at Sharon.

I think those really represent the three main contributors and the expansion of the geri psych.

MR. CORDEAU: Geri psych I think is very important, seeing that that’s the one area of the hospital that we turn away 20 to 40 patients every month, so the expansion, the plant expansion of five additional beds, that certainly has a significant impact on that, and, again, reiterate EMS.

The confidence of the EMS community to be able to send patients to us allows for that decanting to

happen to our area, because there are currently patients that are equal distance between us and Vassar and Northern Dutchess that the EMS has to make that decision whether to go to one of those other hospitals or Sharon, or they have to go to Sharon and turn around and drive to one of those other hospitals, so that's part of the service enhancement that's going to allow for those patients to stay and that decision to keep EMS local and be available again for more calls.

MS. SCHAEFFER-HELMECKI: The Applicants are projecting an incremental growth in discharges of 53 percent between fiscal year '16 and '18. Please explain how Health Quest intends to achieve a 53 percent increase in inpatient discharges over just two years.

MR. BERGERON: Again, Christian Bergeron. Again, the message remains the same. I think, primarily, from an inpatient perspective, adding physicians in the community are going to be a primary factor, increasing the capabilities within the hospital, reducing the transfers and, again, also contingent up on the seniors expansion.

MR. CORDEAU: And, lastly, one other area that we didn't touch upon today is with the ability to access physicians through Health Quest. Orthopedics is a

great example, where 650 primary and secondary service patients left our community this year. Having access to providers to provide a broader set of basic bread and butter, what would be expected to be provided at a community hospital really adds into that.

You know, Robert and I were at a community event at the hospital, where employees said to Robert I really hope that Dr. X comes here, because I want to have my knee done at Sharon Hospital, so it's just a great example of someone in the community that would have to seek services outside the hospital if we didn't have access to those providers, so that's certainly in there.

MS. SCHAEFFER-HELMECKI: May I ask why the inpatient discharges are so much more dramatic than when looking at the total numbers?

MR. PING: It's a lot of small numbers. It's lot of small numbers. You've got small numbers today, so anything that we add is going to be a big increase, and the other thing, and, if we've said this I apologize for repeating it, but the other thing we're looking to do is, on those inpatient admissions, is to have several patients stay that now go to Northern Dutchess or they go to Vassar Brothers, because the inn is full at Northern Dutchess and at Vassar Brothers, and,

so, if could keep patients that are in the Sharon market area at Sharon, as opposed to going to Vassar and Northern Dutchess, we want to do that. We believe that we can have up to six patients a day or an average daily census of six come to here, and that starts to add up very quickly, in terms of the discharges then.

MS. SCHAEFFER-HELMECKI: Thank you.

MR. FERNANDES: OHCA is also required by statute to consider the financial feasibility of each proposal and/or how a proposal will impact the financial strength of the State's healthcare system.

The following question pertains to financial projections, insurance reimbursement, cost reductions, etcetera.

The Applicant projects net operating revenues for the hospital of 66.3 million in fiscal year '18. I'll just repeat the question.

The Applicant projects net operating revenues for the hospital of 66.3 million in fiscal year '18, based on incremental increases of 14.7 million, specifically due to this transaction.

The financial projections provided for the hospital further result in an estimated incremental operating margin of 15.4 percent in that year. The

Applicant projects results similar to this going forward for fiscal year 2020, so what specific strategies will be implemented to achieve these aggressive financial goals at Sharon Hospital? Be specific, in terms of plans to increase net revenue, increase both discharges and outpatient visits, maximizing reimbursement and reducing operating expenses, in order to achieve overall hospital and system cost savings.

MR. FRIEDBERG: So it's Robert Friedberg. I'll start with this and saying the same topics that we've covered in regards to physician activity and being able to generate the revenue side, and the admissions, discharges, and outpatient activity we've covered.

The other side of that, though, is that there is an advantage that we'll be able to bring with our leveraging of costs, because of the size of the health system, our ability to participate in our GPOs, and being able to look at how we're going to reduce the overall cost.

Because of the local proximity between the two institutions, between Health Quest and Sharon, there are economies that we'll be able to gain simply by being part of the health system that's a continuous geographic area.

Whether or not that's in purchasing, or whether or not that is in back office functionality, we expect to have the ability to reduce our overall cost structure.

As a matter of fact, we've already started doing some of that, an example being Sharon Hospital was outsourcing its coding of its medical records at a cost of $120,000. We're able to just turn that internally to Health Quest, because we have the capacity to be able to handle the additional coding, so that $120,000 just comes off. It doesn't need to be spent.

There are examples, after examples, after examples, as we go through the process and being able to look at the synergies that we'll be able to achieve, because we're able to take a small hospital and leverage that up with a large health system.

MR. FERNANDES: Has Health Quest had similar experience at any of its other hospitals or providers within the Health Quest system?

MR. FRIEDBERG: So I'll give you two examples that we have, which is both Northern Dutchess Hospital and Putnam Hospital Center.

Northern Dutchess Hospital came into the health system in 1999, and they were at a minus operating

income, and they were at a very low reserve for their cash days on hand.

Over the course of the last number of years since then and, specifically, the last five to seven years, we've seen a vast increase in the activity on the Northern Dutchess campus to which point we've gone from them being a negative operating margin to a 13.5 percent operating margin at the current moment and sustaining 13.5 percent operating margins on a chassis of 68 beds.

So they've been very successful in being able to do a lot of things that we've talked about; bring physicians to the community, be able to get the community engaged in the process of understanding and what the capabilities are, and, also, leveraging the cost structure associated with being part of a health system.

I can tell you the exact same story for Putnam, as well.

MR. FERNANDES: Just to add to the Northern Dutchess improvement over the last five to seven years, could you provide documentation as a late file, indicating the growth within the past five years?

MR. FRIEDBERG: Sure.

MS. RIGGOTT: And can I just follow-up

with one question on that? You purchased that hospital in 1999?

MR. FRIEDBERG: That's correct.

MS. RIGGOTT: And, so, that growth was not seen until the last five or so years?

MR. PING: Northern Dutchess in 1999, as Robert said, was nanoseconds of cash on hand, and it's grown steadily through the years. Over the past, in 2005, Northern Dutchess added and replaced a number of beds and a number of services in a new building, and that was, again, because of the Health Quest to fund that expansion project for them, and, since that time forward, it's been -- that was like an igniter for them.

And we had our second major expansion we just finished in February of last year, which replaced all of the medical surgical beds at Northern Dutchess Hospital, and they've seen, again, over this past year, 13 percent growth in their discharges, and, again, that was a second igniter for them, and we've gone back to the State and applied for additional beds and have gotten 16 additional beds as a result of what's been going on there for the last three or four years, but they had growth for the 2005 time frame.

MS. RIGGOTT: So could we see a longer

period of time for that late file, then? Would that be possible?

MR. PING: I don't know how far back we've got the data, but we'll go back as far as we can go.

HEARING OFFICER HANSTED: All right. Just for the record, that will be Late File No. 2.

MR. FERNANDES: What strategies might Health Quest use if the projected results are not realized at Sharon Hospital?

MR. FRIEDBERG: I guess the strategy is what the strategy is. I mean, you know, putting physicians into communities, putting access points into communities is going to generate more activity associated with meeting those needs, as long as the community need exists.

So, you know, in our assessment, the community need does exist for adding physicians to the community. If our projections are off, for example, instead of making $5 million of operating income it's $4 million, or $3.5 million, it's of no concern to us.

Again, we're a little over a billion dollars, $1.1 billion at the current moment in operating revenues and $68 to $70-something million of operating income.

The stability of the health system as a whole in that aggregate, and that goes back to my comments earlier, because we look at this in the aggregate, I am not concerned with what the operating margin of Sharon Hospital is. I'm concerned with what the operating margin is of the health system.

What Sharon does from a performance standpoint is not material to us from an operational standpoint. It is a part of what we do, or will be a part of what we do, so we are going to look at the aggregate.

So, to answer your question, if it doesn't make $5 million, it makes $2 million, it makes $1 million, that's what it will make, and it doesn't make any difference.

We will continue to put the services in, because as long as the health system continues to be healthy and thrive, our job, as a not-for-profit in this community, is to serve the community with healthcare. That's our mission and our vision.

The operating margin is a means to do it. It's not the driving force.

MR. FERNANDES: Thank you. Okay, so, OHCA must be mindful of the financial impact of the proposal

on patients, so the following questions are in relation to that issue.

Please discuss any changes, due to the transfer that would affect affordability for patients, any increases, decreases in fees or billing charges.

MR. FRIEDBERG: We are not projecting that we are going to change the charge structure associated with the hospital, so the only thing I would say was that our ability to be able to work with managed care will have impacts in multiple directions.

I would tell you that, again, given the context of what is going on in healthcare reform, or re-reform, or however you want to phrase it, that's going to have more of an impact than anything we could possibly come up with.

MR. FERNANDES: And, just to clarify, no additional facility fees or --

MR. FRIEDBERG: No.

MS. RIGGOTT: I have just a quick question regarding the comment you made about no change in charge structure.

I just was curious. Has there been any type of independent cost analysis performed as the result of this possible sale?

MR. FRIEDBERG: I'm not sure I understood the question.

MS. RIGGOTT: I'm wondering if there was any kind of independent cost analysis done with respect to patient affordability or the financial impact of the proposal on the financial affordability for patients?

MR. FRIEDBERG: No, but I would say that, again, you know, if we break it down, Medicare is Medicare, and Medicaid is Medicaid, and, as it relates to the managed care contracts associated with the rest of the population, at the time of transition, we're accepting assignments from Essent Health to Vassar Connecticut, so whatever contracts are in existence will exist in the same form upon transaction.

Our ability to negotiate with managed care is going to be an ongoing discussion.

MR. FERNANDES: When does Sharon Hospital's current contracts with insurers expire?

MR. BERGERON: Christian Bergeron. It's a variety of dates, so contracts straddle. They may be a year to three years typically, in terms of they'll look at each contract and they'll be assigned under the existing terms.

MR. FERNANDES: Will they be negotiated by

Sharon Hospital or the overall health system?

MR. BERGERON: Once they come up upon renewal, then they'll be negotiated by Health Quest, but everything that exists as of today will be assigned as is as of today, so whatever negotiations have taken place, which have been done by Region --

MR. FERNANDES: What advantages does being part of Health Quest's system bring to the negotiation table for Sharon Hospital?

MR. BERGERON: I'll answer a little bit. I mean to the extent, obviously, there's a -- so there's a volume play for us, who are dealing with many of the same local managed HMO plans and, also, plans that we don't have access to today, so it really provides those two things; access to New York payers that won't actively contract with the hospital today, as well as in the future, I think, you know, purchasing power, if you will, from the contractual perspective, which will add, you know, a value to the organization.

MR. FERNANDES: And the last question for me, at least, does Sharon Hospital continue to hold a Medicare designation as a sole community hospital?

MR. BERGERON: Yes, it does.

MR. FERNANDES: And is that reflected in

the financial attachment?

MR. BERGERON: Yes, it is.

MR. FERNANDES: Thanks.

MR. LAZARUS: Excuse me. Regarding the cost savings, you have stated on page 934 that the savings are largely made possible, due to the proximity of Sharon Hospital and Health Quest, and you had already alluded a little bit about that.

Can you elaborate a little bit about how the proximity interest into cost savings, specifically?

MR. FRIEDBERG: Well, for an example, because we'll be able to purchase underneath a single GPO and deliver to our warehouse, because of our proximity, we can go there from our warehouse, so that allows us to purchase at higher bulk. That's just a simple example.

Also, our ability to be able to share services. Again, you know, you can have a half FTE at our corporate offices that we can expend and have that half FTE fill some roles over here, just by getting in their car and driving over.

The proximity just allows us to be a little bit more fluid in our ability to be able to share resources.

MR. LAZARUS: All right, thank you. Could

you provide a little bit of detail on how there would be a reduction in drug -- in the supply and drug costs if the projected patient volume is to increase by 53 percent by fiscal year 2018? It was on the financial worksheet, that there's a reduction in the supplies and drug costs, and the worse thing the projected volume is expected to be increased by 53 percent by 2018. How is that related to the reduction or the cost savings?

MR. BERGERON: Christian Bergeron. So I think what the exhibit is intended to represent are the savings of drug supply purchases, because of, again, the purchasing contracts that Health Quest has relative to Essent today.

It's not represented that we're going to have volume -- it's not a volume adjusted number, so, as you can see in the projections, you'll see an increase in our supply and drug cost line items, not a reduction, so we're expecting volume increases partially offset by contractual savings.

MR. LAZARUS: Thank you. Now, under Health Quest, will the Inpatient Psychiatric Facility, the IPF, maintain its exemption from the Perspective Payment System, the PPS?

MR. CORDEAU: Yes.

MR. LAZARUS: All right. There was also mention in the pre-filed testimony that Health Quest will establish a system-wide GME program in 2019. I believe there was a footnote on page 914. Will Sharon Hospital also be approved for the GME patient program?

MR. ZMRHAL: We are in the process of starting at least eight residency programs throughout the system, and those will start in 2019 and 2020.

We would expect that there will be some rotations done here, however, we're still evaluating that, because, because of the sole provider status of Sharon Hospital, it's not particularly advantageous to bring residents here, and, so, we have to do it on a sort of individual basis, looking at what the needs are and what programs, such as psych, we would bring here, because, obviously, the Psych Unit at Sharon Hospital will provide great experience, so we'll do that sort of on an individual basis.

None of the programs would be housed at Sharon Hospital, but we would probably rotate certain people through Sharon Hospital.

MR. LAZARUS: Would that have any effect on reimbursement, if there is some sort of a GME rotation through Sharon Hospital?

MR. ZMRHAL: It won't -- again, it will have a small effect on Medicare reimbursement at Sharon Hospital, but because of the sole community provider status, you don't get the full change in reimbursement that you get at our other facilities, just because it's carved out, the sole community providers are carved out of the majority of the GME reimbursement.

MR. LAZARUS: All right, thank you. Are there any other designations for the federal reimbursement, for the reimbursement purposes that Sharon Hospital currently holds or will soon qualify for that may apply here and if that impact was assumed in the projections?

MR. BERGERON: No.

MR. LAZARUS: No? All right. And, with that, I'm done. I'm going to turn it over to Kaila to bring us home.

MS. RIGGOTT: All right. I just have just a couple of very, I hope, quick questions on the status of the HQMP physicians becoming Connecticut Medicaid providers.

It's my understanding that that's in process, and I was wondering where in the process that is.

MR. ZMRHAL: Yes, so, we are in the process of the application. I can't tell you exactly where it is in the process. I know that we have filled out all the paperwork, and it's either been filed or is about to be filed, but we're getting ready to bring providers over, you know, actually very soon, and, so, we need those contracts as quickly as we can, and I'm pushing as hard as I can to get them out the door.

MS. RIGGOTT: Okay and just a follow-up. Have there been any specific plans to improve access to the Medicaid population in the service area?

MR. ZMRHAL: Not specifically, other than we are looking at, like I said, two primary care providers and an OBGYN shortly. The other thing is we, throughout HQMP, we don't discriminate in any way on ability to pay. We take all comers. I mean that's always been part of our mission.

The other thing I will tell you is we're very good partners with Hudson River Healthcare, and they have a center in Amenia, and, so, for people, who have dual diagnoses and things like that, that require health home we, you know, we work with them to make sure that those people have a smooth transition, as well, so --

MALE VOICE: They are not in QHC -- they

are in an upgrade that is close by.

MS. RIGGOTT: Thank you.

HEARING OFFICER HANSTED: That concludes OHCA's questioning. Just an administrative point. The late files that have been ordered, how long do you think you need for that?

MR. PING: We can get you the medical staff plan tomorrow, and the ADH(phonetic) stuff I'm sure we can get you next week and maybe even --

HEARING OFFICER HANSTED: All right. Why don't we say by April 14th?

MS. FUSCO: Yeah. We should have it sooner.

HEARING OFFICER HANSTED: That's fine. I'll set the date as April 14th. And just one last time, are there any individuals, who would like to give public comment here that did not already have the opportunity to do so?

Okay. Hearing and seeing none, please remember that, if you just don't want to speak in front of a microphone, you can submit written comments, and the address to send those is on the information sheet that was provided at the beginning of the hearing.

If anyone needs one of those information

sheets, just please approach us at the end of the hearing and we'll supply that to you.

A FEMALE VOICE: (Indiscernible - too far from microphone).

HEARING OFFICER HANSTED: It's very late. I will allow you to do that if you keep it to one minute each person. Did somebody want to come up again?

(Whereupon, a member of the public spoke.)

HEARING OFFICER HANSTED: Okay, with that, I thank everyone for coming. I know it's been a long night, but thank you, again, and I'll conclude this hearing. We're adjourned.

(Whereupon, the hearing adjourned at 8:05 p.m.)

AGENDA

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 17th day of April, 2017.

Paul Landman
President

Post Reporting Service
1-800-262-4102

User, OHCA

From: Alice Yoakum <aliceyoakum@gmail.com>
Sent: Saturday, April 15, 2017 3:27 PM
To: User, OHCA
Subject: Public comment Sharon Hospital
Attachments: Sharon hospital.docx

Please see the attached letter. Thank you.

Alice Yoakum

Alice B Yoakum
196 Millerton Road, P. O. Box 271
Lakeville Connecticut 06039

Tel. 860 435 2639 **aliceyoakum@gmail.com**

April 14, 2017

Office of Health Care Access (OHCA)
Hartford, CT

Re: Public comment Sharon Hospital

I write to express my strong support for the purchase of Sharon Hospital by Health Quest.

I have lived in Lakeville for 55 years, raised my children here, lured my parents and my husband's mother to retire here, and encouraged my brother and his family to move here. My father, my sister-in-law, and I all served on the Sharon Hospital board at one time or another before it's purchase by Essent. I am presently on the board of the Foundation for Community Health (FCH.) Three generations of my family have used the emergency room, the radiology department, the PT center, the laboratory, and have been in-patients of the hospital. We have supported the hospital with contributions, and have depended upon its presence here in the Northwest corner.

In light of the hospital's recent financial statements it seems apparent that Sharon Hospital cannot continue to exist unless it is part of a larger group of hospitals in this region. RCCH, with no other hospitals in the area, will sell it or simply close it. Health Quest is a logical

purchaser with facilities and a physician network including medical specialists in nearby New York state.

----If the hospital closes the community will lose one of its largest employers.

----If FCH keeps the three million dollars that is to be its contribution to the purchase price these funds and more will not make up for the additional costs of providing access to health care for elderly and disabled residents of the Sharon Hospital catchment area when the hospital closes and its affiliated corps of GPs and specialists dwindles further. Funding access to health care services has been the largest single category of grants given by FCH.

----Sharon Hospital has always been an important draw for retirees and young families and doctors moving into the area, as well as for the two flourishing retirement facilities, Noble Horizons and Geer, and for the nursing home across the road from the hospital. Again, the loss of the hospital would cause hardship to these facilities, and reduce the appeal of the NW corner and adjacent New York as a place to raise a family or retire.

----Sharon Hospital as part of a non-profit entity will once again be able to call on the community for financial support. It is a generous community and will respond to requests for volunteers and contributions.

----The terms of the agreement with Health Quest provide for a local hospital board the majority of which will be selected by the FCH, giving the local community much more of a say in the policy and operation of the

hospital.

These are sensible, fiscal, reasons for approving this sale of Sharon Hospital to Health Quest. There are also the personal reasons like my own. When my parents, in their eighties and nineties, had to be hospitalized from time to time I could visit them daily even though I was working full time. I can't imagine what it will be like for my family or friends to have to drive to Poughkeepsie or Torrington on winter evenings to visit me in my declining years. I don't like having to drive to Torrington to see my cardiologist; I hated having to drive my 94-year-old, wheelchair-bound, husband to Torrington to see an oncologist. And when I my car ran over me, and I was bleeding copiously I might not have made it if I'd had to be taken to Torrington or Poughkeepsie.

So, as a patient/fan of-- and survivor thanks to-- Sharon Hospital, I hope you will issue the CON and enable our hospital to continue, and improve, its service to this community.

Sincerely yours,

Alice Yoakum

Olejarz, Barbara

Subject: FW: Dockets: 16-32132-CON and 16-32133-CON
Attachments: 16-32132-CON 16-32133-CON Order.pdf

From: Carney, Brian
Sent: Friday, April 21, 2017 2:22 PM
To: dping@health-quest.org; victorger@pipeline.com; Jennifer Groves Fusco <jfusco@uks.com>
Cc: Hansted, Kevin <Kevin.Hansted@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>
Subject: Dockets: 16-32132-CON and 16-32133-CON

Dear Attorney Fusco, Mr. Ping and Mr. Germack:

Please see attached Order for the above referenced dockets. Please confirm receipt of this email and the corresponding attachment.

Sincerely,
Brian A. Carney

Brian Carney, MBA
Associate Research Analyst
Connecticut Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134-0308
Phone - 860-418-7014
brian.carney@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTERS OF:

Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc. (16-32132-CON)
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.(16-32133-CON)

ORDER

By letter dated April 13, 2017, The Community Association to Save Sharon Hospital ("CASSH") filed a response to the late files in the above-referenced matters on behalf of the Applicants. Specifically, the response raised three issues: the lack of a medical staffing plan; the lack of clear financial statements; and an ongoing investigation by the United States Department of Justice ("DOJ").

The Applicants are hereby ordered to provide the following information to the Office of Health Care Access on or before the close of business on May 12, 2017:

1. A medical services plan, specific to Sharon Hospital, upon which the Applicants intend to rely should the above-referenced certificate of need applications be approved;
2. Revised financial statements addressing CASSH's concerns with Applicants' Late File No. 2;
3. A detailed description and current status of the investigation currently taking place by the DOJ;
4. A current estimate of the impact the DOJ investigation will have on the Applicants' consolidated financial statements.

4/21/17
Date

Kevin T. Hansted
Hearing Officer

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
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Affirmative Action/Equal Opportunity Employer

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Wednesday, April 26, 2017 12:54 PM
To: Hansted, Kevin; Lazarus, Steven; Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David; User, OHCA
Cc: Ping, David
Subject: Sharon Hospital/Regional Healthcare Associates -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: DOCS-#1545516-v1-HEALTH_QUEST_RESPONSE_TO_OHCA_ORDER_(FINAL).PDF; DOCS-#1545511-v1-HEALTH_QUEST_CASSH_MOTION_TO_PRECLUDE_(FINAL).PDF

All:

Attached please find the following submitted on behalf of Applicants:

1. Motion to Preclude Further Participation By the Community Association to Save Sharon Hospital
2. Response to OHCA's Order Dated April 21, 2017

Please let me know if you have any questions or require additional information.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
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One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
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immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.
Docket No. 16-32132-CON

Transfer of Ownership of Regional Healthcare Associates, LLC
to a Subsidiary of Vassar Health Connecticut, Inc.
Docket No. 16-32133-CON

RESPONSE TO OHCA'S ORDER DATED APRIL 21, 2017

The Applicants in the above-referenced Certificate of Need ("CON") dockets, Essent Healthcare of Connecticut, Inc., Sharon Hospital Holding Company, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. and Regional Healthcare Associates, LLC (collectively the "Applicants"), submit the following in response to the Office of Health Care Access' ("OHCA") Order, dated April 21, 2017.

REQUEST No. 1:

Provide a medical services plan, specific to Sharon Hospital, upon which the Applicants intend to rely should the above-referenced certificate of need applications be approved.

RESPONSE:

In its Response to the Applicants' Late File submission, the Community Association to Save Sharon Hospital ("CASSH") has requested a medical staffing/services plan that details "what physicians and what specialists would be added and when, where they would be located, and how their time would be divided between Sharon Hospital and other Health Quest hospitals." Health Quest conducted an analysis of physician needs in the Sharon Hospital service area, which was submitted to OHCA as Late File No. 1. Health Quest will use that study as the basis of its physician staffing plan, and upon approval of the CONs and completion of the transfer of ownership of Sharon Hospital and Regional Healthcare Associates, LLC ("RHA") to Health Quest, will update its analysis as necessary.

The table below includes a preliminary physician staffing plan for Sharon, based on Health Quest's current understanding of Sharon Hospital and the surrounding area Applicants have endeavored to provide the information requested by CASSH to the extent possible, including the specialties being recruited, the anticipated number of FTEs being added to the Sharon service area in each of the first five years of Health Quest ownership, the number of actual physicians that comprise the FTE estimates, and the status of current recruitment efforts. Note that OHCA typically allows purchasers of acute care hospitals a period of time (6 months) post-closing to prepare detailed healthcare services plans (*see e.g.* Docket Nos. 15-32045-CON; 15-32033-CON; 15-32017-486).

Anticipated Physician Recruitment, FYs 2017 - 2020

Physician Type	FY 2017	FY 2018	FY 2019	FY
Family Practice/Internal Medicine	2 FTEs	2 FTEs	2 FTEs	2 FTEs
Ob/Gyn	2 FTEs	0 FTEs	0 FTE	0 FTE
Cardiology	1.25 FTEs	1 FTE	1 FTE	0 FTE
General Surgery	0.5 FTEs	1.0 FTE	0 FTE	0 FTE
Pulmonology	.25 FTEs	1.0 FTE	0 FTE	0 FTE
Oncology	.25 FTEs	1.0 FTE	1.0 FTE	0 FTE
Endocrinologist	0 FTE	1.0 FTE	0 FTE	0 FTE
Pain Medicine	1.0 FTE	0 FTE	0 FTE	0 FTE
Pathology	1.0 FTE	0 FTE	0 FTE	0 FTE

In addition, Health Quest has already made substantial progress towards its year-one goals for recruiting physicians to practice in the Sharon Hospital service area. Below is an update on physician recruitment by specialty, including status of credentialing and whether the recruited physicians are new to the Sharon area.

Family Practice/Internal Medicine:

- One (1) physician recruited who is new to the Sharon area and is starting the credentialing process.
- One (1) physician who currently practices in the Sharon area and is already credentialed at Sharon Hospital has agreed to affiliate with Health Quest.
- Both of these physicians would practice full-time in the Sharon area.

OB/GYN:

- One (1) physician recruited who is new to the Sharon area and is awaiting paperwork to begin the credentialing process.
- Two (2) OB/GYNs who are new to the Sharon area have been offered employment with a Health Quest affiliate; Health Quest is awaiting responses.
- Each of these physicians would practice full-time in the Sharon area.

Cardiology:

- Five (5) physicians who currently practice with the Health Quest Heart Center in Poughkeepsie will be expanding their practices to provide services in Sharon on a part-time basis. Two (2) of these physicians are in the credentialing process at Sharon Hospital. Three (3) of these physicians are in the process of obtaining their Connecticut medical licenses and will then begin the credentialing process.
- One (1) physician who currently practices in the Sharon area has been recruited to join the Health Quest Heart Center, pending OHCA approval of these transactions. He is already credentialed at Sharon Hospital. He will practice in Sharon full-time.

General Surgery:

- One (1) physician who currently practices in the Sharon area and is already credentialed at Sharon Hospital has been recruited to join a Health Quest affiliate. He will practice in Sharon full-time.

Pain Medicine:

- One (1) physician recruited who is new to the Sharon area and is in the process of obtaining credentials at Sharon Hospital. She will practice in Sharon full-time.

Pathology:

- Five (5) pathologists currently employed by HQMP will be expanding their practices to provide services in Sharon on a part-time basis. They are in the credentialing process at Sharon Hospital.

REQUEST No. 2:

Provide revised financial statements addressing CASSH's concerns with Applicants Late File No. 2.

RESPONSE:

Late File No.2 is a chart that shows volume and financial data for Northern Dutchess Hospital ("NDH") for FYs 2000 through 2016. This information was provided at OHCA's request to confirm the supposition that Health Quest has the skills and expertise to "turn around" failing ventures in a short period of time and to achieve sustained positive results in the long-term. The presentation of this information is based on financial statements that are consistent with GAAP and the manner in which Health Quest presents its consolidated financials. Included in the information presented for NDH are the expenses for hospital-based physicians. Accordingly, the financial information presented in Late File No. 2 does not need to be revised, as it is not misleading in the way that CASSH suggests.

REQUEST NO. 3:

A detailed description and current status of the investigation currently taking place by the DOJ.

RESPONSE:

The current footnote accompanying Health Quest's independently audited 2016 Audited Financial Statements related to commitments and contingencies is included as Attachment A. This includes a description of the Department of Justice matter and current status. Health Quest believes that it is adequately reserved for any potential outcome in this matter, and therefore does not believe that the outcome will be material to Health Quest's ability to acquire and operate Sharon Hospital and RHA. The DOJ matter should not, therefore, have any adverse impact on the financial feasibility of Applicants' proposals.

REQUEST NO. 4:

A current estimate of the impact of the DOJ investigation will have on the Applicants' consolidated financial statements

RESPONSE:

Health Quest believes that it is adequately reserved for any potential outcome in this matter, and therefore does not believe that the outcome will be material to Health Quest's ability to acquire and operate Sharon Hospital and RHA. The DOJ matter should not, therefore, have any adverse impact on the financial feasibility of Applicants' proposals. For additional information, see Response to Request No. 3 above.

ATTACHMENT A

Footnote 15 in the 2016 Draft Audited Financial Statements (expected to be approved on April 27, 2017).

In June 2015, the United States Attorney's Office for the Northern District of New York ("DOJ") served a Civil Investigative Demand (CID) on Health Quest Systems, Inc,.and Health Quest Medical Practice, P.C. (collectively, "Health Quest"), seeking information relating to nine topics. Health Quest responded to the CID and has cooperated with the investigation. Cooperation continues, and Health Quest continues to produce documents responsive to the CID. In connection with the issues raised in the CID, and before receipt of the CID, Health Quest had made self-disclosures as to several of the issues in the CID and had refunded several hundred thousand dollars in overpayments. DOJ has continued to seek additional information and documents from Health Quest, which continues to cooperate with DOJ's investigation. As is common in DOJ investigations, the New York State Medicaid Fraud Unit also is working on the investigation with DOJ, and Health Quest also is cooperating with their inquiries, which are joint with DOJ. Lastly, in the ordinary course of auditing payment and complying with the law, Health Quest, its outside counsel, and its outside claims auditors have been auditing, refunding overpayments and implementing corrective action plans in connection with claims billed to payors. Health Quest continues to assess any additional potential overpayment amount, but any such amount is unknown at this time. At December 31, 2016, the Company recorded an estimated liability for potential overpayments related to the four areas, however it is reasonably possible that a change in this estimate will occur in the future and the change could be material to the consolidated financial statements.

The Company is involved in litigations arising in the course of business. While the outcome of these suits cannot be determined at this time, management, based on the advice from legal counsel, currently believes that any loss which may arise from these actions will not have a material adverse effect on the Company's financial position or results of operations. The liabilities, if accrued, might be subject to change in the future based on new developments, or changes in circumstances, which could have a material impact on the Company's results of operations, financial position, and cash flows.

The health care industry is subject to numerous laws and regulations of Federal, state and local governments. Recently, government activity has increased with respect to investigations concerning possible violations by health care providers of fraud and abuse statutes and regulations. Compliance with such laws and regulations are subject to future government review and interpretations as well as potential regulatory actions.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS DIVISION

IN RE: TRANSFER OF OWNERSHIP OF SHARON HOSPITAL TO VASSAR HEALTH CONNECTICUT, INC. IN RE: TRANSFER OF OWNERSHIP OF REGIONAL HEALTHCARE ASSOCIATES, LLC TO A SUBSIDIARY OF VASSAR HEALTH CONNECTICUT, INC.	DOCKET NO. 16-32132-CON & DOCKET NO. 16-32133-CON APRIL 26, 2017

MOTION TO PRECLUDE FURTHER PARTICIPATION BY THE COMMUNITY ASSOCIATION TO SAVE SHARON HOSPITAL

Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital ("Essent"), Sharon Hospital Holding Company ("SHHC"), Health Quest Systems, Inc. ("Health Quest"), Vassar Health Connecticut, Inc. ("Vassar Connecticut"), and Regional Healthcare Associates, LLC ("RHA") (collectively "Applicants"), Applicants in the above-referenced CON proceedings under Docket Nos. 16-32132-CON and 16-32133-CON, hereby request that OHCA exercise its authority to limit the participation of the Community Association to Save Sharon Hospital ("CASSH") in these proceedings and preclude CASSH from submitting any additional information or evidence, whether written or oral, including but not limited to a response to Applicants' Response to OHCA's Order Dated April 21, 2017, which has been filed along with this Motion.

In support of their Motion, Applicants offer the following:

- On March 23, 2017, CASSH filed a Request for Intervenor Status. On March 24, 2017, over Applicants' objection, CASSH was designated as an Intervenor with Limited Rights. These rights were described by OHCA in its Order as follows:

The Petitioner is granted the right to inspect and copy records on file with OHCA related to the CONs filed under Docket Numbers 16-32132-CON and 16-32133-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicant until the issuance of a final decision by OHCA. As an intervenor with limited rights, the Petitioner may be cross-examined by the Applicant but the Petitioner may not cross-examine the Applicant.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioner throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

- Upon information and belief, CASSH was advised of the need to pre-file all of its substantive testimony in this matter by March 29, 2017, the same date by which Applicants were required to file their written testimony and evidence.
- On March 29, 2017, CASSH submitted a nine-page, single-spaced document identified as the testimony of Victor Germack, CASSH's Vice President.
- The testimony was copied to Attorney General George Jepsen, among others, and requested specific action by the Attorney General in connection with these CON proceedings. The Attorney General has no jurisdiction over the above-referenced CONs, a fact known to Mr. Germack (*see* March 27, 2017 letter from Victor Germack to AAG Gary W. Hawes included in the OHCA records of the above-referenced CON dockets). Still, Mr. Germack persisted on behalf of CASSH in requesting the participation of the Attorney General in these proceedings.
- The testimony submitted by CASSH was replete with requests that extend far beyond the CON jurisdiction of OHCA, as Mr. Germack was certainly aware. These included numerous requests for changes to a funding agreement between Health Quest and the Foundation for Community Health ("FCH"), a public charity that is not a party to these CON proceedings.

- On March 31, 2017, two days past the deadline for submission of hearing testimony, CASSH filed unauthorized and untimely rebuttal testimony in response to Applicants' hearing submissions. Applicants did not object to this testimony in the interest of allowing full community participation in these CON proceedings.
- At the April 5, 2017 public hearing on these matters, CASSH was given nearly 30 minutes to make a presentation. Mr. Germack's presentation was almost as long as the Applicants' presentation and it was substantially longer than other members of the public were given to speak, including elected officials, interested community members, local healthcare providers, and other who came out in overwhelming support of the CON proposals.[1]
- At the public hearing, OHCA ordered Applicants to submit certain information via Late Files. OHCA did not ask CASSH to submit any additional information, nor did OHCA request or authorize a rebuttal submission from CASSH.
- On April 11, 2017, Applicants' submitted their Late Files, providing OHCA with the exact information that was requested. This included:
    - A Medical Staff Development Plan for the Sharon area prepared by Veralon, at Health Quest's request, in order to assess physician need; and
    - Historical information regarding volume and operating margins at Northern Dutchess Hospital ("NDH") from FYs 2000 through 2016.
- Notwithstanding the fact that a reply from CASSH was neither requested nor authorized by OHCA, CASSH submitted a response to Applicants' Late Files on April 13, 2017. CASSH's response included questions and arguments that have been raised by Mr.

[1] The only members of the public who voiced concern over any aspect of Applicants' proposals are believed to be members of CASSH.

Germack in every prior submission and responded to by Applicants; a misleading and uninformed "analysis" of the NDH data submitted by Applicants; and questions pertaining to information in the CON dockets entirely unrelated to the Late Files and not previously raised by CASSH, although the information Mr. Germack cites has been available to the public since November of 2016. Once again, in the interest of allowing full community participation in these CON proceedings, Applicants did not object to CASSH's submission.

- Each of CASSH's submissions in response to Applicants' hearing testimony (including the Late Files) is akin to unauthorized cross-examination; CASSH was specifically denied the right to cross-examine Applicants in the matter, and attempting to do so via written submissions is a violation of OHCA's Order regarding CASSH's participation.
- Mr. Germack and other representatives of CASSH spent nearly three hours speaking with Sharon Hospital administrators about these proposals in a private meeting prior to the public hearing. This is in addition to the two-hour Community Forum hosted by Health Quest and RCCH HealthCare Partners on March 16, 2017, which Mr. Germack attended. Mr. Germack gave a statement at the Community Forum, asked multiple questions, which were fully answered by Robert Friedberg of Health Quest, and then had a lengthy private discussion with Mr. Friedberg after the Forum. Moreover, Applicants understand that Mr. Germack spent several hours in a private meeting with representatives of FCH and that he has had countless telephone conversations with elected officials and representatives of various administrative agencies voicing his concerns with this transaction.

Based on the foregoing, CASSH has had a full and fair opportunity to participate in these CON proceedings. As an intervenor with limited rights CASSH has had every chance (and more) to submit written evidence, make arguments and raise issues important to its membership. However it is Applicants, and not CASSH, whose legal rights, duties and privileges are being adjudicated in these contested cases. This is why OHCA typically allows parties to a CON proceeding, and not intervenors, to have the last word through the submission of post-hearing evidence. CASSH's continued insistence on having the last word, on submitting information that is in many instances duplicative, erroneous, irrelevant, and beyond the scope of CON review, is impairing the orderly conduct of and unnecessarily delaying these critical proceedings.

For these reasons, Applicants respectfully request that OHCA issue an Order precluding the submission of any additional information or evidence by CASSH, in any form, or any further participation by CASSH in these proceedings. Applicants further move that any information submitted by CASSH before OHCA rules on this request, or in contravention of an Order by OHCA not to submit additional evidence, be stricken from the record. Lastly, to the extent that Applicants' Response to OHCA's Order Dated April 21, 2017 provides all of the information that the agency requires, Applicants request that the public hearing on these matters be closed.

Respectfully Submitted,

ESSENT HEALTHCARE OF CONNECTICUT, INC; SHARON HOSPITAL HOLDING COMPANY; REGIONAL HEALTHCARE ASSOCIATES, LLC; HEALTH QUEST SYSTEMS, INC.; VASSAR HEALTH CONNECTICUT, INC.

By: *Jennifer G. Fusco*

JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.
265 Church Street
One Century Tower
New Haven, CT 06510
Tel: (203) 786-8300
Fax (203) 772-2037

CERTIFICATION

This is to certify that a copy of the foregoing was sent via electronic mail this 26th day of April, 2017 to the following parties:

Victor Germack
The Community Association
To Save Sharon Hospital
P.O. Box 612
Salisbury, CT 06068
victorger@pipeline.com

Jennifer G. Fusco
JENNIFER GROVES FUSCO, ESQ.
Updike, Kelly & Spellacy, P.C.

User, OHCA

From: Lazarus, Steven
Sent: Thursday, April 27, 2017 7:38 AM
To: User, OHCA
Subject: FW: Sharon Hospital/Regional Healthcare Associates -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: DOCS-#1545516-v1-HEALTH_QUEST_RESPONSE_TO_OHCA_ORDER_(FINAL).PDF; DOCS-#1545511-v1-HEALTH_QUEST_CASSH_MOTION_TO_PRECLUDE_(FINAL).PDF; image001.jpg

Please add to the file.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

-----Original Message-----
From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Wednesday, April 26, 2017 8:10 PM
To: Victorger@pipeline.com
Cc: Lazarus, Steven <Steven.Lazarus@ct.gov>
Subject: FW: Sharon Hospital/Regional Healthcare Associates -- Docket Nos. 16-32132-CON & 16-32133-CON

Victor,

Please see attached. My apologies for leaving you off the initial email transmission.

Jen

_____

From: Jennifer Groves Fusco
Sent: Wednesday, April 26, 2017 12:53 PM
To: Hansted, Kevin (Kevin.Hansted@ct.gov); Lazarus, Steven (Steven.Lazarus@ct.gov); Riggott, Kaila; Schaeffer-Helmecki, Jessica; Fernandes, David (David.Fernandes@ct.gov); ohca@ct.gov
Cc: Ping, David
Subject: Sharon Hospital/Regional Healthcare Associates -- Docket Nos. 16-32132-CON & 16-32133-CON

All:

Attached please find the following submitted on behalf of Applicants:

1. Motion to Preclude Further Participation By the Community Association to Save Sharon Hospital

2. Response to OHCA's Order Dated April 21, 2017

Please let me know if you have any questions or require additional information.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
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www.uks.com<http://www.uks.com/>

[Description: Description: UKS_Meritas]

The Community Association to Save Sharon Hospital

P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

FAX Sheet

Date: April 27, 2017

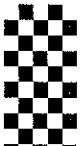
To: Mr. Kevin T. Hansted
Hearing Officer
Office of Health Care Access

Fax Number: 860- 418-7053

From: The Community Association to Save Sharon Hospital

Subject: Attached Letter Answer Response by The Community Association to Save Sharon Hospital to the Response by Essent Healthcare of Connecticut, Inc., Sharon Hospital Holding Company, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. and Regional Healthcare Associates, LLC (collectively the "Applicants") to the Office of Health Care Access ("OHCA") Order, dated April 21, 2017.

Please Note: For speed of communication, could you please contact me at my email address above, fax or phone. Thank you.
Victor Germack



The Community Association to Save Sharon Hospital
P.O. Box 612
Salisbury, CT. 06068
victorger@pipeline.com
Fax: (212) 722-3819
Phone: (917) 582-8411

VIA FAX & ELECTRONIC MAIL

April 27, 2017

Mr. Kevin T. Hansted
Hearing Officer
State of Connecticut Dept. of Public Health
Office of Health Care Access Division
410 Capital Avenue, MS #1 HCA
P.O. Box 340308
Hartford, CT. 06134-0308

Re: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc. &
Transfer of Ownership of Regional Healthcare Associates and Tri State Women's Services to a Connecticut Medical Foundation

DOCKET NO. 16-32132-CON
& DOCKET NO. 16-32133-CON

Answer by The Community Association to Save Sharon Hospital to the Response by Essent Healthcare of Connecticut, Inc., Sharon Hospital Holding Company, Health Quest Systems, Inc., Vassar Health Connecticut, Inc. and Regional Healthcare Associates, LLC (collectively the "Applicants") to the Office of Health Care Access ("OHCA") Order, dated April 21, 2017.

REQUEST No. 1:
Provide a medical services plan, specific to Sharon Hospital, upon which the Applicants intend to rely should the above-referenced certificate of need application be approved.

The Applicants' response shows adding 21.25 FTEs over the next four years. While furnishing some additional information regarding specialties, it is incomplete inasmuch as it doesn't detail where the specialists would be based, and how their time would be divided

between Sharon Hospital and the other Health Quest hospitals. More importantly, the Applicants propose adding 21.25 FTEs between FY 2017 and FY 2020, however, the Veralon study on which the Applicants based their community needs assessment, and staffing, says that "with no replenishment of physicians in the service area, physician supply is projected to decrease by 21 FTEs by 2022 due to retirement." That means we will have to add 21 FTE's just to stand still but we now know we need to add many more physicians in our area. Indeed the Veralon study projects that by 2022, there will be a deficit of 51.6 FTEs – where will this come from and how will it be provided by the Applicants?
We request that they provide this information.

Responding to the Applicants statement that OHCA typically allows purchasers of acute health care hospitals a period of time (6-months) post-closing to prepare detailed healthcare services plans, we understand that Health Quest Systems already has been operating Sharon Hospital for approximately the last six months, thereby already giving them the opportunity to refine and spell-out their staffing plans in much greater detail than they have provided to date.

However we would ask that were OHCA to approve the transfer, that it require the Applicants to submit a detailed plan demonstrating how health care services will be provided by Sharon Hospital for the first five years following the Transfer Agreement, including any consolidation, reduction or elimination of existing services or introduction of new services, and that a monitor be appointed to review and oversee the implementation of their plan, and that the results be communicated to the public on an annual basis. We would also request that OHCA require that Sharon Hospital submit their operating performance and financial measurement results for the first five years, to be submitted twice a year, and that they be made available to the public.

Request No. 2
Provide revised financial statements addressing CASSH's concerns with Applicants Late File No. 2

Late File No. 2 is a chart that shows volume and financial data for Northern Dutchess Hospital ("NDH") for FYs 2000 through 2016. The chart was provided to confirm the supposition that Health Quest has the skills and expertise to "turn around" failing hospitals in a short period of time. We had pointed out, in our response, that the method, that the Applicants used, of calculating the operating results and margins for NDH was incorrect; and we outlined what the correct method should be by allocating the appropriate share of all of their physician and medical group practice costs using the 2015 Health Quest Systems, Inc. Audited Financial Statements. The Applicants' explanation on this point is not responsive and did not address the standard methodology that we used to calculate the operating profit margin, and I say this as a financial professional.

(Professionally, I am considered a financial expert as I was a director and the chairman of the audit committee of a NYSE company for several years, and the founder and President of RateFinancials Inc. – which rates the accounting, financial reporting and governance of public companies. I am also the Treasurer and a director of the Osborne Association – a non-profit that works in many New York State prisons with prisoners, ex-offenders and their families through a variety of programs.)

In fact, if you take an average of the operating profit margins for NDH for the first five years from 2000 to 2004, the average operating profit margin is a negative 1.9%. If you take the first ten years history for NDH, the average operating profit margin is 1.2%. This illustrates our contention that it takes a long time to turn a money-losing hospital around which has lost the bulk of its community support and revenue. This is why we wanted a long-term 10 year commitment from Health Quest to continue supporting Sharon Hospital.

Request No. 3
A detailed description and current status of the investigations currently taking place by the DOJ

The Applicants' answer is to furnish us with their draft footnote 15 of the Health Quest 2016 Audited Financial Statements. Their footnote describes a June 2015 DOJ - CID Investigation of nine topics which are not described in detail but appear to be Medicaid overbilling. The NYS Medicaid Fraud Unit is also working with the DOJ on this matter. The footnote states that Health Quest has "refunded several hundred thousand dollars in overpayments", and Health Quest "has recorded an estimated liability for potential overpayment relating to the (unidentified) four areas." However it is not clear what the "nine topics" and, or the "four areas" mentioned in the footnote relate to, as the footnote is quite ambiguous.

We need to know what has Health Quest determined, working with its outside claims auditor and counsel, to be its maximum financial exposure, and what has it reserved for to-date? What has it already charged off against this reserve? These are the critical questions that OHCA needs to determine to see if it will have a material impact on the Health Quest consolidated financial statements and its operations going forward.

However, if you read footnote 15 from the 2015 Audited Financial Statements, it says, "on April 15, 2016, the DOJ asserted it would be pursuing investigations into two matters that were the subject of the Company's self-disclosure efforts." "The two matters relate to contracts entered into between VBMC and PHC and two separate physician groups." The Company recorded an estimated liability for this. However there is no mention of this investigation in the 2016 Audited Financial Statements – What are we to conclude from this? Were the 2015 and 2016 DOJ investigations the same or were they merged? Was the 2016 investigation concluded and what was the resolution if it was material? Or is it ongoing? These questions should be answered to get a clear picture of the materiality of these issue

Request No. 4
A current estimate of the impact of the DOJ investigation will have on the Applicants' consolidated financial statements

It is a self-serving statement that "Health Quest believes that it is adequately reserved for any potential outcome in this matter, and therefore does not believe that the outcome will be material to Health Quest's ability to acquire and operate Sharon Hospital and RHA. The DOJ matter should not, therefore, have any adverse impact on the financial feasibility of Applicants' proposals."

The short answer is that given the limited information in the draft footnote it is impossible to know what Health Quest's maximum exposure is since they haven't revealed it to us, nor do we know what the scope of the DOJ investigations are or what the dollar amount of the exposure that is covered by the overbilling. Then there is the possibility that if the amount is large enough or the offense serious enough, perhaps the NYS Medicaid or the DOJ could suspend all or part of Medicaid billings for some period by Health Quest, or put certain restrictions on their billing practices. Since both Health Quest and Sharon Hospital have a large number of Medicaid patients, this could be very financially significant and have a material impact on the transfer of Sharon Hospital and on the financial position of Health Quest going forward. The mere fact that their footnote 15 admits that "it is reasonably possible that a change in this estimate will occur in the future and the change could be material to the consolidated financial statements." This should compel OHCA to understand more clearly the potential exposure and impact.

CERTIFICATION

THIS IS TO CERTIFY THAT A COPY OF THE FOREGOING WAS SENT VIA ELECTRONIC MAIL THIS 27TH. SAY OF APRIL, 2017 TO THE FOLLOWING PARTIES:

JENNIFER GROVES FUSCO, ESQ.
UPDIKE, KELLY & SPELLACY, P.C.

VICTOR GERMACK
Vice President
The Community Association to Save Sharon Hospital
P.O. Box 612
Salisbury, CT. 06068

Olejarz, Barbara

From: Lazarus, Steven
Sent: Friday, April 28, 2017 7:46 AM
To: User, OHCA
Cc: Olejarz, Barbara; Martone, Kim; Riggott, Kaila
Subject: FW: Sharon Hospital-RHA -- Docket Nos. 16-32132-CON & 16-32133-CON

Please add this email to the original file.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Friday, April 28, 2017 7:42 AM
To: victorger@pipeline.com; Hansted, Kevin <Kevin.Hansted@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Schaeffer-Helmecki, Jessica <Jessica.Schaeffer-Helmecki@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>
Cc: Ping,David <DPing@Health-quest.org>; User, OHCA <OHCA@ct.gov>
Subject: RE: Sharon Hospital-RHA -- Docket Nos. 16-32132-CON & 16-32133-CON

Hearing Officer Hansted,

Applicants hereby reiterate their request that Mr. Germack and CASSH be precluded from further participation in these CON proceedings and that the attached "Response" by CASSH be stricken from the record in its entirety. Applicants submitted a Motion to Preclude on April 26, 2017, and provided Mr. Germack with a copy. Instead of waiting for OHCA to rule on that motion, Mr. Germack determined on his own that he was entitled to make yet another untimely and unauthorized submission. Mr. Germack's blatant disregard for the administrative process and OHCA's authority is disrupting the orderly conduct of these CON proceedings. Applicants ask that OHCA act without further delay on their motion, strike CASSH's submission of April 27, 2017, and preclude any additional participation by Mr. Germack or his organization.

Respectfully submitted on behalf of Applicants.

Jennifer Fusco

From: victorger@pipeline.com [victorger@pipeline.com]
Sent: Thursday, April 27, 2017 11:34 PM
To: Hansted,Kevin (Kevin.Hansted@ct.gov); Riggott,Kaila; Lazarus,Steven (Steven.Lazarus@ct.gov); Schaeffer-Helmecki,Jessica; Fernandes,David (David.Fernandes@ct.gov)
Cc: Ping,David; ohca@ct.gov; Jennifer Groves Fusco
Subject: Re: Sharon Hospital-RHA -- Docket Nos. 16-32132-CON & 16-32133-CON

To All:

Attached please find The Community Association to Save Sharon Hospital's Answer to Response by the Applicants to the Office of Health Care Access Order, Dated April 21, 2017.

Thank you,

Victor Germack
Vice President
The Community Association to Save Sharon Hospital

Olejarz, Barbara

From: Lazarus, Steven
Sent: Friday, April 28, 2017 7:42 AM
To: Jennifer Groves Fusco (jfusco@uks.com); victorger@pipeline.com
Cc: User, OHCA; Riggott, Kaila; Martone, Kim; Schaeffer-Helmecki, Jessica; Fernandes, David; Olejarz, Barbara; Foster, Tillman; Roberts, Karen
Subject: DNs 16-32132 and 16-32133 Ruling on Applicants Motion
Attachments: DNs 16-32132 and 16-32133 Ruling on Applicants Motion.pdf

Please see the attached ruling on the Applicant's motion dated April 26, 2017, in the matter referenced above. If you have any questions regarding this correspondence, please feel free to contact me.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTERS OF:

Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc. (16-32132-CON)
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.(16-32133-CON)

ORDER

The Applicants' Motion to Preclude Further Participation by the Community Association to Save Sharon Hospital ("CASSH") is hereby **GRANTED**.

OHCA will accept CASSH''s submission dated April 27, 2017. The Applicants may file a response to CASSH's submission. Such response is due on or before May 5, 2017.
CASSH shall not file any further responses with OHCA unless ordered to do so.

4/28/17
Date

Kevin T. Hansted
Hearing Officer

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Olejarz, Barbara

From: Lazarus, Steven
Sent: Tuesday, May 02, 2017 4:33 PM
To: User, OHCA
Cc: Martone, Kim; Olejarz, Barbara; Greer, Leslie
Subject: FW: Sharon Hospital & RHA -- Docket Nos. 16-32132-CON & 16-32133-CON
Attachments: DOCS-#1551134-v1-HEALTH_QUEST_CASH_REPLY_FINAL_(5_2_17).pdf

Please add to the record.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, May 2, 2017 4:31 PM
To: Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Schaeffer-Helmecki, Jessica <Jessica.Schaeffer-Helmecki@ct.gov>; Fernandes, David <David.Fernandes@ct.gov>; User, OHCA <OHCA@ct.gov>
Cc: Ping, David <DPing@Health-quest.org>; victorger@pipeline.com
Subject: Sharon Hospital & RHA -- Docket Nos. 16-32132-CON & 16-32133-CON

All:

Attached please find the Applicant's Reply to CASSH's Response Dated April 27, 2017. This is being filed in accordance with OHCA's April 28, 2017 Order, which permits a reply by the Applicants, but expressly prohibits further filings by CASSH unless ordered by the agency.

Thank you,
Jen

Jennifer Groves Fusco, Esq.
Principal

Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

Transfer of Ownership of Sharon Hospital
to Vassar Health Connecticut, Inc.
Docket No. 16-32132-CON

Transfer of Ownership of Regional Healthcare Associates, LLC
to a Subsidiary of Vassar Health Connecticut, Inc.
Docket No. 16-32133-CON

REPLY TO CASSH'S RESPONSE DATED APRIL 27, 2017

The Applicants in the above-referenced Certificate of Need ("CON") dockets, Essent Healthcare of Connecticut, Inc., Sharon Hospital Holding Company, Health Quest Systems, Inc. ("Health Quest"), Vassar Health Connecticut, Inc., and Regional Healthcare Associates, LLC ("RHA") (collectively the "Applicants"), submit the following reply to the Community Association to Save Sharon Hospital's ("CASSH") April 27, 2017 filing.

With respect to Request Nos. 1 and 2, the Applicants have already provided OHCA with complete, accurate and responsive information. The following is submitted in rebuttal to the unauthorized questions raised by CASSH in its latest filing.

In response to Request No. 1, the Applicants provided a preliminary physician staffing plan, including information requested by CASSH to the extent practicable, and a detailed update on initial physician recruitment. Through their various submissions the Applicants have established that the proposed sale of Sharon Hospital and RHA to Health Quest subsidiaries will improve the quality, accessibility and cost-effectiveness of healthcare delivery in the region (*see* Conn. Gen. Stat. § 19a-639(a)(5)). Moreover, through these same sworn submissions Health Quest has demonstrated how healthcare services will be provided at Sharon Hospital going forward, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services (*see* Conn. Gen. Stat. §19a-639(d)(2)(B)). Health Quest has also shown that it will be able to enhance physician and medical services in the Sharon area in ways that the current owner, RCCH HealthCare Partners, cannot given its geographic limitations and financial restraints relative to hiring less-than-full-time equivalent for physicians and other providers.

In response to Request No. 2, the Applicants provided an accurate financial summary for Northern Dutchess Hospital ("NDH"), based on information that was prepared in accordance with GAAP and independently audited. CASSH's claim that NDH's financial summary was prepared incorrectly is itself incorrect.

Moreover, the successful turnaround of NDH is self-evident. In FY 2000, NDH had a - 6.7% operating margin. By year three of Health Quest operation, the NDH margin was 1.9%. This swing of 8.6 percentage points in three years is greater than the turnaround Health Quest is projecting for Sharon Hospital after three years of operation. After five years of Health Quest operation, NDH had a positive 4.3% margin, making the turnaround a remarkable 11 percentage points. As the data provided demonstrates, Health Quest has the ability to provide health care services to relevant patient populations and payer mix (*see* Conn. Gen. Stat. §19a-639(a)(6)). It

also shows that Health Quest, through its acquisition of a struggling hospital, can impact favorably on the financial strength of a state's healthcare system (*see* Conn. Gen. Stat. §19a-639(a)(4)).

CASSH's comments with respect to the Applicants' responses to Request Nos. 3 and 4 show a lack of understanding of both independent audits and the process and ultimate resolution of investigations such as those referenced in Health Quest's audited financial statements.

For the matters involving the DOJ, two separate and reputable independent audit firms have conducted reviews over the course of the last two years and confirmed the reserving methodology utilized by Health Quest through the issuance of final audits with clean opinions for FYs 2015 and 2016. Moreover, as Footnote No. 15 to Health Quest's audited financial statements indicates, the matters remain in an active resolution process. Activities are being directed by both internal and external counsel and detailed information pertaining to these matters is attorney-client privileged and highly confidential. To comment further with respect to the detail requested by CASSH is inappropriate, and to discuss the specific reserve amount is also counter to the organization's interests.

Health Quest again asserts its belief that the company is adequately reserved for resolution of the DOJ matters, as confirmed by two independent audits. Health Quest further represents that it has received no demand for settlement from government representatives that exceeds the reserve amount. In the unlikely event that a settlement would exceed reserves, Health Quest is a profitable company with a significant cash position that could address any excess amount without materially interrupting any significant strategic imperatives, including its acquisition and operation of Sharon Hospital. Accordingly, considering the foregoing and as testified to by the Applicants under oath both orally and in writing, the proposals before OHCA are financially feasible (see Conn. Gen. Stat. §19a-639(a)(4)).

Furthermore, the Applicants would like to address CASSH's requests in its most-recent filing and others that OHCA impose certain conditions on any transfer of ownership of Sharon Hospital. Just in its latest filing, CASSH asks for a detailed services plan; an independent monitor to review and oversee implementation of the plan; submission of operating and financial performance measures on a semi-annual basis; public disclosure of all of the foregoing information; and a 10-year commitment by Health Quest to continue supporting Sharon Hospital. This is in addition to more than 20 suggested conditions and demands for information made by CASSH in prior filings, many of which are entirely irrelevant to a CON proceeding.

In placing conditions on a hospital transfer of ownership CON, OHCA must weigh the value of such conditions against the individual and cumulative burden of such conditions on the transacting parties and the new hospital (*see* Conn. Gen. Stat. §19a-639(d)(5)). All conditions must be reasonably tailored in time and scope (*see* Conn. Gen. Stat. §19a-639(d)(5)). Placing unnecessary burdens and restrictions on Health Quest's ownership and operation of Sharon Hospital, as recommended by CASSH, will put the acquisition of Sharon Hospital by Health Quest at risk.

An example of a condition that places an undue burden on Health Quest and Sharon Hospital is CASSH's request that Health Quest be required to "support" the Hospital for a period of 10 years. This unclear request goes beyond any condition imposed by OHCA or the Office of the Attorney General on any hospital transfer, including the original for-profit conversion of Sharon Hospital. The Applicants have clearly established a commercially reasonable transaction and deal terms for the acquisition and operation of Sharon Hospital. Moreover, Health Quest has submitted sufficient evidence regarding its current efforts and future plans to sustain and enhance healthcare services for the benefit of Sharon area residents to make any such condition unnecessary.

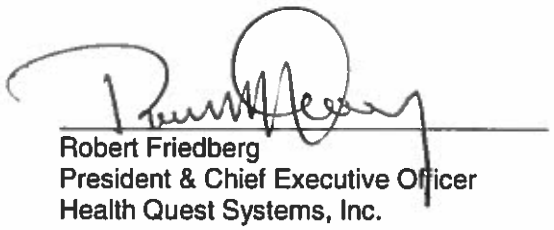
In addition, much of the information that CASSH wants Health Quest to share with the public is information that Sharon Hospital is already required to submit to OHCA in its Twelve Months Actual Filing and Annual Reporting. In addition, as a nonprofit healthcare provider exempt from federal taxation, Health Quest (on behalf of Sharon Hospital) will be submitting detailed information annually with the Internal Revenue Service (Form 990), which will discuss financial operations as well as programmatic services and offerings. This form is also made available to the public through both internet services and upon request. In short, a majority of the information that CASSH is looking for can be found by reviewing these various public filings, making the conditions requested unnecessary.

Lastly, the Applicants accept that CASSH is comprised of concerned citizens who are dedicated to the preservation of an important resource within the community. Health Quest believes it is in the best (and perhaps only) position to help ensure the ongoing viability of Sharon Hospital within its community, and believes it has demonstrated its intent in many ways, including agreeing to acquire the Hospital. The interests of the sides in a larger sense are aligned, but Health Quest disagrees with the approach of CASSH in attempting to legislate specific results (including suggesting acts outside of OHCA's authority) and prolonging an expensive and protracted approval process. The Applicants' hope is to now move forward with the broader community support to complete the transaction and initiate a new vital era for Sharon Hospital.

***

Thank you for the opportunity to submit this rebuttal testimony. Provided that OHCA has all of the information it needs, the Applicants respectfully request that the record of the April 5, 2017 public hearing on these matters be closed.

The foregoing is my sworn testimony.



Robert Friedberg
President & Chief Executive Officer
Health Quest Systems, Inc.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Healthcare Access

May 3, 2017

VIA EMAIL ONLY

Jennifer G. Fusco, Esq.
Updike, Kelly & Spellacy, P.C.,
265 Church Street
New Haven, CT 06510

RE: Transfer of Ownership of Sharon Hospital to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc. (16-32132-CON)
Transfer of Ownership of Regional Healthcare Associates, LLC to Vassar Health Connecticut, Inc., a Subsidiary of Health Quest Systems, Inc.(16-32133-CON)
Closure of Public Hearing

Dear Attorney Fusco:

Please be advised, by way of this letter, the consolidated public hearing held on April 5, 2017, in the above referenced dockets is hereby closed as of May 3, 2017. The Office of Health Care Access will not accept further public comments or filings.

If you have any questions regarding this matter, please feel free to contact Kaila Riggott at (860) 418-7037.

Sincerely,

Kevin T. Hansted
Hearing Officer

C: Victor Germack

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
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User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Wednesday, May 03, 2017 9:22 AM
To: Lazarus, Steven; victorger@pipeline.com
Cc: User, OHCA; Riggott, Kaila; Fernandes, David; Schaeffer-Helmecki, Jessica; Hansted, Kevin; Martone, Kim; Greer, Leslie
Subject: RE: 16-32132 and 16-32133, Close of Public Hearing

Follow Up Flag: Follow up
Flag Status: Completed

Thanks, Steve.

From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Wednesday, May 03, 2017 9:08 AM
To: Jennifer Groves Fusco; victorger@pipeline.com
Cc: User, OHCA; Riggott, Kaila; Fernandes, David; Schaeffer-Helmecki, Jessica; Hansted, Kevin; Martone, Kim; Greer, Leslie
Subject: DNs: 16-32132 and 16-32133, Close of Public Hearing

Please see the attached letter, closing the hearing held on April 5, 2015, in the matter referenced above. Any questions, please feel free to contact me directly.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
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in this e-mail is unauthorized and may be unlawful. If you are not an addressee, please inform the sender immediately and permanently delete and/or destroy the original and any copies or printouts of this message. Thank you. Updike, Kelly & Spellacy, P.C.

Greer, Leslie

From: Schaeffer-Helmecki, Jessica
Sent: Tuesday, July 18, 2017 11:38 AM
To: Jennifer Groves Fusco; Ping, David; victorger@pipeline.com
Cc: Martone, Kim; Riggott, Kaila; Hansted, Kevin; Casagrande, Antony A; User, OHCA; Greer, Leslie
Subject: Agreed Settlement: 16-32132-CON
Attachments: 16-32132-CON Signed Agreed Settlement - SHARON.pdf

Good mid-morning all—

Attached please find the signed Agreed Settlement pertaining to docket number 16-32132-CON, Health Quest's application to acquire Sharon Hospital. Please confirm receipt at your earliest convenience.

Best Regards,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Agreed Settlement

Applicants:

Essent Healthcare of Connecticut, Inc.
50 Hospital Hill Road
Sharon, CT 06069

Vassar Health Connecticut, Inc. & Health Quest Systems, Inc.
1351 Route 55, Suite 200
LaGrangeville, NY 12540

Docket Number: **16-32132-CON**

Project Title: **Transfer of Sharon Hospital from Essent Healthcare of Connecticut, Inc. to Vassar Health Connecticut, Inc., a subsidiary of Health Quest Systems, Inc.**

Project Description: Essent Healthcare of Connecticut, Inc. and Vassar Health Connecticut, Inc. ("Vassar") (collectively "Applicants") seek authorization to transfer ownership of Sharon Hospital and its associated entities to Vassar, a subsidiary of Health Quest Systems, Inc.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the *Republican-American* (Waterbury) on September 28, 29 and 30 2016. On November 3, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project. On March 3, 2017, OHCA deemed the application complete.

On March 3, 2017, OHCA issued an order consolidating the hearing proceedings with that of Docket Number 16-32133-CON, an application for the transfer of ownership of Regional Healthcare Associates, LLC to a Connecticut Medical Foundation that will be a subsidiary of Vassar. On March 7, 2017, the Applicants were notified of the date, time, and place of the public hearing. On March 8, 2017, a notice to the public announcing the hearing was published in the *Republican-American*. On March 23, 2017, the Community Association to Save Sharon Hospital

("CASSH") filed a petition requesting intervenor status. CASSH was granted intervenor status with limited rights. Pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(f)(2), a public hearing regarding the CON application was held on April 5, 2017. The public hearing record was closed on May 3, 2017.

Commissioner Pino designated Attorney Kevin T. Hansted as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform-Administrative Procedure Act (Chapter 54 of Conn. Gen. Stat.).

Findings of Fact and Conclusions of Law

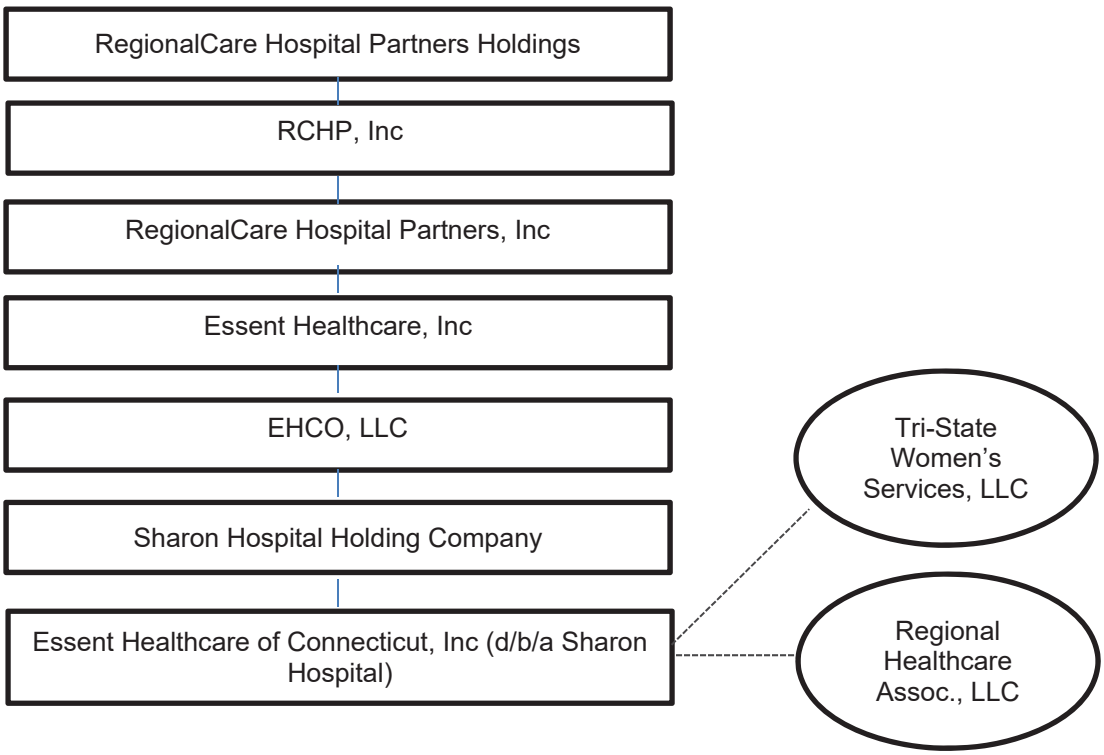
1. Sharon Hospital (the "Hospital") is a 78-bed acute care general hospital, located at 50 Hospital Hill Road in Sharon, Connecticut, which includes an emergency department that is operational 24-hours per day 7 days per week; a stroke center; intensive care, surgical, maternity, and senior behavioral health units; radiology, hospitalist, rehabilitation and cardiology services, as well as, same-day surgery and a wound center. Ex. A, p. 20.

2. In 2002, the Hospital became the first for-profit hospital in Connecticut upon being purchased by Essent Healthcare of Connecticut, Inc. ("Essent"). Ex. A. p. 19; Docket No. 01-486-01.

3. Sharon Hospital Holding Company is the direct parent of the Hospital and provides management and administrative services to the Hospital and group practices associated with the Hospital. Ex. A, p. 20.

4. As shown in the organizational chart below, Essent is a subsidiary of RegionalCare Hospital Partners ("RCHP"). RCHP is a Brentwood, Tennessee-based for-profit entity with 17 regional health systems located in 12 states. The Hospital is the only RCHP-affiliated entity located in Northeastern United States.

ORGANIZATIONAL STRUCTURE PRIOR TO PROPOSAL



Ex. A, pp. 19-20, 549.

5. Patient volume has been decreasing at the Hospital due to an insufficient number of physicians practicing in the area, resulting in a weakening financial outlook. Ex. A, p. 29.

6. The Hospital undertook cost saving measures by "maximizing operational efficiencies, lowering supply costs through group purchasing and curtailing underutilized services." Essent determined the current ownership structure was nonetheless still not viable and affiliation with a larger health network would be more beneficial for the Hospital. Ex. A, p. 29.

7. RCHP evaluated both not-for-profit and investor-owned entities, as well as both Connecticut-based and out-of-state organizations. RCHP determined that Health Quest Systems, Inc. ("Health Quest") was the best option based on its financial strength and proximity to the Hospital. Ex. A, p. 23.

8. On September 13, 2016, the Applicants entered into an asset purchase agreement to transfer, in part, all real, personal and intellectual property of Sharon Hospital Holding Company, the direct parent of the Hospital and a subsidiary of RCHP, to Vassar Health Connecticut, Inc. ("Vassar"), a newly-formed not-for-profit subsidiary of Health Quest. The Applicants anticipate executing the transfer on or before July 31, 2017. Ex. A, p. 79-351.

9. On October 1, 2016 the Applicants also entered into an asset purchase agreement for the transfer of Regional Health Care Associates ("RHA"), an 11-physician group practice currently engaged in a service agreement with SHHC, to a Connecticut Medical Foundation that will be a subsidiary of Vassar. Docket number 16-32133-CON.

10. As a result of this agreement, the Applicants are requesting approval to transfer ownership of the Hospital in order to create a new regional health system. Ex. A.

11. Health Quest, headquartered in LaGrangeville, New York is a not-for-profit health care system that includes three acute care facilities, two physician groups and a rehabilitation facility. The Health Quest system consists of 597 licensed beds and more than 5,000 employees and includes:

    - Vassar Brothers Medical Center, Poughkeepsie, NY ("VBMC") – a 365-bed acute -care hospital offering tertiary services; it provides cardiovascular, neuroscience, oncology, orthopedic services and those specific to women and children; VBMC additionally offers minimally invasive surgery.

    - Northern Dutchess Hospital, Rhinebeck, NY ("NDH") – a 68-bed acute care hospital specializing in orthopedics and women's services; it also offers rehabilitation services, minimally invasive surgery and joint replacement procedures.

    - Putnam Hospital Center, Carmel, NY – a 164-bed acute care facility specializing in orthopedics; it additionally provides inpatient behavioral health services.

- Health Quest Medical Practice ("HQMP"), NY – a physician group associated with Health Quest that includes more than 300 physicians offering services in 27 specialties in five counties.

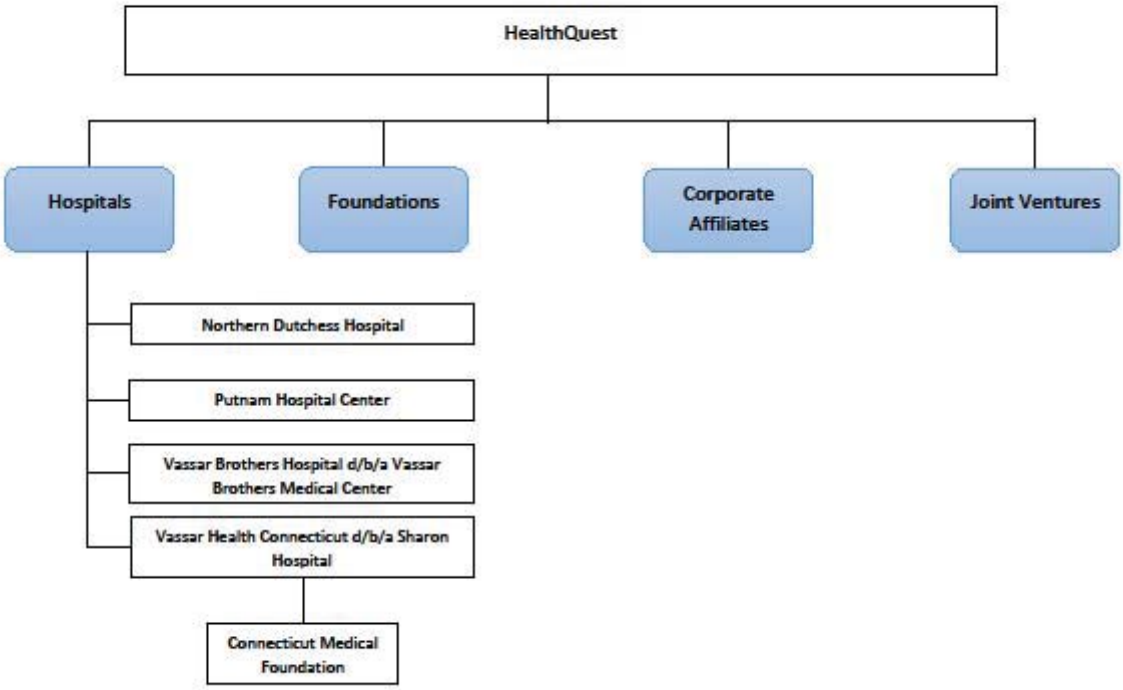
- The Heart Center, NY – a practice unit for 28 Health Quest-affiliated cardiologists in four counties.

- The Thompson House, Rhinebeck, NY – a 100-bed skilled nursing facility located at NDH with a 20-bed sub-acute unit.

Ex. A, pp 21-22.

12. Following implementation of the proposal, the Hospital will become "Vassar Health Connecticut" and a subsidiary of Health Quest, as shown on the organizational chart below. The Hospital will continue to operate under the name "Sharon Hospital."

ORGANIZATIONAL STRUCTURE SUBSEQUENT TO PROPOSAL



Ex. A, p. 551.

13. The Foundation for Community Health ("FCH") was established in 2002 to administer the proceeds from the sale of the Hospital to Essent and the Hospital's charitable assets. FCH's stated mission is, in part, to maintain and improve the physical and mental health of the residents of the area historically served by the Hospital and to invest in the acquisition of the Hospital for the purpose of reconverting the Hospital to a not-for-profit entity. Ex. E, pp. 24, 685.

14. Vassar's Board of Directors will be comprised of 15 trustees, 12 of which will be selected by FCH and subject to the approval of Health Quest. Subsequent to the expiration of the terms of the 12 FCH-selected trustees, the Board will self-perpetuate with Vassar reappointing trustees in a manner consistent with the governance procedures and protocols in place at other Health Quest hospitals. Ex. A, p. 28; Ex. Z, Transcript, Ms. Nancy Heaton, CEO, FCH, pp. 97-98.

15. The Applicants submitted a preliminary plan detailing how services will be provided by the Hospital for the first three years following the transfer of ownership of the hospital. Ex. G, pp. 882-887.

16. Approximately 57% of the Hospital's 2,411 FY2016 inpatient discharges were Connecticut residents and 42% originated from New York. The Hospital's Connecticut primary service area towns are shown in the table below.

TABLE 1
THE HOSPITAL'S
CONNECTICUT PRIMARY SERVICE AREA TOWNS

Town	Discharges (FY 2016)
North Canaan	269 (20%)
Sharon	261 (19%)
Salisbury	223 (16%)
New Milford	79 (6%)
Torrington	63 (5%)
Cornwall	59 (4%)
Canaan	58 (4%)
Kent	49 (4%)
PSA Total	**1,061 (78%)**
Other CT	304 (22%)
CT TOTAL	**1,365 (100%)**

Ex. A, p. 54

17. The Hospital has been experiencing decreases in both inpatient discharges and outpatient visits, as shown in the table below.

TABLE 2
HISTORIC UTILIZATION AT THE HOSPITAL BY SERVICE

Service	Actual Volume*			
	FY2013	FY2014	FY2015	FY2016
Inpatient Discharges	2,878	2,616	2,466	2,411
Outpatient Visits	92,898	92,902	90,592	90,590
Total	95,776	95,518	93,058	93,001

* Includes Connecticut and out-of-state patients
Ex. A, p. 52.

18. The Applicants attribute declining utilization at the Hospital primarily to two factors: the unmet need for higher levels of care locally and reduced and limited physician services. Ex. C, p. 650; Ex. T, Prefiled Testimony of Peter Cordeau, CEO, Sharon Hospital, p. 902.

19. With implementation of the proposal, the Applicants project increases in both inpatient discharges and outpatient visits, as shown in the table below.

TABLE 3
PROJECTED UTILIZATION AT THE HOSPITAL BY SERVICE

Service	Projected Volume*			
	FY2017	FY2018	FY2019	FY2020
Inpatient Discharges	2,798	3,686	3,781	3,835
Outpatient Visits	95,309	102,542	105,315	106,894
Total	98,107	106,228	109,096	110,729

* Includes Connecticut and out-of-state patients as well as increased utilization due to service line expansions
Ex. A, pp. 25, 52; Ex. Z, Transcript, Ms. Christian Bergeron, CFO, Hospital, p. 114-116.

20. The Applicants project an increase in volume due to referrals from Health Quest-owned out-of-state facilities, its anticipated recruitment of physicians and the expansion of physician line services. Ex. A, p. 45.

21. The Health Quest system currently provides no geropsychiatric services and currently turns away 20 to 40 patients per month from its New York facilities. Geropsychiatric patients presenting at Health Quest owned facilities will, when appropriate, be directed to the Hospital. Due to insufficient capacity, the Hospital currently turns away approximately 30 patients seeking geropsychiatric care per month due that will be accommodated by the increase in geropsychiatric beds from 12 to 17. Ex. A, pp. 20, 25; Ex. E, pp. 649-650; Ex. Z, Transcript, Mr. Michael W. Browder, EVP and CFO, RCH HealthCare Partners, p. 115.

22. The Applicants additionally project a 2% increase in patient volume per year between FY 2018 through FY2020 due to the aging of the population and the impact of the newly recruited physicians. Ex. A, p. 45.

23. The Hospital currently does not offer oncological services. Health Quest will establish medical oncology and subspecialty oncology, including surgical and breast, and chemotherapy at the Hospital by FY2020. Ex. E, p. 889; Ex. G, pp. 882-887.

24. The Health Quest network offers tertiary care services[1] not currently offered in the Hospital's primary service area, such as advanced cardiac services, advanced hepatobiliary surgery, Level 3 NICU, Level 2 Trauma, advanced neurosciences, subspecialty cancer services, high-risk obstetric care, advanced robotic surgery, trauma and high-acuity intensive care. Ex. A, p. 24; Ex. E, p. 888.

25. Hospital patients currently requiring tertiary services are referred to hospitals in Waterbury, Hartford, Danbury, Bridgeport or New Haven. Following the transfer of ownership to Health Quest, Sharon Hospital patients needing advanced care may, with their consent, stay within the Health Quest system and be referred to Vassar Brothers Medical Center in Poughkeepsie, NY. Ex. A, p. 27-28; Ex. E, p. 888.

26. In 2017, Veralon, a firm specializing in physician needs and the types of physicians needed relative to a given service area, conducted an assessment of the Hospital's primary service area, encompassing towns in both New York and Connecticut to determine the type and number of physicians needed to adequately serve the population through 2022. It identified family practice and internal medicine physicians as the types most needed in the area. Ex. X, p. 988.

27. By FY 2020, the Hospital intends to recruit 21.25 full-time equivalent physicians to practice in the Sharon area:

    - 8 Family Practice/Internal Medicine physicians
    - 2 Obstetrics and Gynecology physicians
    - 3.25 Cardiologists
    - 1.5 General Surgeons
    - 1.25 Pulmonologists
    - 2.25 Oncologists
    - 1 Endocrinologist
    - 1 Pain Medicine specialist
    - 1 Pathologist

    Ex. A, pp. 36, 45; Ex. CC, p. 999; Ex. G, pp. 883-887.

28. In 2016, HQMP recruited 47 physicians to its Health Quest-affiliated practices in the Sharon-adjacent Hudson Valley region. Ex. E, pp. 647-648, Ex. Z, Transcript, Mr. Glen Loomis, Chief Medical Officer, Health Quest, p. 57.

[1] For purposes herein, "tertiary services" are defined as "specialized consultative services, typically provided on referral from primary or secondary medical care personnel, by specialists working in a center that has the personnel and facilities for special investigation and treatment." Johns Hopkins Medicine, Patient Care, "Tertiary Care Definition," available at https://www.hopkinsmedicine.org/patient_care/pay_bill/insurance_footnotes.html.

29. Two of Health Quest's existing hospitals, VBMC and NDH, are experiencing capacity issues. It will, when medically appropriate, direct patients who reside closer to Sharon than either of those two facilities to seek treatment at Sharon. Ex. A, pp. 20, 25.

30. Health Quest is in the process of developing a strategic plan. However, it does not intend to eliminate or relocate any services currently offered at the Hospital. As stated above, it will be expanding its geropsychiatric unit by five beds as well as expanding the obstetrics and gynecology service, primary care practice, and general and orthopedic surgery services through the recruitment of physicians. Additionally Health Quest will be introducing medical oncology and chemotherapy services. Ex. G, pp. 882-887.

31. The Applicants anticipate Medicare patients will continue to comprise 55% of the Hospital's payer mix. Medicaid patients will continue to comprise 18% of the Hospital's payer mix.

TABLE 4
HOSPITAL'S HISTORIC & PROJECTED PAYER MIX

Payer	FY 2016		Projected					
			FY 2017		FY 2018		FY 2019	
	Patients	%	Patients	%	Patients	%	Patients	%
Medicare*	1,318	55%	1,539	55%	2,027	55%	2,080	55%
Medicaid*	434	18%	504	18%	663	18%	681	18%
CHAMPUS	12	<1%	20	<1%	28	<1%	28	<1%
Total Government	**1,764**	**73%**	**2,063**	**73%**	**2,718**	**73%**	**2,789**	**73%**
Commercial Insurers	588	24%	672	24%	885	24%	907	24%
Uninsured	55	2%	56	2%	74	2%	76	2%
Workers Compensation	4	<1%	7	<1%	9	<1%	9	<1%
Total Non-Government	**647**	**27%**	**735**	**27%**	**968**	**27%**	**310**	**50%**
Total Payer Mix	**2,411**	**100%**	**2,798**	**100%**	**3,686**	**100%**	**3,781**	**100%**

* Includes managed care activity.
Ex. A, p. 53.

32. Following approval of the proposal, the Hospital will adopt Health Quest's financial assistance policies. Ex. A, p. 40.

33. There are no planned changes to the Hospital's existing payer contracts as a result of the proposal. The agreements will be renegotiated at the expiration of their terms in the normal course of business. Additionally, Health Quest hospitals currently accept Connecticut Medicaid and its affiliated physician practices have begun the process to become a Medicaid provider. Ex. A, p. 543; Docket Number 16-32133-CON, Ex. E, p. 629.

34. Health Quest does not plan to impose any new facility fees at the Hospital. Ex. A, p. 40; Ex. Z, Transcript, Mr. Robert Friedberg, President and CEO, Health Quest, p. 125.

35. Health Quest does not plan to adjust its price structure as a result of the proposal. Ex. A, p. 40.

36. The Hospital experienced decreasing operational gains from FY2013 through FY2015. Expenses eclipsed revenues in FY2016.

TABLE 5
HISTORIC OPERATING PERFORMACE AT THE HOSPITAL

	FY2013	FY2014	FY2015	FY2016
Revenue from Operations	$54,176,088	$51,178,395	$50,337,130	$48,815,540
Total Operating Expenses	$49,401,485	$48,236,049	$50,076,702	$52,317,461
Gain/(Loss) From Operations*	$4,774,603	$2,942,346	$260,428	($2,501,921)

* Increasing losses are due primarily to a decrease in both inpatient and outpatient utilization and the termination of oncological services. OHCA Hospital Reporting Data, Sharon Hospital.

37. The Applicants attribute the Hospital's increasing net losses of $1.4 million in FY2014 to approximately $3.18 million in FY 2016 to reduced state reimbursement, increasing bad debt provisions due to self-pay activity, provider tax increases and physician coverage-based costs for specialty call services. Ex. A, p. 23.

38. Health Quest was rated A3 by Moody's with a negative outlook and A- by Standard and Poor's with a stable outlook. Ex. A, p. 41.

39. Health Quest achieved $60.4 million in operating income for the most recently completed fiscal year, 2016, and projects substantial operating gains through FY2020.

TABLE 6
HEALTH QUEST PROJECTED GAINS FROM OPERATIONS

	FY2017	FY2018	FY2019	FY2020
Revenue from Operations	$1,061,809,455	$1,188,335,958	$1,284,176,258	$1,337,250,443
Total Operating Expenses	$991,665,760	$1,105,170,156	$1,193,083,182	$1,240,778,873
Gain From Operations	$70,143,695	$83,165,802	$91,093,076	$96,471,570

Ex. A, p. 532.

40. Health Quest projected gains from operations are based on observed historical trends, increased physician recruitment, the opening of a new bed tower at VBMC, payer contract changes and a shift of inpatient and outpatient service mixes. Ex. A, p. 43.

41. The Applicants project increasing incremental gains from operations as a result of the proposal.

TABLE 7
THE HOSPITAL'S PROJECTED INCREMENTAL GAINS FROM OPERATIONS

	FY2017	FY2018	FY2019	FY2020
Revenue from Operations	$4,648,342	$14,772,159	$16,090,477	$16,549,789
Total Operating Expenses	$1,169,770	$5,001,048	$6,406,302	$7,315,261
Gains From Operations	$3,478,572	$9,771,111	$9,684,175	$9,234,528

Ex. A, p.51.

42. The Hospital's projected incremental gains are based on an increase in operational revenue due to anticipated gains in patient volume from physician recruitment, the referral of patients from out of state, the expansion of the geropsychiatric unit and addition of oncology care. The incremental operating expense projections incorporate administrative savings as a result of its association with Health Quest including bringing coding operations in-house, improved supply chain management and buying power and 1% to 2% in vendor savings. Ex. A, pp. 25, 546; Ex. Z, Transcript, Friedberg, p. 119.

43. The Applicants also project steadily increasing operating margins from 7.2% in FY2017, 15.4% in FY2018, 14.6% in FY2019 and 13.3% in FY2020 at the hospital. Applicants attribute projected increases to the same factors supporting the projected incremental gains and cost savings outlined above. Ex. A, p. 531.

44. Health Quest acquired NDH in the year 2000. At the time of the transfer of ownership to Health Quest, NDH's operating margin was - 6.7%. In FY 2016, its operating margin was 14.9%. Health Quest attributes NDH's improved operating margins to replacing and adding beds and services in a new building, the Rosenthal Pavilion. Ex. X, pp. 704, 989; Ex. Z, Transcript, Mr. Dave Ping, Senior Vice President of Strategic Planning, Health Quest, pp. 122-123.

45. Health Quest will purchase the Hospital for $5 million. Investment bank Cain Brothers assisted in valuing the Hospital and considered prior negative earnings, potential future earnings and the Hospital's physical assets. Ex. C, p. 645.

46. Of the purchase price, $3 million will be funded through an "Asset Purchase Grant" from FCH to Essent. The remaining balance will be paid by Health Quest using its operating funds. Ex. A, p. 41.

47. FCH will contribute up to an additional $6 million to Health Quest in the form of a "Working Capital Grant." FCH will partially reimburse Health Quest for investments made in the Hospital. The funds will be disbursed in annual installments over a period of three to four years after the closing and will be available for strategic investments including direct physician and provider costs, strategic equipment, facility upgrades, ambulatory networks, information technology infrastructure and other programmatic

investments. The Hospital and its affiliated Connecticut-based physician groups will be the sole Health Quest-owned entities directly benefitting from Working Capital Grant expenditures. Ex. A, p. 24; Ex. C, pp. 642, 666.

48. For five years following execution of the proposal, should Health Quest transfer or sell substantially all of the assets and operations of the Hospital, close the hospital, or should its not-for-profit status change, Health Quest will return to FCH any portion of the Asset Purchase Grant and Working Capital Grant already distributed to Health Quest. Ex. E, pp. 671-672; Ex. Z, Transcript, Heaton, p. 90.

49. Needed capital expenditures exceeding the $6 million Working Capital Grant will be paid for with Health Quest's cash reserves. Ex. E, p. 889.

50. Health Quest's FY2015 audited consolidated balance sheet reported $109,359,000 in cash and cash equivalents. Ex. A, p. 521.

51. Although the Applicants are currently in the process of developing a capital expenditure plan, over the course of the first three years following execution of the transfer of ownership, Health Quest intends to, at an approximate cost of $14.1 million, invest in:
    - information technology upgrades, including converting to Cerner electronic medical records system;
    - infrastructure updates, including the replacement of boilers and oil tanks and upgrading its HVAC;
    - intensive care unit renovations and monitor upgrades;
    - installing wireless telemetry on its medical/surgical unit;
    - converting five licensed beds to serve geropsychiatric patients;
    - the purchase of a DaVinci Robot to upgrade its surgical capabilities; and
    - renovation of its medical oncology space. Ex. C, p. 646; Ex. T, pp. 933-934.

52. As a for-profit hospital, the Hospital was not required to conduct a Community Health Needs Assessment ("CHNA") or submit an IRS Form 990 schedule H.

53. As a not-for-profit hospital, the Hospital will conduct a Community Health Needs Assessment ("CHNA") identifying significant health issues in the Sharon area, vulnerable populations and barriers to access. Ex. A, p. 34.

54. In FY2017, Health Quest will conduct an initial assessment of its primary service area and incorporate the Hospital into its 3-year reassessment cycle in place for other Health Quest hospitals. Ex. E, p. 52.

55. In 2014, FCH conducted a needs assessment analyzing the health care needs of the Hospital area. Mental health, access to primary care services and chronic diseases were the most frequently cited health-related concerns. Spanish-speaking focus group members also expressed a need for additional bi-lingual outreach and support services. The Applicants will use this as a starting off point when conducting its own assessment. Ex. A, pp. 420-421, 434-435; Ex. Z, Transcript, Ping, pp. 76-77.

56. The CHNA will incorporate the Center for Disease Control and Prevention's ("CDC's") 6/18 initiatives as well DPH's Healthy Connecticut State Health Improvement Plan. Ex. Z, Transcript, Ping, p. 77.

57. Health Quest has a dedicated team of in-house physician recruiters and, in 2016, recruited 47 physicians to its Hudson Valley Region offices. It will also recruit through Health Quest Medical Practice, Health Quest's physician medical group that employs more than 300 physicians. Ex. A, p. 27, C, p. 648.

58. Health Quest submitted its statements of deficiencies resulting from New York Department of Health's for its site surveys conducted at Health Quest's New York-based hospitals. While standard level deficiencies were identified during inspection activities conducted by the New York Department of Public Health, the facility was noted to be in substantial compliance with 42 CFR, Part 82 Conditions of participation for Hospital Ex. E, p. 803.

59. Health Quest's quality initiatives and best practices will be implemented at the Hospital, consistent with the systems practices and objectives. These include, reducing average length of stay, 30-day readmissions, and catheter associated UTIs; implementing a sepsis policy; and implementing dashboards to monitor patient satisfaction. Ex. A, pp.37-38.

60. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

61. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

62. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

63. The Applicants have demonstrated that the proposal will improve the overall financial strength of the health care system and that it is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

64. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)).

65. The Applicants have shown that there would be no adverse change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).

66. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

67. The Applicants provided historical utilization of Sharon Hospital services in the service area that would support this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

68. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

69. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).

70. The Applicants have satisfactorily demonstrated that the proposal will not have a negative impact on the diversity of health care providers in the area. (Conn. Gen. Stat. § 19a-639(a)(11)).

71. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or accessibility to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

72. The Applicants have demonstrated that they fairly considered other alternative proposals. (Conn. Gen. Stat. § 19a-639(d)(2)(A)).

73. The Applicants submitted a preliminary plan that demonstrates how health care services will be provided at the Hospital for the first three years following the transfer of ownership. (Conn. Gen. Stat. § 19a- 639(d)(2)(B)).

DISCUSSION

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

The Hospital is a 78-bed acute care general hospital based in Sharon that includes an emergency department; stroke center; intensive care, surgical, maternity, and senior behavioral health units; radiology, hospitalist, rehabilitation and cardiology services, as well as, same-day surgery and a wound center. *FF1*. In 2002, the Hospital became the first for-profit hospital in Connecticut upon being purchased by Tennessee-based Essent. *FF2.*

The Applicants fairly considered alternative proposals and submitted a preliminary plan demonstrating how health care services will be provided for the first three years in accordance with Conn. Gen Stat. sec. 19a-639(d)(2).

The Hospital began experiencing net operating losses, increasing from $1.41 million in FY 2014 to $3.18 million in FY2016. *FF37*. This, coupled with decreases in patient volume due to difficulties recruiting physicians and gaps in services available to patients, suggested to Essent that the Hospital would be best served by affiliating with a larger, more local health system. *FF5,6*. Essent and its parent company, RCCH, evaluated both not-for-profit and investor-owned entities as well as both Connecticut-based and out-of-state organizations. They concluded that New York-based Health Quest was the best option based on its financial strength and proximity to the Hospital. *FF7*.

On September 13, 2016, the Applicants entered into an asset purchase agreement to transfer all personal, intellectual and real property of the Hospital and its parent holding company to Vassar Health Connecticut, a newly-formed subsidiary of Health Quest. *FF8*. Health Quest is a not-for-profit health care system that includes acute care hospitals VBMC, NDH and Putnam Hospital Center in Dutchess County and is composed of 597-licensed beds and more than 5,000 employees. *FF11*. Pending approval, the Applicants anticipate executing the transfer on or before July 31, 2017. *FF8*.

As discussed below, Health Quest will not reduce or eliminate any services currently provided at the Hospital for, at minimum, the first three years of operations. Rather, geropsychiatric beds and oncology services will be added. Additionally, through the recruitment of physicians, the Hospital will expand OB/GYN, primary care, and general and orthopedic surgery services. *FF30*.

The Applicants have identified the patient population the Hospital will be serving and have, as required by Conn. Gen. Stat. sec. 19a-639(a)(7), demonstrated a need for additional primary and secondary care physicians and geropsychiatric and oncological services in the area.

In 2017, Health Quest retained a health care consulting firm to conduct an audit of the types of physicians needed in the area relative to the number of physicians practicing. *FF26*. Based on the

results of the assessment, Health Quest intends to recruit 21.25 full-time equivalent physicians to affiliate with the hospital and work in the Sharon area by 2020, including 8 primary care physicians, 2 obstetricians and gynocologists, 3.25 cardiologists, 1.5 general surgeons, 1.25 pulmonologists, 2.25 oncologists, 1 endocrinologist, 1 pain management specialist and 1 pathologist. *FF27*. According to Mike Browder, EVP and CFO of RCCH HealthCare Partners, there is a trend toward physicians preferring to affiliate with a hospital rather than establishing their own, independent medical practices. Recruiting physicians, he stated, to a rural area such as Sharon where the physician may be the sole specialist has proved challenging. Sharing resources with a larger system, such as Health Quest, in which physicians may rotate through several facilities, will make the Hospital a more attractive option.[2]

Utilization volume at the hospital is also expected to increase with the addition and expansion of services offered at the hospital. The Hospital currently does not offer oncology services but will begin offering medical oncology and subspecialty oncology care, including surgical oncology, breast oncology and chemotherapy subsequent to the transfer of ownership. *FF23*.

Health Quest will additionally be converting five unassigned beds to support geropsychology treatment. The Hospital currently turns away approximately 30 patients each month due to insufficient capacity. *FF21*. Health Quest currently lacks geropsychology services at all of its facilities and has been unable to serve between 20 and 40 individuals seeking care each month. Health Quest intends to direct such patients to the Hospital. *FF21*. Furthermore, Health Quest has been experiencing capacity issues at VBMC and NDH and will, when medically appropriate and convenient for patients, direct those patients to the Hospital. *FF29*. Ultimately, the Applicants anticipate inpatient discharges and outpatient visits increasing from 106,228 in FY2018 to 110,729 in FY2020. *FF19*.

While the consultant's study identified an unmet need for primary and specialty physicians in the area, an evaluation of services has not been conducted since FCH's community needs assessment in 2014. That assessment identified access to primary care, mental illness and the prevalence of chronic diseases as the top health concerns in the area. *FF55.* Upon attaining not-for-profit status, the Hospital will perform an analysis of vulnerable populations and unmet need in the Sharon area, using FCH's assessment and DPH's Healthy Connecticut State Health Improvement Plan as a starting point.

Health Quest will initiate its assessment of the Hospital's primary service area in FY2017 and incorporate the Hospital in its system-wide 3-year reassessment cycle. *FF54*. It will then develop a Strategic Implementation Plan to outline how it will address the identified gaps in services. *FF56*. Health Quest will allocate the funds necessary to provide the community benefit programs that include community building activities addressing the areas of need identified in the CHNA, according to President and CEO Robert Friedberg.[3]

The Applicants have shown that there is a need for additional physicians, expanded geropsychology capacity and oncological care in the Sharon area, all of which Health Quest intends to provide at the Hospital. As such, the Applicants have provided sufficient evidence to

[2] Ex. Z, Transcript, p. 24.
[3] Ex. Z, Transcript, p. 83.

demonstrate they have identified the population it will be serving and demonstrated there is an existing need for their services.

The proposal will offer improved access to and quality of acute care services within the system while maintaining the cost afforded to consumers, including those with Medicaid coverage, satisfying Conn. Gen. Stat. sec. 19a-639(a)(5)

The Hospital's primary service area currently lacks tertiary services. Existing NY-based Health Quest facilities located within or near the Hospital's primary service area, however, offer services such as advanced cardiac services, advanced hepatobiliary surgery, Level 3 NICU, Level 2 Trauma, advanced neurosciences, subspecialty cancer services, high-risk obstetric care, advanced robotic surgery, trauma and high-acuity intensive care. *FF24*. Following the transfer of the Hospital to Health Quest, patients will have access to these advanced care services within their health system, improving the ease of transferring records and inter-staff communication.

Moreover, Health Quest's proposed four-year, $14.1 million capital investment plan at the Hospital will also enhance patients' access to care. Among its priorities are upgrading to Cerner electronic medical records system, renovations and addition of beds to the geropsychiatric unit and the re-introduction of updated medical oncology and infusion services. Health Quest also intends to install telemedicine equipment in the intensive care unit, with the goal of keeping more patients in the Hospital by providing direct access to intensivists and specialists at VBMC, reducing the need for patients to travel from the Hospital. *FF48*.

Based on Health Quest's past performance as well as its anticipated enhancements, the quality of care at the Hospital will likely be improved as a result of the proposal. Health Quest submitted its statements of deficiencies resulting from New York Department of Health's site surveys conducted at Health Quest's New York-based hospitals. While standard level deficiencies were identified during inspection activities conducted by the New York Department of Public Health, the facility was noted to be in substantial compliance with 42 CFR, Part 82 Conditions of participation for Hospital *FF58.* Health Quest's quality initiatives and best practices will be implemented at the Hospital, consistent with the systems practices and objectives. These include, reducing average length of stay, 30-day readmissions, and catheter associated UTIs; implementing a sepsis policy; and implementing dashboards to monitor patient satisfaction. *FF59.*

The proposal will be at least as cost effective as the Hospital's current provision of health care for consumers in the region. The Applicants have stated they do not believe there will be any change in the cost to consumers or additional facility fees imposed as a result of the proposal. *FF34,35*. Financial assistance to indigent or economically disadvantaged patients is expected to be improved. Health Quest will implement its charity care and financial assistance policy at the Hospital which is, overall, more generous than that currently in place at the Hospital. *FF32.* Furthermore, upon becoming a not-for-profit entity, the Hospital will be required to accept Medicaid and any improvements afforded to other payers and patients will extend to Medicaid patients as well. *FF31*.

The Applicants have demonstrated that the proposal will increase patients' access to specialists, with capital investments, such as in telemedicine equipment, further enhancing the efficiency and

effectiveness of patient contact with physicians system-wide. The absence of patient-care violations at Health Quest's New York-based hospitals, coupled with Health Quest's implementation of its quality initiatives and best practices, are expected to improve quality of care at the Hospital. The overall cost to uninsured or underinsured consumers will be improved and any enhancements to access or quality of care at the Hospital will equally benefit Medicaid and indigent patients. Therefore, the Applicants have satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region.

The proposal is financially feasible in that funding for both the purchase and necessary capital expenditures is available and will improve the financial stability of the Hospital, as required by Conn. Gen. Stat. sec. 19a-639(4)

Investment bank Cain Brothers assisted in valuating the Hospital and considered prior negative earnings, potential future earnings and the Hospital's physical assets. *FF43*. Health Quest will purchase the Hospital from Essent for $5 million, $3 million of which will be contributed by FCH[4] in the form of an "Asset Purchase Grant." Health Quest will pay the remaining balance of $2 million from its operating revenue. *FF46*.

FCH will grant an additional $6 million to Health Quest to support strategic investments at the Hospital. Only investments directly benefitting the Hospital will qualify for coverage and grant funds will not be spent for the benefit of other Health Quest-owned entities. *FF47*. Health Quest must contribute a percentage of the cost of the expenditures and the grant must be spent within four years of closing on the transfer. The agreement was, according to Nancy Heaton, Chief Executive Officer of FCH, structured in a manner to encourage Health Quest to move forward with needed capital investments as expeditiously as possible.[5] Any planned capital expenditures exceeding the amount of the grant will be paid for from Health Quest's cash reserves. *FF49*. Health Quest's FY2015 audited consolidated balance sheet reported $109,359,000 in cash and cash equivalents. *FF50*. As such, the proposal and tentative capital investment plan is financially feasible for Health Quest.

The Hospital's financial outlook has been declining and Health Quest's acquisition will likely bolster the Hospital's financial position. The Hospital realized $4.78 million in operational revenues in FY2013. By FY2016, however, the Hospital's revenues from operations were eclipsed by its expenses by more than $2.5 million. *FF36*. The Applicants project, though, that operating margins will steadily increase from 7.2% in FY2017 to 13.3% in FY2020 following the transfer of ownership to Health Quest. Over the same period, the Applicants anticipate incremental gains increasing from $3.48 million to $9.23 million. *FF41,43*. The incremental gains projected for the Hospital are a result of an increase in revenue from operations due to its

[4] FCH was established in 2002 to administer the charitable assets and purchase price of the Hospital upon its conversion to a for-profit entity. FCH's stated purpose, in part, is to maintain and improve the physical and mental health of the residents of the area historically served by the Hospital and to invest in the acquisition of the Hospital for the purpose of reconverting the Hospital to not-for-profit entity. Amended and Restated By-Laws of The Foundation for Community Health, *Section 1.3 Purposes.*

[5] Ex. T, p. 928.

anticipated gains in patient volume and maximizing reimbursement. The Applicants' projections regarding incremental operating expenses incorporate administrative savings as a result of its association with Health Quest, such as bringing coding operations in-house, improved supply chain management and buying power and alignment with a regional system and include 1% to 2% in vendor savings. *FF41*.

The Applicants cite the improved financial performance of NDH following Health Quest's acquisition of it in 2000 as an example of its ability to turn around financially struggling hospitals. NDH, at the time of its acquisition, had an operating margin of -6.7%. By FY2016, NDH achieved a 14.9% operating margin. While Health Quest attributes this growth in part to replacing and adding beds as well as the expansion of service lines offered in a newly constructed medical pavilion, it anticipates similar operating margin increases at the Hospital under its management due to its proven experience identifying opportunities to increase revenues and savings at similarly financially struggling hospitals. *FF44*.

In his testimony, Robert Friedberg, President and CEO of Health Quest, elaborated that even if the Hospital did not achieve the projections, the Hospital will be a "part of the Health Quest fabric" that would be very difficult to disconnect from the integrated system. He additionally stated that Health Quest's primary concern is the stability of the health system as a whole as it will be able to absorb any shortfalls that the Hospital may experience.[6]

Based on the Applicants' demonstration that Health Quest has sufficient assets to outlay for both the purchase price of the Hospital and planned capital investments, the Applicants have satisfactorily shown the proposal is financially feasible. The Applicant's projected operational savings, coupled with increases in revenues from expanded patient services and utilization, will improve the financial viability of the Hospital. Furthermore, Health Quest has made assurances that even if the changes at the Hospital do not yield the operational gains predicted, the health system is capable of supporting the hospital.

<u>The proposal aligns with Conn. Gen. Stat. sec. 19a-639(a)(2) and the Statewide Health Care Facilities and Services Plan.</u>

Among the guiding principles of the Statewide Health Care Facilities and Services Plan are the promotion of the long term viability of the state's health care delivery system; encouragement of health education and prevention initiatives; support of a sufficient health care workforce; and encouragement of collaboration to develop health care delivery networks.[7]

Multiple aspects of the transfer of the Hospital to Health Quest address these goals. First, the proposal provides enhanced financial stability for the Hospital due to the support of a larger health network. This is expected to ensure the long term viability of the Hospital, which is of particular importance due to its isolated geographic location. Second, the re-introduction of a CHNA and resultant community benefit programs will likely enhance preventative care for residents of the area. Third, a major component of Health Quest's development plan is the

[6] Ex. Z, pp. 31, 123-124.

[7] Department of Public Health, OHCA, *Statewide Health Care Facilities and Services Plan* p. 2 (Oct. 2012).

recruitment of physicians to the Hospital which will help ensure a sufficient health care workforce in the rural area. Fourth, the association with Health Quest will encourage the sharing of resources with other, geographically proximate Health Quest-owned facilities. For the above reasons, the proposal supports the Statewide Health Care Facilities and Services Plan.

As a result of these combined factors, the Applicants have satisfactorily demonstrated that there is a clear public need for the proposal and that access to and quality of care will improve through integration with a regional system providing a variety of clinical and financial benefits. The Applicants have provided adequate evidence that the transfer of ownership of the Hospital to Health Quest and its subsidiary, Vassar Health Connecticut, will provide continued access to high quality and affordable health care. As such, the application is approved with conditions pursuant to Conn. Gen. Stat. sec. 19a-639(d)(5).

ORDER

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the transfer of ownership of the Hospital to Vassar Health Connecticut, Inc., a subsidiary of Health Quest, is hereby **Approved** under Conn. Gen. Stat. § 19a-639(a) subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether Health Quest, or its subsidiary Vassar Health Connecticut, remains the parent company and sole shareholder of the Hospital. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including but not limited to, the right to impose and collect a civil penalty under Conn. Gen. Stat. § l9a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. For three (3) years following the Closing Date, Vassar shall allow for twelve (12) community representatives to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting members under the Hospital's Board of Director Bylaws. Health Quest shall select, from those nominated by FCH in accordance with Section 2.7.1 of the Grant Agreement dated September 8, 2016, the community representatives in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF14.*

2. For three (3) years following the Closing Date, Health Quest and Vassar shall hold a meeting of the Health Quest Board and the Hospital Board ("Joint Board Meetings") at least twice annually. At least one Joint Board Meeting shall include the entire Hospital Board and the Hospital Board Chairperson shall otherwise attend all meetings of the Health Quest Board. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF12,14.*

3. Vassar intends and shall use its best efforts as described in the Application to enhance access to physician services in the Northwestern Connecticut region by recruiting and retaining at least 21.25 full time equivalent additional physicians required to respond to local community need by the end of FY 2020. Additionally, Vassar will recruit additional physicians and other health care providers for which there is a need, as identified in the CHNA described in Condition 9 herein. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF18,20,27.*

4. Health Quest shall not impose a single Health Quest system-wide pricing structure and shall, for the Hospital and affiliated physician practices and medical foundation, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Northwestern Connecticut. OHCA is imposing this Condition to ensure the transfer of ownership does not adversely affect health care costs. *Legal and Factual Basis: Stat. §§ 19a-639(a)(12), 19a-639(d)(3); FF33-35.*

5. Vassar shall work toward making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations. Specifically, Vassar shall ensure that the Hospital shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, Vassar shall provide at the Hospital, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, Vassar shall ensure that the Hospital shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis; Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF55.*

6. Health Quest shall support Vassar's development of community benefit programs and community building activities for the Hospital consistent with the scope of activities at Health Quest's other hospitals, including its support of the commitments in Conditions, 3, 5, 7, 9, and 11 of this Agreed Settlement. Vassar shall provide such community benefit programs and community building activities at a level that is at least as generous and benevolent to the community as the programs and activities currently in place at the Hospital. To assess the baseline level of these programs and activities, Vassar shall assemble the information required to complete Schedule H of the IRS Form 990 for the last completed fiscal year and shall provide this information to OHCA within ninety (90) days of the date of closing. . Vassar shall apply no less than a 1% increase per year for the next three (3) fiscal years toward the Hospital's community benefits and community building activities in terms of dollars spent. In determining the Hospital's participation and investment in both community benefits and community building activities, Vassar shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-56.*

7. Vassar shall ensure that the Hospital maintains and adheres to Health Quest's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as Heath Quest's current policies, consistent with state and federal law. These policies shall be posted on the Hospital's website, via a link to the Health Quest website, and as additionally

required by applicable law. OHCA is imposing this Condition to ensure continued access to cost effective health care in the region, in particular for indigent persons. *Legal and Factual Basis: Stat. §§ 19a-639(a)(5)&(12); FF59.*

8. For three (3) years following the Closing Date, Vassar shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of the Hospital within one (1) month of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the Hospital's website, via a link to the Health Quest website, simultaneously with their submission to OHCA.OHCA is imposing this Condition to ensure continued access to cost effective health care in the region, in particular for indigent persons. *Legal and Factual Basis: Stat. §§ 19a-639(a)(5)&(12); FF59.*

9. Health Quest shall participate with Vassar, and the key community stakeholders and health organizations, in conducting future Community Health Needs Assessments ("CHNAs") and shall complete a CHNA and Implementation Strategy within 18 months of the Closing Date and submit it to OHCA within thirty (30) days of completion. Health Quest and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA, as well as any applicable community health improvement plan issued by any local health department in the Service Area.[8] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control and Prevention's ("CDC's") 6/18 initiative to the extent the health priorities identified in the CHNA correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. The CHNA and the Implementation Strategy shall be published on the website of the Hospital. OHCA is imposing this condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3)&(7); FF52-56.*

10. Health Quest and/or Vassar agrees to file the following documents or information within one (1) month of the Closing Date:

    a) Schedules which set forth the Hospital's inpatient bed allocation (using available beds as the measurement) and the location and hours of operation for all outpatient services, by department, as of the Decision Date. Vassar shall publish this same information on the Hospital' website.

    b) Notice identifying the legal entity that shall directly own and operate the Hospital and hold the Hospital's license post-closing and the Certificate of Incorporation for such entity. This entity shall be duly organized and validly existing under the laws of Connecticut.

[8] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

c) Notice to OHCA of the effective date of the transfer of ownership transaction. Such notice shall be accompanied by the Final Execution copies of all agreements related to same, including but not limited to:

i. the Asset Purchase Agreement, including any and all schedules and exhibits; and
ii. Bylaws or similar governance documents for Vassar.

Health Quest and/or Vassar may redact from submission under (10)(C)(i) above, any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If Vassar redacts materials in accordance with the previous sentence, Vassar shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why each redacted schedule or exhibit is specifically being claimed as exempt for public record purposes. To the extent that any member of the public requests access to information that Vassar claims is exempt from disclosure under Conn. Gen. Stat. § 1-210, OHCA shall notify Vassar. Vassar shall have an opportunity to respond to any such request and provide further information, as necessary, to support the exemption before any information is disclosed. OHCA is requiring this condition to enable its assessment as to how health care services will be provided in the community and as a practical means of fulfilling its monitoring of the proposal. *Legal and Factual Basis: Stat. §§ 19a-613(a)&(b), 19a-639(d)(2); FF12,15,23,30.*

11. Vassar agrees to file the following documents and information on a semi-annual basis. For purposes of this Order, semi-annual periods are October 1 - March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period and due dates are May 31 and November 30. The initial filing of this material will include at least a full six months of information and may include more, depending on the closing date

a) A report on the capital or investment commitments made in the Hospital and its affiliates. The Capital Investment Report shall include the following in a format to be agreed upon:
   i. A list of the capital expenditures or investments that have been made in the prior six (6) month period (except that the initial filing may include additional months depending on the initial date of such expenditures or investments) with descriptions of each associated project; and
   ii. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
   iii. The funding source of the capital expenditure or investment, indicating whether it was drawn from intercompany loans, operating revenue, capital contributions from the FCH Working Capital Grant or another source. If funding was drawn from another source, indicate the source.
   iv. The capital or investment commitment information in (11)(a)(i - iii) will be submitted until the capital or investment commitment is satisfied.

b) A report of cost savings attained and related financial impact as was described in the CON application. This report will be required for three (3) years following the Closing Date and shall be filed with OHCA on a semi-annual basis for the entity, Vassar Health Connecticut, Inc. d/b/a Sharon Hospital:

i. The cost saving totals achieved in the following Operating Expense Categories for the Hospital: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report.

The semi-annual submission shall also contain narratives describing:

A. the major cost savings achieved for each expense category for the semi-annual period;

B. the effect of these cost savings on the clinical quality of care; and

C. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for the Hospital and its immediate parent corporation. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/300 (balance sheets), 150/350 (statement of operations) or successor reports.

ii. A report of financial measurements. This report shall be required for three (3) years following the Closing Date and shall be filed with OHCA on a semi-annual basis for both the Hospital and its immediate parent corporation. This report shall show current month and year-to-date data and comparable prior year period data. The following financial measurements/indicators should be addressed in the report:

FINANCIAL MEASUREMENT/INDICATORS

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Net Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4)&(5); FF30,36-43,51.*

12. Vassar agrees to file the following documents and information on an annual basis. These filings are due within one (1) month following the anniversary of the Closing Date for a period of three (3) years and shall be posted on the Hospital's website.

a) A written report describing the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by Sharon Hospital, including with respect to physician recruitment and resource commitments for clinical service programming

b) A written report on its activities directed at meeting Condition 5 above, regarding efforts towards making culturally and linguistically appropriate services available and integrated throughout the Hospital's operations

c) A written report identifying the amounts and uses related to community benefits and community building in accordance with Condition 6 above. The report shall include a full discussion of how such investments and support are being applied toward the health needs identified in the Community Health Needs Assessment and population health management objectives.

d) A list of the names, accompanied by a brief biography in first filing due subsequent to the member's appointment, of the fifteen Hospital Board of Trustee members described in Condition 1 above and an indication as to which were nominated by FCH.

e) An affirmation document attesting to the following:
   i. Affirmation that Health Quest and Vassar are meeting the obligations of Conditions 2 – 4.
   ii. Affirmation that no Health Quest and/or Vassar physician office has been converted to hospital-based status
   iii. Affirmation that the Hospital's commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms
   iv. Affirmation that the Hospital shall use its best efforts to continue to maintain medical and surgical services, the intensive care unit and emergency department, obstetrics, geropsychiatry, OB/GYN, diagnostic imaging, primary care, rehabilitation, lithotripsy, laboratory, hospitalist and urology services, subject to the availability of appropriate physicians and community need.

OHCA is requiring this Condition to enable its assessment as to how health care services will be provided in the community and as a practical means to fulfill its monitoring of the proposal. *Legal and Factual Basis: Stat. §§ 19a-613(a)&(b), 19a-639(d)(2); FF14, 27,30,52-56,73.*

13. On an annual basis, Health Quest and/or Vassar shall submit an updated plan demonstrating how health care services will be and are being provided by Vassar for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format consistent with that provided by Health Quest to OHCA in its response to Question 2 in the Second Completeness letter, dated Feb. 21, 2017. Health Quest and/or Vassar shall annually attest that there has been no change in the plan provided on February 21, 2017 or, if services have or are planned to change from the February 21, 2017 submission, Health Quest and/or Vassar shall specify all changes, any consolidation, reduction, or elimination of existing services or introduction of new services. OHCA is

requiring this Condition to comply with statutorily-imposed reporting requirements. *Legal and Factual Basis: Stat. §§ 19a-639(d)(2)(B); FF73.*

14. The Sharon Hospital inpatient accrued charges divided by the case mix adjusted discharges (i/p prices per CMAD) is historically higher than the statewide average (using OHCA's HRS filings by the state hospitals). Vassar agrees to report its total inpatient accrued charges and case mix adjusted discharges on a semi-annual basis for a period of three (3) years as a calculation for inpatient charges per CMAD. If a reduction in average inpatient charges is reported, Vassar shall explain how the reduction was achieved. OHCA is requiring this Condition to ensure continued access to affordable, cost effective health care. *Legal and Factual Basis: Stat. §§ 19a-639(a)(5), 19a-639(d)(3);FF35,63.*

15. Within six months following the Closing Date, Vassar shall file with OHCA the total price per "unit of service" using the below definitions for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for the Hospital services. The first filing shall be for the period June 1, 2016 through June 30, 2017. Vassar shall provide the same information for three (3) fiscal years thereafter (FY 2017, FY 2018 and FY 2019), within sixty (60) days following the end of a fiscal year.

    a) For inpatient hospital services, a "unit of service" shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of Insurance pursuant to Conn. Gen. Stat. § 38a-1084aas among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.

    b) for outpatient hospital services, a "unit of service" shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to Conn. Gen. Stat. § 38a-1084a as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.

    c) For physician services, a "unit of service" shall be a work Relative Value Unit (wRVU). The baseline to be established as of the Date of Closing for the Hospital's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.

    OHCA is requiring this Condition to ensure continued access to affordable, cost effective health care. *Legal and Factual Basis: Stat. §§ 19a-639(a)(5), 19a-639(d)(3); FF35,63.*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

7/18/17
Date

Yvonne T. Addo, MBA
Deputy Commissioner

7/17/17
Date

Duly Authorized Agent for
Essent Healthcare of Connecticut, Inc.

Signed by Michael W. Browder
(Print name)

EVP & CFO
(Title)

July 17, 2017
Date

Duly Authorized Agent for
Vassar Health Connecticut, Inc.

Signed by Robert Friedberg
(Print name)

As President of Health Quest Systems, Inc
Sole member
(Title)

July 17, 2017
Date

Duly Authorized Agent for
Health Quest Systems, Inc.

Signed by Robert Friedberg
(Print name)

President and CEO
(Title)

Greer, Leslie

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, July 18, 2017 11:44 AM
To: Schaeffer-Helmecki, Jessica; Ping, David; victorger@pipeline.com
Cc: Martone, Kim; Riggott, Kaila; Hansted, Kevin; Casagrande, Antony A; User, OHCA; Greer, Leslie
Subject: RE: Agreed Settlement: 16-32132-CON

Received, thank you Jessica.

From: Schaeffer-Helmecki, Jessica [mailto:Jessica.Schaeffer-Helmecki@ct.gov]
Sent: Tuesday, July 18, 2017 11:38 AM
To: Jennifer Groves Fusco; Ping, David; victorger@pipeline.com
Cc: Martone, Kim; Riggott, Kaila; Hansted, Kevin; Casagrande, Antony A; User, OHCA; Greer, Leslie
Subject: Agreed Settlement: 16-32132-CON

Good mid-morning all—

Attached please find the signed Agreed Settlement pertaining to docket number 16-32132-CON, Health Quest's application to acquire Sharon Hospital. Please confirm receipt at your earliest convenience.

Best Regards,

Jessica Schaeffer-Helmecki, JD, MPA
Planning Analyst, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov

Greer, Leslie

From: Victor Germack <victorger@pipeline.com>
Sent: Tuesday, July 18, 2017 2:59 PM
To: Schaeffer-Helmecki, Jessica
Cc: Jennifer Groves Fusco; Ping, David; Martone, Kim; Riggott, Kaila; Hansted, Kevin; Casagrande, Antony A; User, OHCA; Greer, Leslie
Subject: Re: Agreed Settlement: 16-32132-CON

Received. Thank you.
Victor Germack
Community Association to Save Sharon Hospital

Sent from my iPhone

On Jul 18, 2017, at 11:37 AM, Schaeffer-Helmecki, Jessica <Jessica.Schaeffer-Helmecki@ct.gov> wrote:

> Good mid-morning all—
>
> Attached please find the signed Agreed Settlement pertaining to docket number 16-32132-CON, Health Quest's application to acquire Sharon Hospital. Please confirm receipt at your earliest convenience.
>
> Best Regards,
>
> **Jessica Schaeffer-Helmecki, JD, MPA**
> Planning Analyst, Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS #13 HCA, Hartford, Connecticut 06134
> P: (860) 509-8075|F: (860) 418-7053|E: jessica.schaeffer-helmecki@ct.gov
>
> <image001.jpg> <image002.jpg>
>
> <16-32132-CON Signed Agreed Settlement - SHARON.pdf>

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Thursday, August 17, 2017 2:29 PM
To: Roberts, Karen
Cc: Martone, Kim; Cotto, Carmen; Clarke, Ormand; User, OHCA
Subject: RE: Compliance with CON Docket #16-32132-CON

Thanks, Karen.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, August 17, 2017 2:03 PM
To: Jennifer Groves Fusco
Cc: Martone, Kim; Cotto, Carmen; Clarke, Ormand; User, OHCA
Subject: Compliance with CON Docket #16-32132-CON

Hi Jen -

Pursuant to Condition #10 of the Agreed Settlement under Docket Number 16-32132-CON, Health Quest and Vassar agreed to the following:

10. Health Quest and/or Vassar agrees to file the following documents or information within one (1) month of the Closing Date:
    a) Schedules which set forth the Hospital's inpatient bed allocation (using available beds as the measurement) and the location and hours of operation for all outpatient services, by department, as of the Decision Date. Vassar shall publish this same information on the Hospital' website.
    b) Notice identifying the legal entity that shall directly own and operate the Hospital and hold the Hospital's license post-closing and the Certificate of Incorporation for such entity. This entity shall be duly organized and validly existing under the laws of Connecticut.
    c) Notice to OHCA of the effective date of the transfer of ownership transaction. Such notice shall be accompanied by the Final Execution copies of all agreements related to same, including but not limited to:
        i. the Asset Purchase Agreement, including any and all schedules and exhibits; and
        ii. Bylaws or similar governance documents for Vassar.

    Health Quest and/or Vassar may redact from submission under (10)(C)(i) above, any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If Vassar redacts materials in accordance with the previous sentence, Vassar shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why each redacted schedule or exhibit is specifically being claimed as exempt for public record purposes. To the extent that any member of the public requests access to information that Vassar claims is exempt from disclosure under Conn. Gen. Stat. § 1-210, OHCA shall notify Vassar. Vassar shall have an opportunity to respond to any such request and provide further information, as necessary, to support the exemption before any information is disclosed.

In your email below regarding part (c) of this condition, you ask for clarification regarding the filing of this material with OHCA. Please note that OHCA will allow the filing of this material to contain "redactions based on FOIA exemptions". However this must be accompanied by the detail highlighted in yellow above. Upon receipt of the filing and review by OHCA staff, OHCA may require further explanation, justification or clarification or may require the filing of the redacted material. OHCA reserves its rights in this regard. Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Wednesday, August 16, 2017 4:03 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Sharon Documents

Hi, Karen.

When you have a chance can you give me a call to discuss our submission of the Sharon Hospital closing documents? We are going to submit the APA as requested, with redactions based on FOIA exemptions. I believe you (and Kevin) said that you'd want to see an un-redacted version as well, is that correct? If so, is this something you want me to submit or should I arrange to come in with a copy that you can review?

Thanks and let me know when you have a few minutes to discuss.

Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, August 29, 2017 11:13 AM
To: Roberts, Karen
Cc: User, OHCA; Cordeau, Peter R. (Peter.Cordeau@sharonhospital.com)
Subject: Sharon Hospital Compliance -- Docket No. 16-32132-CON
Attachments: DOCS-#1642844-v1-HEALTH_QUEST_SHARON_HOSPITAL_ONE-MONTH_COMPLIANCE.PDF

Good morning, Karen.

Per Condition No. 10 of the Agreed Settlement, attached are the documents/information that Vassar Health Connecticut, Inc. and Health Quest Systems, Inc. are required to file with OHCA within one month of closing. The originals are being sent to you via overnight mail.

Please confirm receipt and let me know if you have any questions or require additional information.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

MERITAS LAW FIRMS WORLDWIDE

Jennifer G. Fusco
(t) 203.786.8316
(f) 203.772.2037
jfusco@uks.com

August 29, 2017

VIA ELECTRONIC &
OVERNIGHT MAIL

Karen Roberts, Principal Health Care Analyst
Office of Health Care Access
410 Capital Avenue, MS #13HCA
P. O. Box 340308
Hartford, CT 06106-0308

Re: Vassar Health Connecticut, Inc. & Health Quest Systems, Inc.
Transfer of Ownership of Sharon Hospital
Docket No. 16-32132-CON

Dear Karen:

This office represents Vassar Health Connecticut, Inc. ("Vassar") and Health Quest Systems, Inc. ("Health Quest") in connection with the above-referenced docket. Please accept this correspondence and attachments as compliance with Condition No. 10 of the Agreed Settlement, dated July 18, 2017 ("Agreed Settlement"). Condition No. 10 requires the filing of certain documents within one month of the date of closing on the sale Sharon Hospital to Vassar, which took place on August 1, 2017.

Specifically, Condition No. 10 requires submission of the following information:

(a) Schedules which set forth the Hospital's inpatient bed allocation (using available beds as the measurement) and the location and hours of operation for all outpatient services, by department, as of the Decision Date. Vassar shall publish this same information on the Hospital's website.

RESPONSE:

Schedule 1 setting forth the allocation of available inpatient beds, and Schedule 2 setting forth the location and hours of operation for Sharon Hospital outpatient services, are attached as Exhibit A. Location and hours of operation for outpatient services are also

available on the Sharon Hospital website (http://www.healthquest.org/sharon-hospital/sharon-hospital.aspx).

Note that Schedule 2 differs slightly from the list of outpatient services submitted with the CON Application. That list included physician services provided by an affiliated physician practice, Regional Healthcare Associates, LLC. Schedule 2 includes Sharon Hospital outpatient services only.

(b) Notice identifying the legal entity that shall directly own and operate the Hospital and hold the Hospital's license post-closing and the Certificate of Incorporation for such entity. This entity shall be duly organized and validly existing under the laws of Connecticut.

RESPONSE:

The legal entity that owns and operates Sharon Hospital as of August 1, 2017 is Vassar Health Connecticut, Inc., a duly-licensed Connecticut non-stock corporation. Copies of the General Hospital License issued by the Department of Public Health and Certificate of Incorporation for Vassar Health Connecticut, Inc. are attached as Exhibit B.

(c) Notice to OHCA of the effective date of the transfer of ownership transaction. Such notice shall be accompanied by the Final Execution copies of all agreements related to same, including but not limited to:

i. The Asset Purchase Agreement, including any and all schedules and exhibits; and
ii. Bylaws or similar governance documents for Vassar.

RESPONSE:

The execution version of the Asset Purchase Agreement ("APA") for the sale of Sharon Hospital is attached as Exhibit C. This version includes all final schedules and exhibits. In addition, the Bylaws of Vassar Health Connecticut, Inc. are attached as Exhibit D.

Pursuant to the terms of the Agreed Settlement, Vassar and Health Quest are exercising their right to redact certain information from the APA as exempt from disclosure under the Connecticut Freedom of Information Act ("FOIA"), at Section 1-210 of the Connecticut General Statutes. The redacted information can be found in the Escrow Agreement attached to the APA as Exhibit B. Specifically, the parties to the Escrow Agreement have redacted the names and contact information of those individuals authorized to provide direction and initiate or confirm transactions, including funds transfer instructions, under the Agreement. They have also redacted wire transfer instructions including bank names and addresses, beneficiaries, and routing and account numbers. This information is being redacted to ensure that no unauthorized transfers of

funds occur based upon information taken from the OHCA public record to be used for unlawful purposes.

The redacted information is exempt from public disclosure pursuant to Conn. Gen. Stat. § 1-210(b)(5)(B), which provides that nothing in FOIA shall be construed to require the disclosure of "commercial or financial information given in confidence, not required by statute." The information is "commercial information" in that it is information related to the business or trade of the parties who are subject to the Escrow Agreement. Pub. Citizens Health Research Group v. FDA, 704 F.2d 1280, 1290 (D.C. Cir. 1983). It is also "financial information" by its very nature in that it includes banking information and mechanisms for the transfer of funds. The information is "given in confidence" to OHCA either under express assurance of confidentially or in circumstances from which such an assurance can be inferred – namely, the information is given in accordance with Condition No. 10 of the Agreed Settlement, which allows for redaction of the APA to maintain the confidentiality of highly sensitive information. Chief of Staff, Office of the Mayor, City of Hartford v. Connecticut Freedom of Information Commission, 1999 Conn. Super. LEXIS 2209, *8 (August 12, 1999). Also, the redacted information is not available to the public from other sources. In Re Connecticut Association of Assessing Officers, Conn. F.O.I.C. Advisory Opinion # 69. Lastly, there is no statute that requires the parties to disclose the redacted information to OHCA. For these reasons, the redacted information is exempt from disclosure under Section 1-210 of the General Statutes.

***

Please let me know if you have any questions or if you need anything further for your review.

Very truly yours,

Jennifer Groves Fusco

JGF/dla

cc: Peter R. Cordeau,
President & CEO,
Sharon Hospital

EXHIBIT A

Schedule 1: Sharon Hospital Inpatient Bed Allocation

Inpatient Bed Type	Number of Available Beds/Bassinets
Medical/Surgical	28
Intensive Care	9
Obstetrics	6
Senior Behavioral Health	12
TOTAL AVAILABLE BEDS:	**55**
Bassinets	16

Schedule 2: Sharon Hospital Outpatient Services

Outpatient Service	Location	Hours of Operation
Advanced Therapy/Rehabilitation	50 Hospital Hill Road Sharon, CT 06069	M. 7am – 7pm T. 7am – 8pm W. 7am – 6pm Th. – 7am – 8pm F. 7am – 5pm
Cardiac Testing & Rehabilitation	50 Hospital Hill Road Sharon, CT 06069	M.-F., 7:30am – 4 pm
Cardiopulmonary Testing & Services	50 Hospital Hill Road Sharon, CT 06069	M.-F., 7:30am – 4 pm 24/7 for Emergencies
Diagnostic Imaging	50 Hospital Hill Road Sharon, CT 06069	M.-F., 7:30am – 5 pm 24/7 for Emergencies
Emergency Department	50 Hospital Hill Road Sharon, CT 06069	24/7
Laboratory	50 Hospital Hill Road Sharon, CT 06069	M.-F., 7am – 5pm Sat., 7am – 12pm
Lithotripsy	50 Hospital Hill Road Sharon, CT 06069	As scheduled during normal business hours, M.-F.
Same-Day Surgery	50 Hospital Hill Road Sharon, CT 06069	M.-F., 6am – 6pm
Vein Clinic	50 Hospital Hill Road Sharon, CT 06069	As scheduled during normal business hours, M.-F.
Wound Care	50 Hospital Hill Road Sharon, CT 06069	M.-F., 8am – 4:30pm

EXHIBIT B

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0076

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Vassar Health Connecticut, Inc. of Sharon, CT d/b/a Sharon Hospital is hereby licensed to maintain and operate a General Hospital.

Sharon Hospital is located at 50 Hospital Hill Road, Sharon, CT 06069-2096.

The maximum number of beds shall not exceed at any time:

16 Bassinets
78 General Hospital Beds

This license expires **June 30, 2019** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, August 1, 2017. INITIAL.

License Revised to Reflect:
*CHOW of OE and RP effective 8/1/17

Raul Pino, MD, MPH
Commissioner

FILING #0005648138 PG 01 OF 05 VOL B-02241
FILED 09/08/2016 01:00 PM PAGE 02375
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF INCORPORATION

OF

VASSAR HEALTH CONNECTICUT, INC.

(a Connecticut nonstock, nonprofit corporation)

The undersigned Incorporator hereby certifies and establishes Vassar Health Connecticut, Inc. as a body politic and corporate under the Revised Nonstock Corporation Act of the State of Connecticut, Chapter 602 of the Connecticut General Statutes (the "Act").

FIRST: The name of the Corporation is Vassar Health Connecticut, Inc. (the "Corporation").

SECOND: The Corporation is not organized for pecuniary profit and shall not have or issue shares of capital stock of any kind or nature whatsoever or pay dividends or make distributions of any kind from profits.

THIRD: The Corporation shall be governed by and operated in accordance with this Certificate of Incorporation (the "Certificate") and the bylaws of the Corporation (the "Bylaws") by a Board of Trustees (the "Board"), the initial members of which shall be elected by the Incorporator and thereafter shall be elected by the Sole Member in accordance with the Bylaws. The trustees shall be elected and shall hold office for such term(s) as specified in this Certificate and the Bylaws, but at no time shall the number of trustees comprising the Board be less than three (3).

FOURTH: The Corporation shall have a sole member, and the sole member shall be Health Quest Systems, Inc. (the "Sole Member"). Pursuant to the provisions of Section 33-1080(b) of the Act, there is reserved specifically and exclusively to the Sole Member, the following rights and powers, and no attempted exercise of any such rights or powers by anyone other than the Sole Member shall be valid or of any force or effect whatsoever:

(a) Corporate Documents. Adopt, approve, amend and repeal this Certificate or the Bylaws of the Corporation or establish, approve, amend and repeal any auxiliary or advisory board of the Corporation and the bylaws thereof.

(b) Appointment and Removal of Trustees and Board Chair. Fix the number of and elect, appoint, fill vacancies in and remove, with or without cause, the Trustees; and elect and remove, with or without cause, the Chair or the Vice Chair of the Board, provided the Chair of the Board is consulted prior to the removal of the Vice-Chair.

(c) Strategic and Financial Plan. Approve the strategic and financial plan of the Corporation.

(d) Rationalization of Clinical Services. Subject to the requirements of law, open, close, locate or relocate any and all clinical services of the Corporation.

(e) Sale or Acquisition of Assets. Subject to the requirements of law and after notice to the Chair of the Board:

(i) Approve any sale, mortgage, lease, loan, gift or pledge of any of the Corporation's real property irrespective of amount, or of any other assets (other than real property, but including intellectual property) in excess of an amount to be fixed from time to time by the Sole Member;

(ii) Approve any acquisition of real property for the Corporation, including the acquisition of any leasehold interests irrespective of amount;

(iii) Approve any acquisition by the Corporation of other assets (other than real property, but including intellectual property) whose value exceeds an amount to be fixed from time to time by the Sole Member.

(f) Merger, Consolidation, Dissolution. Approve any merger, consolidation or dissolution of the Corporation and approve the disposition of the assets of the Corporation at the time of dissolution, after notice to the Chair of the Board.

(g) Reorganization and Formation of New Entities. Approve any corporate reorganization of the Corporation and the development or dissolution of any subsidiary organizations, including corporations, partnerships or other entities, after notice to the Chair of the Board.

(h) Approval of Budgets. Approve any capital or operating budgets of the Corporation.

(i) Approval of Debt. Approve the debt of the Corporation that is in excess of such limits as are established by the Sole Member.

(j) Approval of CON Applications. Approve the submission of certificate of need applications by the Corporation.

(k) Election and Removal of Hospital President. Elect, appoint and remove, with or without cause, the Hospital President of the Corporation after consultation with the Chair of the Board, or if any such action is

recommended by the Chief Executive Officer of the Sole Member, approve such action as recommended.

(l) Evaluation of Hospital President. Approve the criteria for and the process of evaluating the performance of the Hospital President of the Corporation, or if any such action is recommended by the Chief Executive Officer of the Sole Member, approve such action as recommended.

(m) Compensation of Hospital President. Determine the compensation of the Corporation's Hospital President.

(n) Appointment of Auditor. Appoint a certified public accountant to prepare certified audits of the Corporation's accounts for and on behalf of the Sole Member, in addition to the annual financial audit prepared for and on behalf of the Board.

(o) Settlement of Litigation. Approve settlement of any litigation to which the Corporation is a party after consultation with the Chair of the Board.

(p) Subsidiary Corporations. Act for the Corporation, to the full extent of the Sole Member's legal authority, whenever the Corporation acts as member or shareholder of another corporation.

(q) Philosophy and Mission Statement. Approve, interpret, and change the statement of mission and philosophy to be adopted by the Corporation and to require the Corporation to operate in conformance with its statement of mission and philosophy.

FIFTH: The street address of the registered office of the Corporation is 100 Pearl Street, 17th Floor, Hartford, Connecticut 06123-1277. The registered agent of the Corporation at such registered office is Updike, Kelly & Spellacy, P.C.

SIXTH: The name and address of the sole incorporator of the Corporation is as follows:

NAME	MAILING ADDRESS
John F. Wolter	Updike, Kelly & Spellacy, P.C. 100 Pearl Street, 17th Floor Hartford, CT 06103

SEVENTH: The Corporation is organized and will be operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") by engaging, directly or indirectly, in activities in support of such purposes and by making contributions or distributions to organizations that qualify as organizations described in Section 501(c)(3)

of the Code. Subject to and in furtherance of the foregoing, and consistent with Section 501(c)(3) of the Code, the Corporation may (a) establish and maintain a hospital for the care of persons suffering from illnesses or disabilities which require that the patients receive in-patient or out-patient hospital care; (b) promote and carry on educational activities relating to rendering care to the sick and injured and the promotion of health; (c) promote and carry on scientific research related to the care of the sick and injured; (d) participate in activities designed and carried on to promote the general health of the community; and (e) engage in any lawful act or activity for which a corporation may be formed under the Act.

EIGHTH: Notwithstanding any other provisions of this Certificate, the Corporation shall not conduct or carry on any activities not permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Code or by any organization contributions to which are deductible under Section 170(c)(2) of the Code.

NINTH: As a means of accomplishing the foregoing purposes, the Corporation shall have all powers of a corporation formed under the Act; provided, however, that notwithstanding any other provision of this Certificate, only such powers shall be exercised as are consistent with the nature and purpose of an organization exempt under Section 501(c)(3) of the Code, and by an organization, contributions to which are deductible under Section 170(c)(2) of the Code.

TENTH: No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to the Corporation's trustees or officers or any other private individual, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services actually rendered and to make payments and distributions in furtherance of its purpose. Further, no trustee or officer of the Corporation or any private individual shall be entitled to share, directly or indirectly, in whole or in part, in the distribution of any of the corporate assets upon dissolution of the Corporation.

ELEVENTH: No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in any political campaign on behalf of or against any candidate for public office nor shall the Corporation engage in any activities that are unlawful under applicable federal, state or local law.

TWELFTH: In the event of the dissolution of the Corporation or the winding up of its affairs, the Sole Member and the Board shall, after discharging or making provision for the payment of all the liabilities of the Corporation, distribute or otherwise dispose of all of the assets of the Corporation exclusively to such organizations organized and operated exclusively for charitable, scientific or educational purposes, or to such other organizations to which contributions are deductible under Section 170(c)(2) of the Code and which qualify as tax exempt organizations under Sections 170(c)(2) and 501(c)(3) of the Code.

THIRTEENTH: The personal liability of any trustee of the Corporation or any member for monetary damages for breach of duty, other than such a breach that was a knowing and culpable violation of law, enabled such trustee to receive an improper personal economic gain, showed a lack of good faith and a conscious disregard for such trustee's duty to the Corporation under circumstances in which such trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or constituted a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duties to the Corporation, shall be limited to an amount equal to the total amount of compensation received by such trustee for servicing the Corporation during the year of the alleged violation.

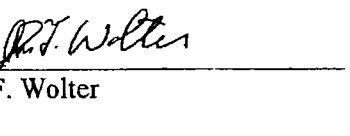
FOURTEENTH: The Corporation shall indemnify its trustees and officers to the fullest extent permitted by Sections 33-1117 and 33-1122, respectively, of the Act, in each case as limited by Section 33-1121 thereof.

FIFTEENTH: The email address of the Corporation is: none.

I hereby declare, under the penalties of false statement, that the statements made in the foregoing Certificate are true.

In Witness Whereof, the undersigned has hereto subscribed his/her hand this 8th day of September, 2016.

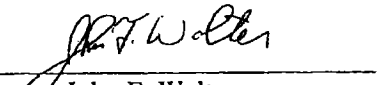
Incorporator:



John F. Wolter

ACCEPTANCE OF APPOINTMENT OF REGISTERED AGENT

UPDIKE, KELLY & SPELLACY, P.C.

By: 

Name: John F. Wolter
Title: President

Date: September 8, 2016

STATE OF CONNECTICUT } SS. HARTFORD
OFFICE OF THE SECRETARY OF THE STATE

I hereby certify that this is a true copy of record
in this Office.
In Testimony whereof, I have hereunto set my hand
and affixed the Seal of said State, at Hartford,
this 9th day of September A.D. 2016

SECRETARY OF THE STATE EAV

EXHIBIT C

ASSET PURCHASE AGREEMENT

AMONG

HEALTH QUEST SYSTEMS, INC.,

VASSAR HEALTH CONNECTICUT, INC.

ESSENT HEALTHCARE OF CONNECTICUT, INC.,

SHARON HOSPITAL HOLDING COMPANY.

REGIONAL HEALTHCARE ASSOCIATES, LLC,

TRI STATE WOMEN'S SERVICES, LLC

AND

REGIONALCARE HOSPITAL PARTNERS, INC.,

(solely for the limited purpose of Section 13.32 and 13.33 herein)

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Exhibits

ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (the "**Agreement**") is made and entered into this 13th day of September, 2016, by and among **ESSENT HEALTHCARE OF CONNECTICUT, INC.** d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**") Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**") Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**") and Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**" and with Sharon, SHHC and RHA, individually a "**Seller**" and collectively, the "**Sellers**"), **HEALTH QUEST SYSTEMS, INC.**, a New York non-profit corporation ("**Health Quest**") and **VASSAR HEALTH CONNECTICUT, INC.**, a Connecticut non-profit corporation ("**Newco**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**"). Sharon, SHHC, RHA, TSWS, Sellers, Health Quest, Newco and Buyer may be referred to individually as a "**Party**" and, collectively, as the "**Parties.**" RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**") joins this Agreement solely for the purposes of Sections 13.32 and 13.33 herein.

RECITALS

WHEREAS, SHHC and Sharon own and operate Sharon Hospital, currently licensed as a 78-bed general acute care community hospital located in Sharon, Connecticut (the "**Hospital**"), and SHHC, Sharon, RHA and TSWS own or lease and operate the other healthcare facilities or operations listed on Exhibit A (collectively, with the Hospital, the "**Facilities**");

WHEREAS, Sharon is an indirect wholly-owned subsidiary of RCHP;

WHEREAS, RHA and TSWS are physician-owned group practice entities that employ or otherwise engage physicians who provide services at the Facilities and both RHA and TSWS are managed by the Hospital;

WHEREAS, the Parties desire to enter into this Agreement to provide for the sale by the Sellers to Buyer of substantially all of the assets, real and personal, tangible and intangible, constituting the Facilities; and

WHEREAS, Sharon and Newco or an affiliate thereof (the "**Manager**") will enter into a management agreement as of the date hereof wherein the Manager will provide management services and other services as set forth therein at the Facilities commencing as of the date hereof until the Closing Date (the "**Management Agreement**").

NOW, THEREFORE, in consideration of the mutual covenants set forth herein and other good and valuable consideration, the adequacy and receipt of which hereby are acknowledged, the Parties, intending to be legally bound, agree as follows:

AGREEMENT

ARTICLE I

DEFINITIONS

"**Actual Closing Net Working Capital Statement**" has the meaning set forth in Section 2.6(b).

"**ADA**" means the Americans with Disabilities Act.

"**Advisory Board**" has the meaning set forth in Section 11.4.

"**Affiliate**" means, as to the entity in question, any person or entity that directly or indirectly controls, is controlled by or is under common control with the entity in question; provided that "Affiliate" shall not include any person or entity that directly or indirectly owns equity securities of RegionalCare Hospital Partners Holdings, Inc. nor any Affiliate or portfolio company of such person or entity that would otherwise be an Affiliate of the entity in question.

"**Agents**" has the meaning set forth in Section 13.17.

"**Agreed Accounting Principles**" means GAAP consistently applied; provided that, with respect to any matter as to which there is more than one generally accepted accounting principle, Agreed Accounting Principles means the generally accepted accounting principles applied in the preparation of the Sellers' most recent audited financial statements.

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

"**AHLA**" has the meaning set forth in Section 13.14(b).

"**ALTA**" means the American Land Title Association.

"**Application**" has the meaning set forth in Section 4.7.

"**Assets**" has the meaning set forth in Section 2.1.

"**Assignment and Assumption Agreements**" has the meaning set forth in Section 3.2(c).

"**Assumed Contracts**" has the meaning set forth in Section 2.1(j).

"**Assumed Liabilities**" has the meaning set forth in Section 2.3.

"**Attorney General**" has the meaning set forth in Section 11.4.

"**Audit Firm**" has the meaning set forth in Section 2.6(c).

"**Balance Sheet Date**" has the meaning set forth in Section 4.4(c).

"**Benefit Plans**" has the meaning set forth in Section 4.13(a).

"**Bills of Sale**" has the meaning set forth in Section 3.2(b).

"**Business**" has the meaning set forth in Section 2.1(a).

"**Buyer**" has the meaning set forth in the Preamble.

"**Buyer Fundamental Representations**" has the meaning set forth in Section 12.4(c).

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.2(a).

"**Certificate of Need**" means a written statement issued by OCHA or other agency having jurisdiction thereof evidencing community need for a new, converted, expanded or otherwise significantly modified health care facility, health service or hospice.

"**Change**" has the meaning set forth in Section 12.4(e).

"**Closing**" has the meaning set forth in Section 3.1.

"**Closing Date**" has the meaning set forth in Section 3.1.

"**Closing Net Working Capital**" has the meaning set forth in Section 2.5.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Commitments**" has the meaning set forth in Section 6.11.

"**Compliance Program**" has the meaning set forth in Section 4.25.

"**Confidential Information**" has the meaning set forth in Section 13.17.

"**Connecticut Facility**" has the meaning set forth in Section 11.8(a).

"**Consent Satisfaction**" has the meaning set forth in Section 2.7.

"**Control**" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity, whether through ownership of voting securities, by contract or otherwise.

"**Corrected Schedules**" has the meaning set forth in Section 13.1.

"**CT DEEP**" has the meaning set forth in Section 11.8.

"**Damages**" means any and all actual losses, liabilities, damages, claims, costs (including, without limitation, court costs and costs for appeal) and expenses (including, without limitation, reasonable attorneys' fees and fees of expert consultants and witnesses) but not including consequential damages, special damages, indirect damages, punitive damages and/or damages based on a purchase price multiple, except to the extent such damages are payable to a third-party in connection with an indemnifiable claim.

"**DEA Power of Attorney**" has the meaning set forth in Section 3.2(m).

"**Disputed Items**" has the meaning set forth in Section 2.6(c).

"**DSS**" means the Connecticut Department of Social Services.

"**EEOC**" means the Equal Employment Opportunity Commission.

"**Effective Time**" has the meaning set forth in Section 13.25.

"**Environmental Claim**" means any claim, action, cause of action, investigation or notice (in each case in writing or, if not in writing, to the knowledge of the Sellers) by any person alleging potential liability (including potential liability for investigatory costs, cleanup costs, governmental response costs, natural resources damages, property damages, personal injuries, or penalties) arising out of, based on or resulting from: (i) the presence, or release or threat of release into the environment, of any Materials of Environmental Concern at any location, whether or not owned or operated by a Seller Party; or (ii) circumstances forming the basis of any violation or alleged violation of any Environmental Law.

"**Environmental Laws**" means, as they exist on the date hereof and as of the Closing Date, all applicable United States federal, state, local and non-U.S. laws, regulations, codes, and ordinances and common law relating to pollution or protection of human health (as relating to the environment or the workplace) and the environment (including ambient air, surface water, ground water, land surface or sub-surface strata), including laws, and regulations relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the use, treatment, storage, disposal, transport or handling of Materials of Environmental Concern, including, but not limited to Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. Section 9601 et seq., Resource Conservation and Recovery Act, 42 U.S.C. Section 6901 *et seq.*, Toxic Substances Control Act, 15 U.S.C. Section 2601 *et seq.*, Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq.*, the Clean Air Act, 42 U.S.C. Section 7401 *et seq.*, the Clean Water Act, 33 U.S.C. Section 1251 *et seq.*, each as may have been amended or supplemented, and any applicable environmental transfer statutes or laws.

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

"**ERISA Affiliate**" means each Seller, each entity which is treated as a single employer with RCHP for purposes of Section 414 of the IRC, each entity that has adopted or has ever participated in any Benefit Plan, and any predecessor or successor company or trade or business of the Sellers.

"Erroneous Applicability Determination" has the meaning set forth in Section 12.2(a).

"**Escrow Agent**" has the meaning set forth in Section 2.5.

"**Escrow Agreement**" has the meaning set forth in Section 2.5.

"**Escrow Amount**" has the meaning set forth in Section 2.5.

"**Excluded Assets**" has the meaning set forth in Section 2.2.

"**Excluded Liabilities**" has the meaning set forth in Section 2.4.

"**Executive Order 13224**" means Executive Order 13224 on Terrorism Financing, effective September 24, 2001.

"**Executives**" has the meaning set forth in Section 10.1.

"**Exemption Certificate**" means a written statement from OCHA or other agency having jurisdiction thereof stating that a health care project or expenditure is not subject to the Certificate of Need requirements under applicable state law.

"**Existing TI Obligations**" means tenant improvement expenses (including all hard and soft construction costs, whether payable to the contractor or tenant) and tenant allowances which are the obligation of the landlord under any Tenant Lease.

"**Facilities**" has the meaning set forth in the Recitals.

"**Facility Benefit Plans**" has the meaning set forth in Section 4.13(a).

"**Financial Statements**" has the meaning set forth in Section 4.4.

"**GAAP**" means U.S. generally accepted accounting principles, consistently applied by the Seller, in effect at the date of the financial statement to which it refers.

"**Health Quest**" has the meaning set forth in the Recitals.

"**Healthcare Providers**" has the meaning set forth in Section 4.9.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HIPAA**" means collectively the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended and supplemented by the Health Information Technology for Clinical Health Act of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations, when each is effective and as each is amended from time to time.

"**Hired Employees**" has the meaning set forth in Section 10.1(a).

"**Hospital**" has the meaning as set forth in the Recitals.

"**Immaterial Contracts**" means any contract or agreement of the Sellers that is not a Material Contract.

"**Indemnification Deductible**" has the meaning set forth in Section 12.4(a).

"**Indemnified Party**" has the meaning set forth in Section 12.5.

"**Indemnifying Party**" has the meaning set forth in Section 12.5.

"**Information Privacy and Security Laws**" has the meaning set forth in Section 4.9.

"**Interim Statements**" has the meaning set forth in Section 6.6.

"**IRC**" means the Internal Revenue Code of 1986, as amended, and the rules and regulations promulgated thereunder.

"**Joint Commission**" has the meaning set forth in Section 4.8.

"**Knowledge of the Sellers**" has the meaning set forth in Section 4.29.

"**Landlord Estoppel**" has the meaning set forth in Section 6.10.

"**Leased Real Property**" has the meaning set forth in Section 2.1(b).

"**Legal Dispute**" has the meaning set forth in Section 13.14(b).

"**Licensed Environmental Professional**" has the meaning set forth in Section 11.8(a).

"**Management Agreement**" has the meaning set forth in the recitals.

"**Material Adverse Effect**" means (a) the Hospital's exclusion from participation in the Medicare, Medicaid or CHAMPUS/TRICARE programs or the loss of the Hospital's active provider numbers with the Medicare and Medicaid programs; (b) the destruction of or material damage to the Hospital or a majority of the Assets to an extent that would permit Buyer to terminate this Agreement pursuant to Section 13.31; or (c) an event, occurrence, condition, change or circumstance or a series of events, occurrences, conditions, changes or circumstances that, individually or in the aggregate, would prevent, or would reasonably be expected to prevent, Buyer from operating the Hospital in a manner generally consistent with its historic operations. For the avoidance of doubt, none of the following occurring after the date hereof shall constitute a Material Adverse Effect or be taken into account in determining whether a Material Adverse Effect has occurred: (i) changes in the economy of the United States; (ii) changes generally affecting the industry in which the Sellers operate, including changes in any government or private payor programs generally applicable to operators of hospital and health care facilities in the United States; (iii) changes in GAAP or any interpretation thereof; (iv) acts of God, calamities or national political or social conditions (including the engagement by any country in hostilities); (v) changes as a result of the announcement of this transaction; or (vi) changes in the financial condition, prospects or results of operations of the Sellers, the Facilities or the Assets, except to the extent resulting in an event, occurrence, condition, change or circumstance described in (a), (b) or (c), above.

"**Material Contract**" has the meaning set forth in Section 4.18.

"**Materials of Environmental Concern**" means chemicals, pollutants, contaminants, hazardous materials, hazardous substances and hazardous wastes, Medical Waste, toxic substances, petroleum and petroleum products and by-products, asbestos-containing materials, PCBs, toxic mold, and any other chemicals, pollutants, substances or wastes, in each case so defined, identified, or regulated under any Environmental Law.

"**Medical Waste**" includes, but is not limited to, (a) pathological waste, (b) blood, (c) sharps, (d) wastes from surgery or autopsy, (e) dialysis waste, including contaminated disposable equipment and supplies, (f) cultures and stocks of infectious agents and associated biological agents, (g) contaminated animals, (h) isolation wastes, (i) contaminated equipment, (j) laboratory waste and (k) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings or animals. "Medical Waste" also includes any substance, pollutant, material or contaminant listed or regulated as "Medical Waste," "Infectious Waste," or other similar terms by federal, state, regional, county, municipal or other local laws, regulations and ordinances insofar as they purport to regulate Medical Waste or impose requirements relating to Medical Waste and includes "Regulated Waste" governed by the Occupational Safety and Health Act, 29 U.S.C. Section 651 *et seq*.

"**Net Working Capital**" means an amount equal to the value of the Sellers' inventories, supplies, and Prepaids, to the extent that each of these assets is an Asset, less the value of the Sellers' accounts payable, construction payable, accrued payroll, accrued vacation, holiday/paid time off, recorded sick time, up to the maximum amount of paid time off that can be accrued under Buyer's paid time off program, and the liability reflected on Schedule 2.3(c) relating to Sellers' assumed unrecorded extended illness benefits, and other current liabilities consistent with the Sellers' historical practices, to the extent that each of these liabilities is a current liability and is an Assumed Liability.

"**Net Working Capital Estimate**" has the meaning set forth in Section 2.6(a).

"**NSPS**" means the National Society of Professional Surveyors.

"**Objection**" has the meaning set forth in Section 2.6(c).

"**OFAC**" means the Office of Foreign Asset Contract.

"**OHCA**" has the meaning set forth in Section 4.7.

"**OIG**" means the Office of Inspector General.

"**Owned Intellectual Property**" has the meaning set forth in Section 2.1(j).

"**Owned Real Property**" has the meaning set forth in Section 2.1(a).

"**Party**" and "**Parties**" has the meaning set forth in the Preamble.

"**PCBs**" means polychlorinated biphenyls.

"**Personal Property**" has the meaning set forth in Section 2.1(c).

"**Permitted Encumbrances**" has the meaning set forth in Section 4.11.

"**Physician Agreement**" means any agreement, whether in writing or oral, between a Seller and either a physician or a legal entity in which a physician has an ownership interest.

"**Prepaids**" means all deposits, prepaid expenses, advances, escrows, prepaid Taxes and claims for refunds in connection with the Facilities or the Assets (including, without limitation, rebates from vendors received subsequent to the Closing).

"**Prohibited Transaction**" has the meaning set forth in Section 6.7.

"**Property Transfer Law**" means Section 22a-134 through 22a-134e of the Connecticut General Statutes, as amended by Public Acts 09-235 and 09-3 and all associated regulations, guidance documents and policies.

"**Providing Party**" has the meaning set forth in Section 13.17.

"**Purchase Price**" has the meaning set forth in Section 2.5.

"**Purchase Price Discount**" has the meaning set forth in Section 2.7.

"**RAC**" means Recovery Audit Contractors.

"**RCHP**" has the meaning set forth in the Preamble.

"**Real Property**" has the meaning set forth in Section 2.1(b).

"**Receiving Party**" has the meaning set forth in Section 13.17.

"**Records**" has the meaning set forth in Section 13.5.

"**RSRs**" has the meaning set forth in Section 11.8.

"**Seller Cost Reports**" has the meaning set forth in Section 2.2(b).

"**Seller Fundamental Representations**" has the meaning set forth in Section 12.4(c).

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.1(a).

"**Seller Leases**" has the meaning set forth in Section 2.1(j).

"**Seller Review Period**" has the meaning set forth in Section 13.2.

"**Sellers**" has the meaning set forth in the Preamble.

"**Sharon**" has the meaning set forth in the Preamble.

"**SNDA**" has the meaning set forth in Section 6.12.

"**Straddle Period**" has the meaning set forth in Section 13.9.

"**Survey Costs**" has the meaning set forth in Section 6.11.

"**Surveys**" has the meaning set forth in Section 6.11.

"**Tax Allocation**" has the meaning set forth in Section 13.2.

"**Tax Return**" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes required or permitted to be filed with a Taxing Authority, including any schedule or attachment thereto, and including any amendment thereof.

"**Taxes**" means any and all federal, state, local, foreign and other net income, tax on unrelated business taxable income, gross income, gross receipts, sales, use, ad valorem, unclaimed property, payments in lieu of taxes, transfer, franchise, profits, license, lease, rent, service, service use, withholding, payroll, employment, excise, severance, privilege, stamp, occupation, premium, property, windfall profits, alternative minimum, estimated, customs, duties or other taxes, fees, assessments or charges of any kind whatsoever, together with any interest and any penalties, additions to tax or additional amounts with respect thereto.

"**Taxing Authority**" means any United States, federal, state, local or any foreign or governmental entity, political subdivision, or agency responsible for the imposition, enforcement, assessment or collection of any Tax

"**Tenant Estoppel**" has the meaning set forth in Section 6.9.

"**Tenant Leases**" has the meaning set forth in Section 2.1(j).

"**Title Company**" has the meaning set forth in Section 6.11.

"**Title Policy Costs**" has the meaning set forth in Section 6.11.

"**Trade Name Cancellation**" has the meaning set forth in Section 11.3.

"**Transition Patients**" has the meaning set forth in Section 2.9.

"**Transition Services**" has the meaning set forth in Section 2.9.

"**Transition Services Agreement**" has the meaning set forth in Section 3.2(h).

"**Updated Schedules**" has the meaning set forth in Section 13.1.

"**USA Patriot Act**" means the United and Strengthening America by Providing Tools Required to Intercept and Obstruct Terrorism Act of 2001, H.R. 3162, Public Law 107-56.

"**WARN Act**" means the Worker Adjustment and Retraining Notification Act.

ARTICLE II

PURCHASE OF ASSETS

2.1 Sale of Assets. Subject to the terms and conditions of this Agreement, on the Closing Date, the Sellers shall sell, assign, convey, transfer and deliver to Buyer, and Buyer shall purchase, the assets that are owned by the Sellers or otherwise used exclusively in connection with the operation of the Facilities, other than the Excluded Assets (hereinafter defined) (the "**Assets**"), including, without limitation, the following:

(a) all real property owned by any of the Sellers and used in connection with the operation of any of the Facilities (collectively, the "**Business**"), as more specifically described in Schedule 2.1(a), together with all buildings, improvements and fixtures located thereupon, all easements, rights of way, and other appurtenances thereto (including appurtenant rights in and to public streets), all architectural plans or design specifications relating to the development thereof and all construction in progress (collectively, the "**Owned Real Property**"), such Schedule 2.1(a) to include a legal description for each such parcel of Owned Real Property consistent with the vesting deed for such Owned Real Property into the applicable Seller;

(b) all real property subject to a leasehold, sub-leasehold, license, concession or other non-owned real estate in favor of any of the Sellers, as tenant, subtenant, licensee, concessionaire or otherwise, and held or used in or ancillary to the operation of the Business, all such leased premises as more specifically described on Schedule 2.1(b) (collectively, the "**Leased Real Property**"; the Owned Real Property and the Leased Real Property being sometimes referred to herein collectively as the "**Real Property**");

(c) all tangible personal property, including, without limitation, all major, minor or other equipment, vehicles, furniture, fixtures, machinery, office furnishings and instruments, the list of which, as of May 31, 2016, is set forth on Schedule 2.1(c) hereto (collectively, the "**Personal Property**");

(d) all supplies, drugs, inventory and other disposables and consumables existing on the Closing Date and located at any of the Facilities or owned by any of the Sellers in connection with the Business;

(e) all Prepaids that exist as of the Closing Date, excluding the settlement amounts described in Section 2.2(b);

(f) all claims, causes of action and judgments in favor of the Sellers relating to the physical condition or repair of the Assets, all insurance proceeds due to Buyer under Section 13.31, and, to the extent assignable, all warranties (express or implied) and rights and claims assertable by (but not against) the Sellers related to the Assets;

(g) to the extent legally assignable or transferable, all financial, patient, medical staff, personnel and other records relating to the Business or the Assets, including, without limitation, all accounts receivable records, equipment records, medical and administrative libraries, medical records, patient billing records, documents, construction plans

and specifications, catalogs, books, records, files, operating manuals and current personnel records; provided, however that Sellers shall be entitled to retain copies of any such Records to which Seller reasonably determines it may need access to following the Closing Date in order to collect any amounts owed to Sellers, to defend Sellers in any action, or to comply with any legal obligation of Sellers.

(h) all rights and interests in, to and under those lease, sublease, license or other agreements pursuant to which any of the Sellers, as landlord, sublandlord, licensor or otherwise, has leased, subleased, licensed or otherwise granted use and occupancy to a third party, as tenant, subtenant, licensee or otherwise, all or some portion of the Owned Real Property or the Leased Real Property, all such agreements being set forth on Schedule 2.1(h) together with all amendments and modifications thereto, collectively, the "**Tenant Leases**");

(i) all rights and interests in, to and under those lease, sublease, license or other agreements pursuant to which any of the Sellers, as tenant, subtenant, licensee or otherwise, is leasing, subleasing, licensing or otherwise using and occupying all or some portion of the Leased Real Property, all such agreements being set forth on Schedule 2.1(i) (together with all amendments and modifications thereto, collectively, the "**Seller Leases**");

(j) other than Excluded Contracts listed on Schedule 2.2(e), all rights and interests in, to and under (i) the Material Contracts listed on Schedule 4.18 and (ii) all Immaterial Contracts (collectively, the contracts in (i) and (ii) are "**Assumed Contracts**");

(k) to the extent assignable or transferable, all licenses, Certificates of Need, Exemption Certificates, provider agreements, provider numbers, franchises, accreditations, registrations, other licenses and permits relating to the ownership, development, and operation of the Facilities (including, without limitation, any pending approvals set forth on Schedule 2.1(k));

(l) all of Sellers' rights and interest in the name "Sharon Hospital" and all patents, trade names, domain names, copyrights, software, computer programs, trade secrets, trademarks, service marks and other intellectual property rights associated with the Business or any of the Assets, all goodwill associated therewith, and all applications and registrations associated therewith (the "**Owned Intellectual Property**");

(m) all goodwill associated with the operation of the Business and the Assets;

(n) all other assets, other than the Excluded Assets, of every kind, character or description used or held for use primarily in the Business or related to the Assets, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by the Sellers in connection with the Business or the Assets; and

(o) all property of the foregoing types arising or acquired by the Sellers between the date hereof and the Closing Date.

The Sellers shall transfer good and marketable title to the Assets to Buyer, free and clear of all claims, assessments, security interests, liens, restrictions and encumbrances, except for (i) the

Assumed Liabilities, (ii) liens and encumbrances related to the Assumed Liabilities, (iii) liens for Taxes not yet due and payable, and (iv) the Permitted Encumbrances.

2.2 Excluded Assets. Those assets of the Sellers described below, together with any assets described on Schedule 2.2 hereto, shall be retained by the Sellers (collectively, the "**Excluded Assets**"), and shall not be conveyed to Buyer:

(a) cash, short-term investments and cash equivalents;

(b) all amounts payable to any of the Sellers in respect of third party payors pursuant to retrospective settlements (including, without limitation, pursuant to Medicare, Medicaid and CHAMPUS/TRICARE cost reports) filed or to be filed by any of the Sellers for periods ending on or prior to the Closing Date ("**Seller Cost Reports**") and all appeals and appeal rights relating to such settlements, including recapture of depreciation and other cost report settlements, for periods ending on or prior to the Closing Date;

(c) all records relating to the Excluded Assets and Excluded Liabilities as well as all records which by law the Sellers are required to maintain in their possession;

(d) the corporate record books, minute books and Tax records of the Sellers;

(e) any Material Contract listed on Schedule 2.2(e) and any other contract listed on Schedule 2.2(e) that Buyer determines in its reasonable discretion is not in compliance with applicable law (the "**Excluded Contracts**");

(f) any reserves or prepaid expenses made in connection with the Excluded Assets and Excluded Liabilities (including, without limitation, prepaid legal expenses or insurance premiums);

(g) all rights to Tax refunds or claims under or proceeds of insurance policies related to the Business or the Assets resulting from the periods ending on or prior to the Closing Date;

(h) except as otherwise provided in Section 13.31, all insurance proceeds (other than payments of patient receivables) arising in connection with the Business or the Assets for periods ending on or prior to the Closing Date and all insurance proceeds relating exclusively to the Excluded Assets and Excluded Liabilities;

(i) the amounts due to any of the Sellers from Affiliates of the Sellers disclosed on Schedule 2.2(j);

(j) prepaid pension costs and other assets associated with the Sellers' qualified employee benefits plans;

(k) all notes receivable, accounts receivable and other rights to receive payment for goods and services provided by the Sellers in connection with the Business, billed and unbilled, recorded or unrecorded, including amounts charged off as bad debt and/or

submitted to collection agencies or otherwise, accrued and existing in respect of services rendered through the Closing Date;

(l) all notes receivable from patients;

(m) all rights of the Sellers under this Agreement;

(n) all claims, causes of action and judgments in favor of the Sellers associated with or arising out of any of the Excluded Assets and/or the Excluded Liabilities;

(o) all self-insured retention trusts related to professional and general liability claims and causes of action;

(p) for the avoidance of doubt, all multi-facility contracts, agreements and arrangements of RCHP and its Affiliates, including information technology contracts and computer software, scheduling systems, business and policy manuals, other media, documentation and manuals and any other proprietary information of RCHP, or an affiliate thereof, licensed or used by Sellers or the Facilities; provided, however, that this provision shall not exclude any contract, agreement, or arrangement where Sellers are the only RCHP Affiliate parties;

(q) any other current and long term assets not related to Sharon's current operating activity except as otherwise expressly included as an Asset under Section 2.1.

2.3 Assumed Liabilities. In connection with the conveyance of the Assets to Buyer, Buyer agrees to assume, as of the Effective Time, the payment and performance of the following liabilities of the Sellers (the "**Assumed Liabilities**"):

(a) all obligations accruing, arising or to be performed after the Closing with respect to the Assumed Contracts, the Tenant Leases and the Seller Leases;

(b) the accounts payable, construction payable, and other current liabilities consistent with historical practices of the Sellers, but only to the extent such liabilities are current liabilities that are recorded on the Net Working Capital Estimate and are included within the calculation of Net Working Capital; and

(c) to the extent recorded on the Financial Statements or disclosed on Schedule 2.3(c), obligations and liabilities as of the Closing Date in respect of accrued vacation, sick time and paid time off benefits, and the amount of unrecorded extended illness benefits set forth on Schedule 2.3(c) of the employees at the Facilities who commence employment with Buyer as of the Effective Time, and related Taxes not yet due and payable.

Notwithstanding anything herein to the contrary, Buyer acknowledges and agrees that Seller shall have no liability for the operation of the Facilities, the Business or the Assets after the Effective Time.

2.4 Excluded Liabilities. Except for the Assumed Liabilities, Buyer shall not assume and under no circumstances shall Buyer be obligated to pay, discharge or assume, and

none of the assets of Buyer shall be or become liable for or subject to, any liability, indebtedness, commitment or obligation of any of the Sellers, whether known or unknown, fixed or contingent, recorded or unrecorded, currently existing or hereafter arising or otherwise (collectively, the "**Excluded Liabilities**"), including, without limitation, the following:

(a) any debt, obligation, expense or liability that is not an Assumed Liability;

(b) any liability arising out of or in connection with the ownership or operation of the Facilities, the Business or the Assets prior to the Effective Time, including, without limitation, claims or potential claims for medical malpractice or general liability relating to events asserted to have occurred on or prior to the Closing;

(c) those claims and obligations (if any) specified in Schedule 2.4(c) hereto;

(d) any liabilities or obligations associated with or arising out of any of the Excluded Assets;

(e) liabilities and obligations in respect of periods ending on or prior to the Closing Date arising under the terms of the Medicare, Medicaid, CHAMPUS/TRICARE, Blue Cross or other third party payor programs, including, without limitation, in respect of any Seller Cost Report, any or audit under Medicare's RAC Program or any noncompliance with applicable law or contractual obligations relating to the billing and collection for services;

(f) Tax liabilities or obligations in respect of periods ending on or prior to the Closing Date, or any period that begins before but does not end on the Closing Date to the extent allocable under Section 13.2 to the portion of such period ending on the Closing Date, including, without limitation, any income tax, franchise tax, real or personal property tax, tax recapture, sales and/or use tax and any state and local recording fees and taxes, excluding any Taxes payable with respect to any employee benefits constituting Assumed Liabilities under Section 2.3(c) hereof;

(g) liability for any and all claims by or on behalf of current or former employees arising out of or related to acts, omissions, events or occurrences on or prior to the Closing Date, including, without limitation, liability for any EEOC claim, ADA claim, Family and Medical Leave Act claim, wage and hour claim, unemployment compensation claim, or workers' compensation claim, and any liabilities or obligations under COBRA, the Public Health Service Act or similar state laws for qualifying events occurring on or prior to the Closing Date (provided, however, that this clause (g) shall not apply to those benefits constituting Assumed Liabilities and identified in Section 2.3 hereof);

(h) any obligation or liability accruing, arising out of or relating to any federal, state or local investigations of, or claims or actions against, any of the Sellers, or any of their respective directors, officers, employees, medical staff, agents, vendors or representatives, with respect to acts or omissions on or prior to the Closing Date, including, but not limited to, any post-Closing defense of any such obligation or liability;

(i) any civil or criminal obligation or liability accruing, arising out of, or relating to any acts or omissions of any of the Sellers or their respective directors, officers,

employees, medical staff, agents, vendors or representatives claimed to violate any constitutional provision, statute, ordinance or other law, rule, regulation, interpretation or order of any governmental entity;

(j) liabilities or obligations arising out of any breach by any of the Sellers prior to the Closing of any Assumed Contract, Tenant Lease or Seller Lease;

(k) any obligations or liabilities with respect to any Benefit Plans; any post-retiree medical benefits or benefits described in Section 4.13; any other obligations or liabilities of the Sellers or any ERISA Affiliate arising under or in connection with ERISA or the IRC; and any incurred but not paid (regardless of whether reported) medical and dental claims made pursuant to any Benefit Plan;

(l) all deferred compensation liabilities related to periods ending on or prior to the Closing;

(m) any account payable of a Seller to any other Seller or Affiliate thereof;

(n) liabilities or obligations whenever arising relating to any Excluded Contract;

(o) except as otherwise expressly assumed by Buyer under this Agreement, any existing indebtedness of Sellers, including, without limitation, any liability under any capital leases;

(p) any and all liabilities or obligations owed by Sellers to the Hospital's medical staff, except as otherwise expressly assumed by Buyer under this Agreement;

(q) any liability or obligation owed by Sellers to the Medical Foundation for Community Health, Inc., or any affiliate thereof, unless otherwise expressly assumed by Buyer under this Agreement;

(r) any obligation or liability arising from or under any Environmental Law related to acts or omissions of the Sellers or which occurred on or prior to the Closing Date; and

(s) any liability arising from or related to compliance with the Property Transfer Law in connection with the transaction covered by this Agreement.

2.5 Consideration. Subject to the terms and conditions hereof and in reliance upon the representations and warranties of the Sellers set forth herein, as consideration for the conveyance and transfer of the Assets, Buyer shall: (i) pay to the Sellers Five Million Dollars ($5,000,000) less any applicable Purchase Price Discount, which amount shall be increased or decreased by the amount of the Sellers' Net Working Capital as of the Closing Date (the "**Closing Net Working Capital**"), (as so adjusted, the "**Purchase Price**"); and (ii) assume as of the Effective Time the Assumed Liabilities. At the Closing, Buyer shall deposit Five Hundred Thousand Dollars ($500,000) of the Purchase Price (the "**Escrow Amount**") with the escrow agent (the "**Escrow Agent**") identified in that certain Escrow Agreement substantially in the

form of Exhibit B hereto (the "**Escrow Agreement**"), which amount shall be held and disbursed by the Escrow Agent in accordance with the terms of the Escrow Agreement.

2.6 Determination of Purchase Price; Net Working Capital Adjustment.

(a) For purposes of determining the amount of cash or otherwise immediately available funds to be delivered by Buyer at the Closing in accordance with Section 2.5, not later than two (2) business days prior to the Closing Date, the Sellers shall deliver to Buyer their good faith estimate of the amount of the Closing Net Working Capital, together with supporting documentation of reasonable specificity, which shall be subject to review and approval by Buyer (such estimate being the "**Net Working Capital Estimate**"). At the Closing, Buyer shall pay to the Sellers by wire transfer of immediately available funds to an account or accounts of the Sellers' designation Five Million Dollars ($5,000,000), plus or minus the Net Working Capital Estimate, minus the Escrow Amount.

(b) Within one hundred and fifty (150) days after the Closing Date, Buyer shall prepare, or cause to be prepared, and deliver to the Sellers a statement (the "**Actual Closing Net Working Capital Statement**") setting forth an itemized calculation of the Closing Net Working Capital and all supporting schedules for such calculations. The Actual Closing Net Working Capital Statement shall be prepared in accordance with Agreed Accounting Principles.

(c) The Sellers and their accountants shall have forty-five (45) days to review the Actual Closing Net Working Capital Statement after their receipt thereof, and Buyer shall provide Sellers access to all relevant books and records and any work papers of Buyer and its accountants used in preparing the Actual Closing Net Working Capital Statement. If the Sellers dispute the accuracy of the Actual Closing Net Working Capital Statement, the Sellers shall inform Buyer in writing (an "**Objection**") setting forth a specific description of the basis of the Objection, which Objection must be delivered to Buyer on or before the last day of such forty-five (45)-day period. Buyer and the Sellers shall then have thirty (30) additional days to attempt in good faith to reach an agreement with respect to any disputed matters in respect of the Closing Net Working Capital. In reviewing any Objection, Buyer and its accountants shall have reasonable access to the work papers of the Sellers and their accountants. If Buyer and the Sellers are unable to resolve all of their disagreements with respect to the determination of the foregoing items within said thirty (30)-day period, they shall submit the remaining items subject to dispute (the "**Disputed Items**") to KPMG LLP (the "**Audit Firm**"). The Audit Firm shall determine in accordance with this Agreement and Agreed Accounting Principles, and only with respect to the Disputed Items, whether and to what extent, if any, the Actual Closing Net Working Capital Statement requires adjustment. The Parties shall direct the Audit Firm to use all reasonable efforts to render its determination within thirty (30) days after such submission. The Audit Firm's determination of the Closing Net Working Capital shall be conclusive and binding upon the Parties. The fees and disbursements of the Audit Firm in rendering its determination shall be paid fifty percent (50%) by the Sellers and fifty percent (50%) by Buyer. Buyer and the Sellers shall make readily available to the Audit Firm all relevant books and records and any work papers (including those of the Parties' respective accountants) relating to the Actual Closing Net Working Capital Statement and all other items reasonably requested by the Audit Firm. The Closing Net Working Capital shall be deemed to be (i) the amount of Net Working Capital as stated in the Actual Closing Net Working Capital Statement if no Objection is

delivered by the Sellers during the thirty (30)-day period specified above, or (ii) if an Objection is so delivered by the Sellers, the amount of the Closing Net Working Capital as determined by either (A) the agreement of the Parties or (B) the Audit Firm.

(d) If the Closing Net Working Capital is less than the Net Working Capital Estimate, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the Net Working Capital Estimate and the Closing Net Working Capital shall be paid by the Sellers to Buyer via wire transfer of immediately available funds as an adjustment to the Purchase Price. If the Net Working Capital Estimate is less than the Closing Net Working Capital, then within thirty (30) days after the final determination of the Closing Net Working Capital, the amount of the difference between the Closing Net Working Capital and the Net Working Capital Estimate shall be paid by Buyer to the Sellers via wire transfer of immediately available funds as an adjustment to the Purchase Price

2.7 Purchase Price Discount. If, as of the Closing Date, (i) consents have been obtained to assign to Buyer commercial payor contracts or (ii) evidence reasonably satisfactory to Buyer that successor or comparable contractual arrangements or non-contracted commercial payor arrangements will continue after the Closing (together, "**Consent Satisfaction**"), that in the aggregate, together with government payment programs, self-pay and non-contracted commercial payment programs constitute at least 90% of the Hospital's revenue for 2015, but less than 95% of the Hospital's revenue for 2015, then the Purchase Price shall be discounted as follows: for each 0.1% below 95% of the Hospital's revenue for 2015 the Purchase Price shall be discounted by $10,000 up to a maximum of $500,000 (the "**Purchase Price Discount**"). For example, if on the Closing Date Consent Satisfaction representing 92.5% percent of the Hospital's revenue for 2015 has been obtained, the Purchase Price will be reduced by $250,000

2.8 Prorations and Utilities. To the extent not otherwise prorated pursuant to this Agreement, Buyer and the Sellers shall prorate as of the Closing Date, charges against the Real Property and the Personal Property, power and utility charges and all other income and expenses that are normally prorated upon the sale of a going concern. As to charges against the Real Property and the Personal Property, all prorations shall be based upon the most recent tax bill(s) received by the Sellers. As to power and utility charges, such amounts shall be prorated as of the Closing Date among the parties on the basis of an estimate of the amounts in accordance with GAAP and mutually agreed upon by Buyer and the Sellers.

2.9 Transition Patients. To compensate Sellers for services rendered and medicine, drugs and supplies provided on or before the Closing Date (the "**Transition Services**") with respect to patients admitted to the Facilities on or before the Closing Date (or who were in the Facilities' emergency department or in observation beds on the Closing Date and immediately thereafter admitted to the Facilities) but who are not discharged until after the Closing Date (such patients being referred to herein as the "**Transition Patients**"), the parties shall take the following actions:

(a) Medicare, Medicaid, TRICARE and Other Seller DRG Transition Patients. As soon as practicable after the Closing Date, Buyer shall deliver to Sellers a schedule identifying the charges, on an itemized basis, for the Transition Services provided by Sellers on

or through the Closing Date to Transition Patients whose care is reimbursed by the Medicare, Medicaid, TRICARE or other third party payor programs on a diagnostic related group ("**DRG**") basis, case rate, or similar basis (each patient a "**Seller DRG Transition Patient**"), as well as a schedule of any DRG and outlier payments, the case rate payments, or other similar payments received by Sellers and any deposits or co-payments made by such Seller DRG Transition Patient to Sellers. Buyer shall include in the amount of Assets in the calculation of Net Working Capital an amount equal to: (x) the DRG and outlier payments, the case rate payments or other similar payments received by Buyer on behalf of each Seller DRG Transition Patient, plus any deposits or co-payments made by such Seller DRG Transition Patient to Buyer multiplied by a fraction, the numerator of which shall be the total charges for Transition Services provided to such Seller DRG Transition Patient by Sellers prior to the Closing Date, and the denominator of which shall be the sum of total charges for all services provided to such Seller DRG Transition Patient both before and after the Closing Date; minus (y) the DRG and outlier payments, the case rate payments or other similar payments received by Sellers, if any, on behalf of each Seller DRG Transition Patient, plus any deposits or co-payments made by such Seller DRG Transition Patient to Sellers multiplied by a fraction, the numerator of which shall be the total charges for Transition Services provided to such Seller DRG Transition Patient by Buyer after the Closing Date, and the denominator of which shall be the sum of total charges of all services provided to such Seller DRG Transition Patient both before and after the Closing Date.

(b) For all Transition Patients not covered by Section 2.9(a), Buyer shall include in the amount of Assets in the calculation of Net Working Capital the amount equal to the amount received by Buyer related to the services provided by Sellers prior to Closing, if separately identifiable on the claim (for example, when services are compensated based on the number of days). If not identifiable on the claim, then the Buyer and Sellers shall follow the process identified in Section 2.9(a) in order to allocate the total payment between the Buyer and Sellers based on total charges, unless the payor requires a separate "cut-off" bill from Sellers, in which case all amounts collected in respect of such cut-off billings shall be included in the amount of Assets in the calculation of Net Working Capital.

ARTICLE III

CLOSING

3.1 Closing. Subject to the satisfaction or waiver by the appropriate Party of all of the conditions specified in ARTICLES VIII and IX hereof, the consummation of the transactions contemplated by and described in this Agreement (the "**Closing**") shall take place on a date mutually agreed to in writing by the Parties that is as soon as practicable after all required regulatory and other approvals for the transaction have been obtained and after all conditions precedent have been satisfied, except those that are to be satisfied on the Closing Date, but in no event later than July 31, 2017 or the first anniversary of the date hereof, whichever is later, or on such later date or at such other location as the Parties may mutually designate in writing (the date of consummation is referred to herein as the "**Closing Date**").

3.2 Actions of the Sellers at the Closing. At the Closing and unless otherwise waived in writing by Buyer, the Sellers shall deliver to Buyer the following:

(a) one or more special warranty deeds in recordable form executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer good and marketable fee title to the Owned Real Property, subject only to the Permitted Encumbrances affecting such parcels;

(b) one or more General Assignments, Conveyances and Bills of Sale in the form attached as Exhibit C (the "**Bills of Sale**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer good and marketable title to the Assets, free and clear of all claims, assessments, liens, security interests, restrictions and encumbrances other than the Permitted Encumbrances, liens for Taxes not yet due and payable and the Assumed Liabilities;

(c) one or more Assignment and Assumption Agreements in the form attached as Exhibit D (the "**Assignment and Assumption Agreements**"), fully executed by a duly authorized officer of the appropriate Seller(s), conveying to Buyer or an Affiliate designated by Buyer all of Sellers' right, title and interest in, to and under the Assumed Contracts, the Tenant Leases and Seller Leases;

(d) a copy of resolutions duly adopted by the governing body of each of the Sellers authorizing and approving such Seller's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and of full force as of the Closing Date by an appropriate officer of such Seller;

(e) a certificate of the President, a Vice President or other appropriate officer of each Seller, certifying the fulfillment of the conditions set forth in ARTICLE VIII;

(f) a certificate of incumbency for the respective officers of each Seller executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(g) evidence from the Sellers or their financing sources (or representatives thereof) in respect of the indebtedness described on Exhibit E that any liens such parties may have on the Assets or the Real Property in respect of such indebtedness shall be released at or prior to the Closing Date;

(h) a Transition Services Agreement, executed by a duly authorized officer of each Seller for such services and in a form agreed by the parties (the "**Transition Services Agreement**");

(i) such documents as may be required by the Title Company to release the Assets from any and all mortgages and security interests created at any time on or prior to the Closing Date, except the Permitted Encumbrances and the Assumed Liabilities, and to insure Buyer's fee ownership interest in the Owned Real Property and Buyer's leasehold interest in the Leased Real Property;

(j) copies of certificates of insurance evidencing the insurance described in Section 6.8;

(k) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets;

(l) an affidavit executed by each Seller certifying that it is not a "blocked person" under Executive Order 13224, which form shall be acceptable to Buyer;

(m) a DEA limited power of attorney fully executed by a duly authorized officer of Sharon (the "**DEA Power of Attorney**"), substantially in the form attached hereto as Exhibit F;

(n) the Management Agreement in the form attached as Exhibit G executed by Sharon;

(o) a certificate of non-foreign status, dated as of the Closing Date, executed by a duly authorized officer of each Seller, in form and substance required under the Treasury Regulations pursuant to Section 1445 of the IRC;

(p) to the extent applicable to the transaction covered by this Agreement, the appropriate Form under the Property Transfer Law, on which Sharon shall sign as transferor and Newco shall sign as transferee, together with an Environmental Condition Assessment Form prepared by a Licensed Environmental Professional and a bank check or money order in the amount of the initial filing fee required by the Property Transfer Law and all other forms and documentation necessary to comply with the Property Transfer Law, provided, however, that if a Form III or Form IV is required under the Property Transfer Law, Sharon shall also sign as the Certifying Party (capitalized terms as defined under the Property Transfer Law); and

(q) such other instruments and documents as Buyer reasonably deems necessary to effectuate the transactions contemplated hereby.

3.3 Actions of Buyer at the Closing. At the Closing and unless otherwise waived in writing by the Sellers, Buyer shall deliver to the Sellers the following:

(a) the amount of the Purchase Price set forth in Section 2.6(a), which shall be transferred to the Sellers by wire transfer of immediately available funds to an account or accounts of Sellers' designation;

(b) the Assignment and Assumption Agreements, fully executed by a duly authorized officer of the appropriate Buyer or Affiliate designated by Buyer, pursuant to which each such Buyer shall assume the future performance of the Assumed Contracts, the Tenant Leases and the Seller Leases as contemplated herein;

(c) the Transition Services Agreement, executed by a duly authorized officer of Buyer;

(d) a copy of resolutions duly adopted by the governing body of each Buyer, authorizing and approving such Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing Date by an appropriate officer of such Buyer;

(e) a certificate of the President, a Vice President or other appropriate officer of each Buyer, certifying the fulfillment of the conditions set forth in ARTICLE IX;

(f) a certificate of incumbency for the officers of each Buyer executing this Agreement or the agreements herein contemplated or making certifications for the Closing, dated as of the Closing Date;

(g) a certificate of existence and good standing of Newco from the Secretary of State of the State of Connecticut and a certificate of existence and good standing of Health Quest from the Secretary of State of the State of New York, each dated the most recent practical date prior to the Closing Date;

(h) the Management Agreement executed by Newco or its affiliate, as Manager; and

(i) such other instruments and documents as the Sellers reasonably deem necessary to effectuate the transactions contemplated hereby.

ARTICLE IV

REPRESENTATIONS AND WARRANTIES OF THE SELLERS

The Sellers, jointly and severally, represent and warrant to Buyer the following, as of the date hereof and as of the Closing Date:

4.1 Existence and Capacity.

(a) Each of RCHP and SHHC is a Delaware corporation, validly existing and in good standing under the laws of the State of Delaware.

(b) Each of TSWS and RHA is a Connecticut limited liability company, validly existing and in good standing under the laws of the State of Connecticut.

(c) Sharon is a Connecticut corporation, validly existing and in good standing under the laws of the State of Connecticut, whose sole shareholder is SHHC, an indirect wholly-owned subsidiary of RCHP. No other party owns, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in Sharon, nor are there any outstanding subscriptions, options, warrants, puts, calls, agreements, understandings, rights of first refusal, or other commitments of any type relating to the issuance, sale, transfer or voting of any securities of Sharon.

(d) None of the Sellers own, directly or indirectly, beneficially or equitably, any capital stock or other equity interest in any corporation, partnership, limited partnership, limited liability company or other entity or association, nor does any Seller own or hold any right of first refusal, purchase option or other rights with respect thereto.

(e) Exhibit A sets forth each of the Facilities owned, leased or operated by the Sellers. Except as set forth on Exhibit A, none of the Sellers own, lease or operate any healthcare facility.

(f) Each of the Sellers has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by the Sellers and all other agreements referenced herein, or ancillary hereto, to which any of the Sellers is a party, and the consummation of the transactions contemplated herein by the Sellers:

(a) are within each Seller's organizational powers, are not in contravention of law or of the terms of such Seller's organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 4.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) except as set forth on Schedule 4.19(d), will not conflict with, require consent under or result in any breach or contravention of, or the creation of any lien, charge, or encumbrance, under any Assumed Contract, Tenant Lease or Seller Lease;

(d) will not violate any statute, law, ordinance, rule or regulation of any governmental authority to which any Seller or the Assets may be subject; and

(e) will not violate any judgment, decree, order, writ or injunction of any court or governmental authority to which any Seller or the Assets may be subject.

4.3 Binding Agreement. This Agreement and all agreements to which any of the Sellers will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of such Seller, and are and will be enforceable against such Seller in accordance with the respective terms hereof or thereof.

4.4 Financial Statements. Each of the Sellers has made available to Buyer copies of the following financial statements of or pertaining to the Business and the Assets (the "**Financial Statements**"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 4.4(a):

(a) unaudited Balance Sheet dated as of May 31, 2016;

(b) unaudited Income Statement for the four month period ended on May 31, 2016; and

(c) audited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal years ended September 30, 2013, September 30, 2014 and for the fiscal year ended September 30, 2015 (the "**Balance Sheet Date**").

Such Financial Statements are true, complete and accurate in all material respects, and conform to GAAP consistently applied, except as set forth in Schedule 4.4(a). The audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such Balance Sheets present fairly in all material respects the financial condition of the Business as of the dates indicated thereon, and such Income Statements present fairly in all material respects the results of operations of the Business for the periods indicated thereon.

4.5 Certain Post-Balance Sheet Results. Except as set forth on Schedule 4.5, since the Balance Sheet Date, there has not been any:

(a) material damage, destruction or loss (whether or not covered by insurance) affecting the Business or the Assets;

(b) threatened employee strike, work stoppage or labor dispute pertaining to the Facilities;

(c) sale, assignment, transfer or disposition of any item of property, plant or equipment included in the Assets having a value in excess of Twenty Five Thousand Dollars ($25,000), except in the ordinary course of business with comparable replacement thereof;

(d) other than in the ordinary course of business and consistent with prior practice or as required by applicable law, increase in the compensation payable by any of the Sellers to any of such entity's employees or independent contractors, or any increase in, or establishment or amendment of, any bonus, insurance, pension, profit-sharing or other employee benefit plan, remuneration or arrangements made to, for or with such employees;

(e) changes in the composition of the medical staff of the Hospital, other than normal turnover occurring in the ordinary course of business;

(f) changes in the rates charged by the Facilities for their services, other than those made in the ordinary course of business;

(g) adjustments or write-offs in accounts receivable or reductions in reserves for accounts receivable outside the ordinary course of business of the Facilities; or

(h) change in accounting policies or procedures of the Sellers.

4.6 Licenses. The Hospital is duly licensed as a general acute care hospital pursuant to the applicable laws of the State of Connecticut. The Hospital (including, without limitation, all ancillary departments located at the Hospital or operated for the benefit of the Hospital that are required to be specially licensed) holds all licenses material to the operation of the Business as presently operated. Each of the other Facilities has all other licenses, registrations, permits and approvals that are needed or required by law to operate the businesses related to or affecting the

Facilities, the Assets or any ancillary services related thereto. Schedule 4.6 sets forth an accurate list of all such licenses, registrations, permits and approvals, identifying specifically each Seller Party and Facility related thereto, all of which if held by a Seller or the Sellers, are now, and as of the Closing Date shall be, in good standing and, to the knowledge of the Sellers, are not subject to meritorious challenge, and except as set forth on Schedule 4.6, no such licenses are subject to renewal within less than one (1) year of the date of this Agreement.

4.7 Certificates of Need. Except as set forth on Schedule 4.7 hereto, no application for any Certificate of Need, Exemption Certificate or declaratory ruling (an "**Application**") has been made by any of the Sellers with the Connecticut Department of Public Health Office of Health Care Access ("**OCHA**") or other agency having jurisdiction thereof that is currently pending or open before such agency. No Seller has prepared, filed, supported or presented opposition to any Application filed by another hospital or other entity within the past three (3) years. Except as set forth on Schedule 4.7 hereto, no Seller has any Application pending nor any approved Application which relates to a project not yet completed. Each Seller a has properly filed all required Applications with respect to any and all improvements, projects, changes in services, zoning requirements, construction and equipment purchases, and other changes for which approval is required under any applicable federal or state law, rule or regulation, and all such Applications are complete and correct in all material respects.

4.8 Medicare Participation; Accreditation. Each of the Facilities are qualified for participation in the Medicare, Medicaid and CHAMPUS/TRICARE programs; have current and valid provider contracts with such programs; are in material compliance with the conditions of participation and, where applicable, conditions of coverage for such programs; have received all approvals or qualifications necessary for reimbursement; and are accredited by the Joint Commission (the "**Joint Commission**"). A copy of the most recent letter from the Joint Commission pertaining to each of the Facilities' accreditation has been made available to Buyer. All billing practices of each of the Sellers, with respect to all third party payors, including the Medicare, Medicaid and CHAMPUS/TRICARE programs (including the Medicare conditions of participation) and private insurance companies, are in material compliance with all applicable laws and regulations and participating provider agreements of such third party payors and the Medicare, Medicaid and CHAMPUS/TRICARE programs, and none of the Sellers or the Facilities has retained any payment or reimbursement in excess of amounts allowed by law. None of the Facilities has been excluded from participation in the Medicare, Medicaid or CHAMPUS/TRICARE programs, nor, to the knowledge of the Sellers, is any such exclusion threatened. Attached as Schedule 4.8 is a listing of each of the Facilities' active provider numbers with the Medicare and Medicaid programs. To the knowledge of the Sellers, each provider agreement to which a Seller is a party is in full force and effect and no events or facts exist that would cause any such provider agreement not to remain in force or effect after the Closing. None of the officers, directors, employees, physicians or independent contractors of any of the Sellers has been excluded from participating in any federal health care program during the past four years, nor, to the knowledge of the Sellers, is any exclusion threatened or pending. Except as set forth on Schedule 4.8, none of the Sellers are aware of or have received any notice from any of the Medicare, Medicaid or CHAMPUS/TRICARE programs, or any other third party payor program, of any pending or threatened investigations.

4.9 Regulatory Compliance. Except as set forth on Schedule 4.9, each of the Facilities, the Business and the Assets has been and presently is in material compliance with all applicable statutes, rules and regulations of any federal, state and local commissions, boards, bureaus, and agencies having jurisdiction over the Facilities and the Assets, including, but not limited to the false claims, false representations, anti-kickback and all other provisions of the Medicare/Medicaid fraud and abuse laws (42 U.S.C. Section 1320a-7 *et seq.*) and the physician self-referral provisions of the Stark Law (42 U.S.C. Section 1395nn). Each of the Sellers has timely filed all material reports, data, and other information required to be filed with such commissions, boards, bureaus, and agencies regarding the Business and the Assets. All of the Sellers' contracts with physicians or other healthcare providers or entities in which physicians or other healthcare providers are equity owners (collectively, "**Healthcare Providers**") involving services, supplies, payments or any other type of remuneration, whether such services or supplies are provided by a Healthcare Provider to a Seller or by a Seller to a Healthcare Provider, and all of Sellers' leases of personal or real property with Healthcare Providers, whether such personal or real property is provided by a Healthcare Provider to a Seller or by a Seller to a Healthcare Provider, are, to the extent required by law, in writing, are signed, set forth the services to be provided, and provide for a fair market value compensation in exchange for such services, space or goods. None of the Sellers, the Facilities or any of their respective officers, directors, or managing employees have engaged in any activities that are prohibited under 42 U.S.C. Section 1320a-7 *et seq.*, or the regulations promulgated thereunder, or under any other federal or state statutes or regulations, including but not limited to the following:

(a) knowingly and willfully making or causing to be made a false statement or representation of a material fact in any application for any benefit or payment;

(b) knowingly and willfully making or causing to be made a false statement or representation of a material fact for use in determining rights to any benefit or payment;

(c) presenting or causing to be presented a claim for reimbursement for services under Medicare, Medicaid or other state or federal healthcare program that is for an item or service that is known, or should be known, to be (i) not provided as claimed or (ii) false or fraudulent;

(d) failing to disclose knowledge by a claimant of the occurrence of any event affecting the initial or continued right to any benefit or payment on its own behalf or on behalf of another, with intent to fraudulently secure such benefit or payment;

(e) knowingly and willfully offering, paying, soliciting or receiving any remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind, (i) in return for referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made in whole or in part by Medicare, Medicaid, or a state healthcare program or (ii) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part by Medicare, Medicaid or a state healthcare program;

(f) knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit necessary services to individuals who are under the direct care of the physician and who are entitled to benefits under Medicare, Medicaid or a state healthcare program;

(g) providing to any person information that is known or should be known to be false or misleading that could reasonably be expected to influence the decision when to discharge a patient from any Facility;

(h) knowingly or willfully making or causing to be made or inducing or seeking to induce the making of any false statement or representation (or omitting to state a material fact) required to be stated therein (or necessary to make the statement contained therein not misleading) of a material fact with respect to (i) the conditions or operations of a Facility in order that such Facility may qualify for Medicare, Medicaid, or a state healthcare program certification or (ii) information required to be provided under Section 1124A of the Social Security Act (42 U.S.C. Section 1320a-3a); or

(i) knowingly and willfully (i) charging for any Medicaid service money or other consideration at a rate in excess of the rates established by the state or (ii) charging, soliciting, accepting or receiving, in addition to amounts paid by Medicaid, any gift money, donation or other consideration (other than a charitable, religious, or other philanthropic contribution from an organization or from a person unrelated to the patient) (A) as a precondition of admitting the patient or (B) as a requirement for the patient's continued stay in a Facility.

Each of the Sellers and the Facilities: (i) is in material compliance with HIPAA and any applicable state and federal laws and regulations concerning the privacy and/or security of data (collectively, "**Information Privacy and Security Laws**"); (ii) is not under investigation by any governmental authority for a violation of any Information Privacy and Security Laws; (iii) has not received any written notices or audit requests from any governmental authority, including the United States Department of Health and Human Services Office for Civil Rights, Department of Justice, Federal Trade Commission, or the Attorney General of the United States or any governmental authority of any state relating to any such violations, and (iv) to the knowledge of the Sellers, no such investigation or violation has been threatened by a governmental authority.

4.10 Equipment. Set forth on Schedule 4.10 is a depreciation schedule that lists all Assets having a positive book value as of May 31, 2016. All of the Assets consisting of equipment, whether reflected in the Financial Statements or otherwise, are in good operating condition and repair, reasonable wear and tear excepted and except for items that have been written down in the Financial Statements to a realizable market value. Except as disclosed on Schedule 4.10, the only transactions related thereto since May 31, 2016 have been additions thereto and dispositions thereof in the ordinary course of business.

4.11 Real Property. The Sellers own good, insurable and marketable fee title to the Owned Real Property, together with all appurtenances and rights thereto, and good and insurable leasehold title to the Leased Real Property, which ownership interests, as of the Closing Date, will be free and clear of any and all mortgages, deeds of trust, security interests, mechanics or other liens or encumbrances, covenants, conditions, restrictions, reservations, easements or other

matters of record materially adversely affecting the Real Properties, subject only to those matters more particularly described on Schedule 4.11 (the "**Permitted Encumbrances**"). Except as set forth on Schedule 4.11 or otherwise disclosed to Buyer in a writing referencing this Section 4.11 on the date hereof, all improvements, including all utilities which are a part of the Real Property, have been substantially completed and installed in accordance with the plans and specifications approved by the governmental entities having jurisdiction thereover to the extent required by law and to the extent applicable and are transferable to Buyer. Permanent certificates of occupancy, all licenses, permits, Certificates of Need (if applicable), authorizations and approvals required by all governmental entities having jurisdiction thereover, and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions), have been issued for the Real Property, and, as of the Closing, all of the same will be in full force and effect. Subject to Section 4.12, to the knowledge of the Sellers, the improvements which are a part of the Owned Real Property, as designed and constructed, comply with all statutes, restrictions, regulations and ordinances applicable thereto, including but not limited to the ADA and Section 504 of the Rehabilitation Act of 1973. Subject to Section 4.12, the existing water, sewer, gas and electricity lines, storm sewer and other utility systems on or serving the Real Property are, to the knowledge of the Sellers, adequate to serve the utility needs of the Real Property. All approvals, licenses and permits required for said utilities have been obtained and are, and will be as of the Closing, in full force and effect. All of said utilities are installed and operating, and all installation and connection charges have been paid in full. Subject to Section 4.12, the location, construction, occupancy, operation and use of the Real Property (including the improvements which are a part of the Real Property) do not violate any applicable law, statute, ordinance, rule, regulation, order or determination of any governmental authority or any board of fire underwriters (or other body exercising similar functions), judicial precedent or any restrictive covenant or deed restriction (recorded or otherwise) affecting the Real Property or the location, construction, occupancy, operation or use thereof, including, without limitation, all applicable laws. The Real Property comprises all of the real property currently used in connection with the Business or the Assets. Subject to Section 4.12, with respect to the Real Property:

(a) except as described on Schedule 4.11(a), no Seller has received during the past three (3) years notice of a violation of any applicable ordinance or other law, order, regulation, or requirement or notice of condemnation, lien, assessment, or the like relating to any part of the Owned Real Property or Leased Real Property or the operation thereof, and has no knowledge of any such violation, proceeding, lien or assessment;

(b) except as described on Schedule 4.11(b), such properties and their operation are in compliance with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and no Seller has received a written notice that the buildings and improvements constituting a portion of such properties do not comply with all building codes;

(c) except for the Permitted Encumbrances, such properties, are subject to no easements, covenants, conditions, restrictions, reservations encumbrances, or such other limitations or matters of record so as to make any such property unusable for its current use or the title thereof uninsurable or unmarketable or which restrict or impair its use, marketability, value or insurability;

(d) except as described on Schedule 4.11(d), there is no pending, or to the knowledge of the Sellers, threatened litigation, administrative action or complaint (whether from a state, federal or local government or from any other person, group or entity) relating to the Real Property, including compliance of any of such properties with the Rehabilitation Act of 1973, Title III of the ADA or any comparable state statute related to accessibility;

(e) with respect to the Owned Real Property and the Leased Real Property, there are no tenants or other persons or entities occupying any space in such properties other than pursuant to the Tenant Leases described in Schedule 2.1(h);

(f) except as described on Schedule l2.1(j), no Seller is a party to any Seller Lease;

(g) attached as Schedule 4.11(g) is a "rent roll" for all Tenant Leases that sets forth (i) the premises covered; (ii) the date of the Tenant Lease and all amendments and modifications thereto; (iii) the name of the tenant, subtenant, licensee or occupant; (iv) the term; (v) the rents and other charges payable thereunder; (vi) the rents or other charges in arrears or prepaid thereunder, if any, and the period for which any such rents and other charges are in arrears or have been prepaid; (vii) the nature and amount of the security deposits thereunder, if any; and (viii) options to renew or extend the term contained in the Tenant Lease;

(h) except as described on Schedule 4.11(h), no Seller has received any written notice, and has no knowledge, of any existing, proposed or contemplated plans to modify or realign any street or highway or any existing, proposed or contemplated eminent domain proceeding that would result in the taking of all or any part of such properties or that would adversely affect the current use of any part thereof;

(i) except as described on Schedule 4.11(i), the existing improvements located upon such properties do not, with respect to the Facilities, encroach upon adjacent premises or upon existing utility company easements, and existing restrictions are not violated by the improvements located on such properties;

(j) except as described on Schedule 4.11(j), no party owns or holds any right of first refusal to purchase or lease or an option to purchase or lease all or any portion of the Real Property;

(k) except as set forth in Schedule 4.11(k), there will be no incomplete construction projects affecting the Real Property as of the Closing Date. Schedule 4.11(k) identifies all design service contracts, engineering services contracts, construction contracts and construction management contracts relating to those construction projects that will be incomplete as of the Closing Date;

(l) except as set forth in Schedule 4.11(l), all Existing TI Obligations will have been fully performed and funded by each of the Sellers on or before the Closing Date;

(m) no Seller is a person or entity with whom U.S. persons are restricted from doing business with under regulations of the OFAC of the Department of Treasury (including those named on the OFAC's Specially Designated and Blocked Persons list) or under any statute,

executive order (including Executive Order 13224), or the USA Patriot Act, or any other governmental action;

(n) no subdivision shall be required for the lawful conveyance of the Owned Real Property to Buyer; and

(o) no brokerage or leasing commissions or other compensation will be due or payable as of Closing to any person, firm, corporation or other entity with respect to, or on account of, any Tenant Lease, any Seller Lease or any extensions or renewals thereof.

With respect to each Seller Lease, (i) Sellers are not in default beyond any applicable cure or grace period in any respect under any of such Seller Leases, and, to Sellers' knowledge, no other party to any such Seller Lease is in default thereunder, and to Sellers' knowledge, no conditions or events exist which, with the giving of notice or passage of time, or both, would constitute a default under any such Seller Lease, (ii) Sellers' possession and quiet enjoyment of the Leased Real Property under any such Seller Lease is not being disturbed as of the date of this Agreement, and there are no current material disputes with respect to any such Seller Lease that has not been disclosed to Buyer, (iii) no security deposit or portion thereof deposited with respect to such Seller Lease has been applied in respect of a breach or default under such Seller Lease which has not been redeposited in full, (iv) Sellers do not owe, nor will owe in the future, any brokerage commissions or finder's fees with respect to such Seller Lease, and (v) Sellers have not collaterally assigned or granted any security interest in such Seller Lease or any interest therein.

4.12 Title, Condition, and Sufficiency of the Assets.

(a) As of the Closing Date, the Sellers shall own and hold good and valid title to all of the Assets, subject only to the Permitted Encumbrances and Assumed Liabilities. Sellers are the sole and exclusive owners of the Assets.

(b) Except as otherwise set forth on Schedule 4.12, in respect of their physical condition and defects, the Real Property and all machinery and equipment used in the operation of the Business are in good operating condition and repair, reasonable wear and tear excepted, and suitable for the purpose for which they are intended. Except as set forth on Schedule 4.12, there are no material defects, structural or other, in any of the Assets, including, without limitation, the Real Property and the implements, machinery and equipment used in the Business. All of the Personal Property is located at one of the Facilities unless noted on Schedule 2.1(c). Except for the Excluded Assets and services provided under the Transition Services Agreement, the Assets comprise substantially all of the assets and properties currently used in connection with the operation of the Business.

4.13 Employee Benefit Plans.

(a) Schedule 4.13(a) includes a true, complete and correct list of all "employee benefit plans," as defined in ERISA, all specified fringe benefit plans as defined in Section 6039D of the IRC, and all other pension, profit-sharing, stock bonus, stock option, deferred compensation, or other retirement plans; welfare benefit plans; executive compensation, bonus, or incentive plans; severance plans; salary continuation plans, programs, or arrangements;

vacation, holiday, sick-leave, paid-time-off, or other employee compensation, bonus, or incentive plans, procedures, programs, payroll practices, policies, agreements, commitments, contracts, or understandings; or any annuity contracts, custodial agreements, trusts or other agreements related to any of the foregoing (collectively, the "**Benefit Plans**"), whether qualified or nonqualified, funded or unfunded, (i) that are currently, or have been within the past six (6) years, sponsored, maintained or contributed to by any of the Sellers or any ERISA Affiliate; (ii) with respect to which any of the Sellers or any ERISA Affiliate has any liability or obligation to any current or former officer, employee or service provider, or the dependents of any thereof; or (iii) which could result in the imposition of liability or any obligation of any kind or nature, whether accrued, absolute, contingent, direct, indirect, perfected or inchoate or otherwise, and whether or not now due or to become due to any of the Sellers or any ERISA Affiliate. Schedule 4.13(a) shall further identify which of the Benefit Plans listed on the Schedule have any individuals providing services at the Facilities participating in such Benefit Plan (the "**Facility Benefit Plans**")

(b) With respect to the Facility Benefit Plans, Sellers have made available to Buyer accurate and complete copies of the Facility Benefit Plans; the Facilities Benefit Plan's insurance contracts or any other funding instruments; governmental rulings or other correspondence pertaining to the Facility Benefit Plans; determination, advisory, notification, or opinion letters with respect to the Facility Benefit Plans; summary plan descriptions, modifications, memoranda, employee handbooks, and other material written communications regarding the Facility Benefit Plans; and such other documents, records, or other materials related thereto reasonably requested by Buyer. All returns, reports, disclosure statements, and premium payments with respect to any Facilities Benefit Plan have been or will be timely filed, delivered, or paid, as applicable and as required by applicable law.

(c) Except as set forth on Schedule 4.13(c), none of the Sellers or any ERISA Affiliate has ever participated in or sponsored, contributed to, or had an obligation to contribute to a plan subject to Section 412 of the IRC, Section 302 of ERISA and/or Title IV of ERISA, which is a multiemployer plan, which is a multiple employer plan or single employer plan to which at least two or more of the contributing sponsors are not part of the same controlled group; participated in any benefit plan that is a multiple employer welfare arrangement.

(d) Each Benefit Plan that is a pension or other retirement plan and each related trust agreement, annuity contract, or other funding instrument is and has been since its inception qualified and tax-exempt under the provisions of Sections 401(a) and 501(a) of the IRC, respectively; each Benefit Plan that is a nonqualified deferred compensation plan and each related trust agreement, insurance contract, or other funding instrument is in compliance with the requirements of Section 409A of the IRC; and no governmental entity has instituted or threatened a proceeding to terminate any Benefit Plan or to appoint a new trustee for such Benefit Plan. All Benefit Plans have been operated and administered in accordance with their terms and all applicable laws, including ERISA and the IRC.

(e) No Benefit Plan is currently or has been within the last six (6) years under audit, inquiry, or investigation by any governmental entity, and there are no outstanding issues with reference to the Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or

investigations pending or, to the knowledge of the Sellers, threatened against or with respect to any of the Benefit Plans or their assets.

(f) Each of the Sellers and each of the ERISA Affiliates is in material compliance with the continuation coverage provisions of COBRA with respect to all current and former employees and their beneficiaries who provide services at the Facilities. No Facility Benefit Plans provide for the continuation of, medical, dental, vision, life or disability insurance coverage for any current or former employees performing services at the Seller Facility, or their spouses, their dependents or beneficiaries, for any period of time beyond termination of employment (except to the extent of coverage required under COBRA).

(g) The consummation of the transactions contemplated by this Agreement will not accelerate the time of vesting or payment, or increase the amount of any compensation payable to any current or former employee of Seller.

4.14 Litigation or Proceedings. Except as set forth on Schedule 4.14, there are no claims, actions, suits, proceedings, investigations, judgments, decrees, orders, writs or injunctions pending or, to the knowledge of the Sellers, threatened against or related to any of the Sellers, the Business or the Assets, at law or in equity, or before or by any governmental entity. None of the Sellers are in default under any judgment, decree, order, writ or injunction of any court or governmental entity.

4.15 Hill-Burton and Other Liens. None of the Sellers nor any of their predecessors have received any loans, grants or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act or the Community Mental Health Centers Act, as amended, or similar laws or acts relating to healthcare facilities that remain unpaid or which impose restrictions on the operation of the Facilities or the Assets.

4.16 Taxes. Each of SHHC and Sharon have, and except as set forth on Schedule 4.16, to Seller's knowledge RHA and TSWS have, filed all Tax Returns required to be filed by them (all of which are true and correct in all material respects). All Taxes due and owing by each of SHHC and Sharon and, to Sellers' knowledge, RHA and TSWS, (whether or not shown on any Tax Return) have been paid. Neither SHHC nor Sharon and to Seller's knowledge, neither RHA nor TSWS, has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency. Except as set forth on Schedule 4.16(a), neither SHHC nor Sharon is currently the beneficiary of any outstanding extension of time within which to file any Tax Return. Each of SHHC and Sharon has withheld and paid and to SHHC's knowledge, RHA and TSWS have withheld and paid, all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, or other third party, and all Internal Revenue Service Forms W-2 and 1099 required with respect thereto have been properly completed and timely filed. There is no dispute or claim concerning any Tax liability of either SHHC or Sharon or to Sellers' knowledge, of RHA or TSWS, either (i) claimed or raised in writing by any governmental authority or (ii) as to which the Sellers have knowledge. Except as set forth on Schedule 4.16(b), no Tax Returns of SHHC, or Sharon or to Sellers' knowledge RHA or TSWS, have been audited during the last five (5) years or are currently under audit by any governmental authority. Within

the preceding five (5) years, neither SHHC nor Sharon, and to Sellers' knowledge, neither RHA nor TSWS have received a written claim by a governmental authority in a jurisdiction where any Seller does not file Tax Returns that it is or may be subject to taxation by that jurisdiction due to the operation of the Business or the location of the Assets. Neither Sharon nor SHHC have taken, and to SHHC's knowledge, neither RHA nor TSWS have taken, and will not take any action in respect of any Taxes (including, without limitation, any withholdings required to be made in respect of employees) that may have a material adverse Tax impact upon the Facilities or the Assets as of or subsequent to the Closing Date. Neither SHHC nor Sharon, and to Sellers' knowledge, neither RHA nor TSWS is a party to any Tax allocation or sharing agreement or to any "closing agreement" as described in Code Section 7121 (or any corresponding or similar provision of state, local or non-U.S. tax law), other than (i) any agreement that will terminate as of the Closing Date or (ii) contained in a lease or other contract whose primary purpose is not Tax. There are no Tax liens on any of the Assets or Facilities other than statutory liens for Taxes not yet overdue and, to the knowledge of the Sellers, no basis exists for the imposition of any such liens. Except as provided on Schedule 4.16(c), none of the Assets constitutes an ownership interest in a joint venture, partnership or other arrangement or contract that, to the knowledge of the Sellers, could be treated as a partnership for federal income tax purposes.

4.17 Employee Relations.

(a) Except as set forth on Schedule 4.17(a), all employees who provide services at any of the Facilities are employees of the Sellers. The Sellers are not a party to or bound by any collective bargaining agreement, project labor agreement, memorandum of understanding, letter agreement, side agreement, contract or any other agreement or understanding with a labor union or labor organization. There has not been within the last three (3) years, there is not presently pending or, to the knowledge of the Sellers, threatened, any strike, slowdown, picketing, work stoppage, or employee grievance process, or any proceeding against or affecting any of the Sellers relating to an alleged violation of any legal requirements pertaining to labor relations, including any charge, complaint or unfair labor practices claim filed by an employee, union, or other person with the National Labor Relations Board or any governmental entity, organizational activity, or other labor dispute against or affecting any of the Sellers or their operations or assets.

(b) Each of the Sellers has materially complied with all legal requirements relating to employment; employment practices; terms and conditions of employment; equal employment opportunity; nondiscrimination; immigration; wages; hours; benefits; payment of employment, social security, and similar taxes; occupational safety and health; and plant closing. Except as set forth on Schedule 4.17(b), there are no pending or, to the knowledge of the Sellers, threatened claims for failure to comply with any of the foregoing legal requirements. The Sellers will give all notices and make all filings required to comply with the provision of the Worker Adjustment and Retraining Notification Act or any similar state law (collectively referred to as the "**WARN Act**").

(c) The Sellers have made available to Buyer, to the extent requested by Buyer, the personnel records for all employees of the Sellers potentially affected by the transactions contemplated by this Agreement, including records reflecting salary or wages, and sick (or extended illness), paid-time-off, and vacation leave that is accrued or credited but unused

or unpaid. Schedule 4.17(c)(i) lists each employment, consulting, independent contractor, bonus or severance agreement to which any of the Sellers is a party. Each of the Benefit Plans, Sellers and all ERISA Affiliates has properly classified individuals providing services to any of the Sellers as independent contractors or employees, as the case may be. As of the Closing Date, Schedule 4.17(c)(ii) shall set forth the employees who had an "employment loss," as such term is defined in the WARN Act or any similar state or local legal requirements, within the ninety (90) days preceding the Closing Date; in relation to the foregoing, the Sellers have not violated the WARN Act or any similar state or local legal requirements.

4.18 Agreements and Commitments. Schedule 4.18 sets forth an accurate list of all commitments, contracts, leases, and agreements, written or oral, relating to the Business or the Assets to which any Seller is a party or by which any of the Sellers or the Assets or any portion thereof is bound that are: (a) Physician Agreements, (b) those that by their terms do not expire or are not terminable prior to the first anniversary of the date hereof, (c) the Hospital's top eight contracts, which together with the government payment programs, self-pay and other non-contracted payers, including out-of-state Blue Cross plans other than the Empire and Anthem contracts provided, represent not less than 95% of the Hospital's revenue for 2015, or (d) any other contracts or commitments not identified in (a)-(c) above, except for managed care contracts and contracts that involve the provision of items or services to more than one hospital owned directly or indirectly by RCHP, whether in the ordinary course of business or not, which involve future payments, performance of services or delivery of goods or materials, to or by any of the Sellers in an amount exceeding $25,000 on an annual basis (collectively "**Material Contracts**").

4.19 The Material Contracts, Tenant Leases and Seller Leases. Schedule 2.1(h) sets forth an accurate list of the Tenant Leases. Schedule 2.1(i) sets forth an accurate list of the Seller Leases. The Sellers have made available to Buyer accurate copies of the Material Contracts, the Tenant Leases and the Seller Leases. The Sellers represent and warrant with respect to the Material Contracts, the Tenant Leases and the Seller Leases that:

(a) the Material Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of one or more of the Sellers and are enforceable against such Sellers in accordance with their respective terms, and, to the knowledge of the Sellers, the Material Contracts, the Tenant Leases and the Seller Leases constitute valid and legally binding obligations of the other party or parties to the Material Contracts, the Tenant Leases and the Seller Leases and are enforceable against such parties in accordance with their terms;

(b) each Material Contract, Tenant Lease or Seller Lease constitutes the entire agreement by and between the respective parties thereto with respect to the subject matter thereof;

(c) all obligations required to be performed by one or more of the Sellers under the terms of the Material Contracts, the Tenant Leases and the Seller Leases have been performed in all material respects, and no Seller has received notice that any act or omission by any such Seller has occurred or failed to occur which, with the giving of notice, the lapse of time or both, would constitute a default under any such Material Contract, Tenant Lease or Seller Lease, and each of such Material Contracts, Tenant Leases and Seller Leases is now and at the Closing Date will be in full force and effect without default on the part of any of the Sellers;

(d) except as expressly set forth on Schedule 4.19(d), none of Material Contracts, the Tenant Leases or the Seller Leases requires consent to its assignment to and assumption by Buyer; and

(e) except as expressly set forth on Schedule 4.19(e), the assignment of the Material Contracts, the Tenant Leases and the Seller Leases to and the assumption of such Material Contracts, Tenant Leases and Seller Leases by Buyer will not result in any penalty or premium, or variation of the rights, remedies, benefits or obligations of any party thereunder.

4.20 Supplies. All the inventory and supplies constituting any part of the Assets are of a quality and quantity usable and saleable in the ordinary course of business of the Business.

4.21 Insurance. Schedule 4.21 sets forth an accurate schedule disclosing the Sellers' insurance policies covering the Business and the Assets, which Schedule reflects the policies' numbers, identity of insurers, amounts, coverage, and, with respect to professional liability coverage, identifies whether such coverage is on an occurrence basis or on a claims made basis. All of such insurance policies are in full force and effect with no premium arrearage. Each of the Sellers has given in a timely manner to its respective insurers all notices required to be given under such insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Except as set forth on Schedule 4.21, none of the Sellers has (a) received any written notice or other communication from any such insurance company canceling or materially amending any of such insurance policies and, to the knowledge of the Sellers, no such cancellation or amendment is threatened or (b) failed to give any required notice or to present any claim which is still outstanding under any of such policies with respect to the Business or any of the Assets.

4.22 Third Party Payor Cost Reports. Each of the Sellers has duly filed all required Seller Cost Reports for all fiscal years through and including the fiscal year ended September 30, 2015. All of such Seller Cost Reports accurately reflect the information required to be included thereon and such cost reports do not claim, and none of the Facilities nor any of the Sellers have retained, reimbursement in any amount in excess of the amounts provided by law or any applicable agreement. Schedule 4.22 indicates which of such Seller Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances and any and all other unresolved claims or disputes in respect of such cost reports. Each of the Sellers has established adequate reserves to cover any potential reimbursement obligations that such Seller may have in respect of any such Seller Cost Reports, and such reserves are accurately set forth in the Financial Statements.

4.23 Medical Staff Matters. The Sellers have made available to Buyer true, correct and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital, as well as a list of all current members of the medical staff. Except as set forth on Schedule 4.23, there are no adverse actions with respect to any medical staff member of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the knowledge of the Sellers, threatened disputes with applicants, staff members or health professional affiliates, and all appeal periods in respect of any adverse actions

against any medical staff member or applicant have expired. Schedule 4.23 sets forth a brief description of all adverse actions taken against medical staff members or applicants during the past three (3) years that could result in claims or actions against any of the Sellers and which are not disclosed in the minutes of the meetings of the Medical Executive Committee of the Medical Staff of the Hospital, which minutes have been made available to Buyer.

4.24 Experimental Procedures. During the past five (5) years, the Facilities have not performed or permitted the performance of any experimental or research procedure or study involving patients in the Facilities not authorized and conducted in accordance with applicable law and the procedures of the Facilities.

4.25 Compliance Program. The Sellers have made available to Buyer a copy of the Facilities' current compliance program materials, including, without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth on Schedule 4.25, none of the Sellers (a) are a party to an outstanding Corporate Integrity Agreement with the OIG of HHS, (b) have reporting obligations pursuant to any settlement agreement entered into with any governmental entity, (c) to the knowledge of the Sellers, have been the subject of any government payor program investigation conducted by any federal or state enforcement agency, or (d) to the knowledge of the Sellers, have been a defendant in any *qui tam*/False Claims Act litigation and, to the knowledge of the Sellers, no such litigation is threatened. For purposes of this Agreement, the term "**compliance program**" refers to provider programs of the type described in the compliance guidance published by the OIG of HHS.

4.26 Environmental Matters. Except as set forth on Schedule 4.26:

(a) The operations and properties of each of the Sellers are and at all times have been in compliance with the Environmental Laws, which compliance includes but is not limited to the possession by the appropriate Seller of all permits and governmental authorizations required under applicable Environmental Laws, and compliance with the terms and conditions thereof, all such permits and governmental authorizations are valid and in good standing and there is no action pending or threatened to revoke, cancel, terminate, modify or otherwise limit any such permit or governmental authorization.

(b) None of the Sellers has (nor, to the knowledge of the Sellers, has any third party) treated, stored, managed, disposed of, transported, handled, released or used any Material of Environmental Concern, except in the ordinary course of its business and in compliance with all Environmental Laws.

(c) There are no Environmental Claims pending or, to the knowledge of the Sellers, threatened against any of the Sellers, and, to the knowledge of the Sellers, no circumstances exist that could reasonably be expected to lead to the assertion of an Environmental Claim against any Seller Party.

(d) To the knowledge of the Sellers, there are no off-site locations where any of the Sellers have stored, disposed or arranged for the disposal of Materials of Environmental

Concern in violation of any Environmental Laws or that are listed on the Comprehensive Environmental Response, Compensation and Liability Act National Priority List or any state equivalent, and none of the Sellers has been notified in writing that it or any such entity is a potentially responsible party at any such location under any Environmental Laws.

(e) None of the Sellers has assumed or undertaken or otherwise become subject to any liability or corrective, investigatory or remedial obligation of any other person relating to any Environmental Law.

(f) (i) except as set forth on Schedule 4.26(f)(i), there are no underground storage tanks located on property owned, leased or operated by any of the Sellers; (ii) there is no asbestos-containing material (as defined under Environmental Laws) contained in or forming part of any building, building component, structure or office space owned, leased or operated by any of the Sellers; and (iii) there are no PCBs or PCB-containing items contained in or forming part of any building, building component, structure or office space owned, leased or operated by any of the Sellers.

(g) No property used in the Sellers' operation is subject to an encumbrance imposed by or arising under any Environmental Law, and except as disclosed on Schedule 4.26(g), there is no proceeding pending or, to the knowledge of the Sellers, threatened for the imposition of such encumbrance, nor to the knowledge of the Sellers, is there any basis for any such encumbrance or proceeding.

(h) The operations of each of the Sellers are and have been for the past four (4) years in material compliance with laws concerning Medical Waste.

(i) The Sellers have provided to Buyer all material reports, assessments, audits, citations, notices, surveys, studies and investigations in the possession, custody or control of the Sellers concerning compliance with or liability or obligation under Environmental Law, including without limitation those concerning the environmental condition of the properties owned, leased or operated by the Sellers.

(j) Except as set forth on Schedule 4.26(j), neither this Agreement nor the consummation of the transaction that is the subject of this Agreement will result in any obligations for site investigation or cleanup, or notification to or consent of government agencies or third parties, pursuant to any of the so-called "transaction-triggered" or "responsible property transfer" Environmental Law, including the Connecticut Transfer Act, Sections 11a-134 through 22a-134e of the Connecticut General Statutes, and any associated regulations and guidance.

4.27 Intellectual Property Rights.

(a) Schedule 4.27(a) contains a true, complete and correct list of all intellectual property that is owned by the Sellers. Except as set forth in Schedule 4.27(a), all Owned Intellectual Property is owned by the Sellers free and clear of all liens, claims and encumbrances. At the Closing, the Sellers will transfer to Buyer good and valid title to the Owned Intellectual Property, free and clear of all liens, claims and encumbrances. Except as described in Schedule 4.27(a), no Seller has granted any license to any person or entity relating to any of the Owned Intellectual Property.

(b) Schedule 4.27(b) contains a true, complete and correct list of all intellectual property (other than software available on reasonable terms on a commercial off the shelf basis from third party vendors) that is used by the Sellers and constitutes all intellectual property (other than the Owned Intellectual Property) used in connection with the operation of the Business.

(c) No Seller has received notice of any unresolved claim asserting a conflict with the rights of another person or entity in connection with the use by it of any of the intellectual property listed in Schedule 4.27(a) or 4.27(b).

(d) Except as set forth on Schedule 4.27(d), all patents, registered copyrights and registered trademarks that are a portion of the intellectual property of the Sellers and applications with respect thereto, (i) have been duly maintained including without limitation the proper, sufficient and timely submission of all necessary filings and fees, (ii) have not lapsed, expired or been abandoned, and (iii) are not the subject of any opposition, interference, cancellation, or other proceeding before any governmental registration or other authority in any jurisdiction.

(e) None of the Sellers has received any notice that infringement exists by it on the intellectual property rights of any other person or entity that results in any way from the Business or the Assets.

4.28 Absence of Undisclosed Liabilities. Except (i) as and to the extent reflected or reserved against in the Financial Statements (which reserves are believed adequate in amount as of the date of such Financial Statements), and (ii) liabilities incurred in the ordinary course of business since May 31, 2016, none of the Sellers has, and is not subject to, any liability or obligation of any nature that is of a type required to be disclosed or reflected in the Financial Statements in accordance with GAAP, whether accrued, absolute, contingent or otherwise, asserted or unasserted, known or unknown.

4.29 Brokers. Except as set forth on Schedule 4.29, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of the Sellers.

4.30 The Sellers' Knowledge. When used herein, the phrases "**to the knowledge of the Sellers**," "**known**" and similar references to the knowledge of the Sellers shall mean and refer to all matters with respect to which (a) any Seller has received a written notice or (b) the actual knowledge of the representatives of the Sellers set forth on Schedule 4.30 after due inquiry of officers and department heads as to the matter in question.

ARTICLE V

REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to the Sellers the following:

5.1 Existence and Capacity. Newco is a nonstock corporation, duly organized and validly existing in good standing under the laws of the State of Connecticut. Health Quest is a New York not-for-profit corporation, duly organized and validly existing in good standing under the laws of the State of New York. Each Buyer has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder and to conduct its business as now being conducted.

5.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance of this Agreement by the Buyer and all other agreements referenced herein, or ancillary hereto, to which the Buyer is a party and the consummation of the transactions contemplated herein by the Buyer:

(a) are within each Buyer's organizational powers, are not in contravention of law or of the terms of such Buyer's organizational documents and have been duly authorized by all appropriate action;

(b) except as set forth on Schedule 5.2(b), do not require any approval or consent of, or filing with, any governmental agency or authority bearing on the validity of this Agreement which is required by law or the regulations of any such agency or authority;

(c) will neither conflict with, nor result in any breach or contravention of, or the creation of any lien, charge or encumbrance under, any indenture, agreement, lease, instrument or understanding to which each Buyer is a party or by which it is bound;

(d) will not violate any statute, law, rule or regulation of any governmental authority to which each Buyer may be subject; and

(e) will not violate any judgment, decree, writ, or injunction of any court or governmental authority to which each Buyer may be subject.

5.3 Binding Agreement. This Agreement and all agreements to which Buyer will become a party pursuant hereto are and will constitute the valid, legal and binding obligations of Buyer and are and will be enforceable against Buyer in accordance with their respective terms.

5.4 Legal Proceedings. There are no claims, proceedings or investigations pending or, to the knowledge of Buyer, threatened against Buyer before any court or governmental body (whether judicial, executive or administrative) in which an adverse determination would have a Material Adverse Effect on the consummation of the transactions contemplated herein. Buyer is not subject to any judgment, order, decree or other governmental restriction specifically (as distinct from generally) applicable to Buyer that would have a Material Adverse Effect on the consummation of the transactions contemplated herein.

5.5 Brokers. Except as set forth on Schedule 5.5, no broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transactions contemplated herein based upon arrangements made by or on behalf of Buyer.

ARTICLE VI

COVENANTS OF THE SELLERS PRIOR TO THE CLOSING

Between the date of this Agreement and the Closing Date:

6.1 Information. To the extent Buyer does not already have access pursuant to the Management Agreement and subject to applicable law and attorney-client privilege or other applicable privileges, each of the Sellers shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer reasonable access to, and the right to inspect the plants, properties, books, and records of, the Facilities and Assets at such times and in such manner as Buyer may from time to time reasonably request of the Sellers. In addition, subject to applicable law and attorney-client privilege or other applicable privileges, each of the Sellers shall furnish Buyer with such additional financial and operating data and other information in respect of the Business and the Assets as Buyer may from time to time reasonably request to the extent Buyer does not have access to such information pursuant to the Management Agreement.

6.2 Operations. Each of the Sellers, to the extent they have retained control of related aspects of the Business pursuant to the Management Agreement, will:

(a) carry on the Business in substantially the same manner as presently conducted and not make any material change in personnel, general and fiscal policies, charity care policies, accounting policies or real or personal property affecting the Business or the Assets;

(b) maintain the Facilities and the Assets and all parts thereof in their current operating condition, ordinary wear and tear excepted;

(c) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Business or the Assets; and

(d) use its reasonable best efforts to maintain and preserve its business organizations intact, retain its present employees and maintain its relationships with physicians, suppliers, customers, and others having business relations with any of the Sellers.

6.3 Positive Covenants. As, and to the extent, permitted by applicable law, and subject to the terms and conditions of a Collaboration Agreement between the parties, Sellers will collaborate with Buyer on clinical and other initiatives to facilitate the transition of the Facilities into the Health Quest system.

6.4 Negative Covenants. None of the Sellers will, without the prior written consent of Buyer, which shall not be unreasonably withheld, conditioned or delayed:

(a) amend, renew or terminate any of the Assumed Contracts, the Tenant Leases or the Seller Leases or enter into any new Tenant Leases or Seller Leases, except in the ordinary course of business and consistent with prior practice;

(b) enter into any contract or commitment obligating any Seller or Facility to (i) purchase any supplies, assets or services in excess of $25,000, (ii) enter into any contract or arrangement with a term of greater than one year or (iii) enter into any contract or arrangement with a referral source regardless of the amount of consideration under such contract or arrangement, except in the ordinary course of business and consistent with prior practice;

(c) increase compensation payable or to become payable or make or increase any bonus payment to or otherwise enter into one or more bonus agreements with any employee of any of the Sellers, except in the ordinary course of business in accordance with existing personnel policies and consistent with prior practice;

(d) institute, amend or increase the benefits, rights or obligations under any Benefit Plan, policy or arrangement other than as required by applicable law;

(e) create, assume or permit to exist any new debt, lease, mortgage, pledge or other lien or encumbrance upon any of the Assets, whether now owned or hereafter acquired, except in the ordinary course of business and consistent with prior practice;

(f) acquire (whether by purchase or lease) or sell, assign, lease or otherwise transfer or dispose of any personal property, plant, equipment or Real Property, except for dispositions or retirement of equipment in the normal course of business with comparable replacement thereof;

(g) enter into a collective bargaining agreement;

(h) enter into negotiations with or recognize voluntarily a bargaining representative;

(i) take any action outside the ordinary course of business (apart from those actions contemplated by this Agreement), including but not limited to the disposition of any Assets; and

(j) change the titles of, or outside the ordinary course of business change the assignment of, the senior executives of Sellers set forth on Schedule 6.4(j).

6.5 Governmental Approvals; Third Party Consents. Each of the Sellers shall (i) use commercially reasonable efforts to obtain all governmental approvals (or exemptions therefrom) necessary or required to allow it to perform its obligations under this Agreement; and (ii) reasonably assist and cooperate with Buyer and its representatives and counsel in obtaining all governmental consents, approvals and licenses that Buyer deems necessary or appropriate and in the preparation of any document or other material which may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein. The Sellers shall use commercially reasonable efforts to obtain the consent of each other party to the assignment of the Material Contracts to the extent required by such agreements.

6.6 Additional Financial Information. No later than twenty (20) calendar days after Manager has complied with its reporting obligations in the Management Agreement, the Sellers shall deliver to Buyer true and complete copies of the unaudited balance sheets and the related

unaudited statements of income (collectively, the "**Interim Statements**") of, or relating to, the Facilities for each month then-ended, together with a year to date compilation and the notes, if any, related thereto, which presentation shall be true, correct and complete in all material respects, shall have been prepared from and in accordance with the books and records of the Sellers and shall fairly present the financial position and results of operations of the Facilities as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such Interim Statements need not include required footnote disclosures.

6.7 No-Shop Clause. Each of the Sellers agrees that it shall not, and shall direct and cause its officers, directors, employees, agents and representatives (including any investment banker, broker, attorney or accountant retained by it) not to directly or indirectly: (i) offer for sale or lease all or any portion of the Assets or any ownership interest in any entity owning any of the Assets or otherwise solicit, initiate, participate in negotiations with any third party contemplating a transaction involving all or any portion of the Asset, directly or indirectly, whether by sale, merger, consolidation, sale of assets, lease affiliation joint venture or other form of transaction (collectively, a "**Prohibited Transaction**"), (ii) solicit offers to purchase all or any portion of the Assets or any ownership interest in any entity owning any of the Assets, (iii) initiate, encourage or provide any documents or information to any third party in connection with, or discuss or negotiate with any person regarding any inquires, proposals or offers relating to, any disposition of all or any portion of the Assets or a merger or consolidation of any entity owning any of the Assets or (iv) enter into any agreement or discussions with any party (other than Buyer) with respect to the sale, assignment or other disposition of all or any portion of the Assets or any ownership interest in any entity owning any of the Assets or with respect to a merger or consolidation of any entity owning any of the Assets; provided, however, that the Parties agree that this Section shall not apply to the use or consumption of Sellers' supplies, drugs, inventory and other disposables and consumables in the ordinary course of business prior to the Closing. Each Seller will promptly communicate to Buyer the substance of any inquiry or proposal concerning any such transaction, and will notify the third party of the existence of this covenant. Without limiting the foregoing, it is understood that any violation of the restrictions set forth in this Section 6.8 shall be deemed a material breach of this Agreement by the Sellers.

6.8 Tail Insurance. For each general or professional liability insurance policy that is underwritten on a claims-made basis, the Sellers, at their sole cost and expense, shall either self-insure or obtain "tail" insurance to insure against professional and general liabilities of the Sellers, the Facilities and/or the Assets relating to all periods from the date of Sellers' acquisition of the Facilities or the Assets and ending on or prior to the Closing Date. Such tail insurance or self-insurance shall have coverage levels equal to those in place as of the date hereof.

6.9 Tenant Estoppels. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, either in the form attached hereto as Exhibit H (the "**Tenant Estoppel**") or in such other form as may be prescribed in any relevant Tenant Lease, estoppel certificates for all Tenant Leases, pursuant to which each such tenant shall certify as of a date within thirty (30) days of the Closing Date all of the matters set forth on the Tenant Estoppel or on the form prescribed in the relevant Tenant Lease, as the case may be, including, but not limited to, confirming no defaults exist under such Tenant Lease.

6.10 Landlord Estoppels. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, either in the form attached hereto as Exhibit I (the "**Landlord Estoppel**") or in such other form as may be prescribed in any relevant Seller Lease, landlord estoppel certificates for all Seller Leases, pursuant to which each such landlord shall certify as of a date within thirty (30) days of the Closing Date all of the matters set forth on the Landlord Estoppel or on the form prescribed in the relevant Seller Lease, as the case may be, including, but not limited to, confirming no defaults exist under such Tenant Lease.

6.11 Title Insurance and Survey.

(a) Buyer has heretofore received commitments (the "**Commitments**") from Chicago Title Insurance Company (the "**Title Company**") to issue as of the Closing Date an ALTA owner's policy of title insurance (Form 2006), which policy shall be issued with endorsements for extended coverage, zoning (ALTA 3.1 plus parking and loading docks), owner's comprehensive (ALTA 9.2), access, tax parcel, same as survey, subdivision, location, utility facility, environmental lien, waiver of arbitration, non-imputation and contiguity, for the Owned Real Property, together with improvements, buildings and fixtures thereon, in amounts equal to the reasonable value assigned to such Owned Real Property by Buyer and in the customary form prescribed for use in the State of Connecticut, but with any mandatory arbitration provision deleted therefrom. Buyer ordered the Commitments through the Title Company's National Commercial Services office located at 10 South LaSalle Street, Suite 3100, Chicago, Illinois 60603, and such National Commercial Services office shall be responsible for all underwriting decisions with respect to the policy or policies issued pursuant to the Commitments. The Commitments provide for the issuance of such policy (or policies) to Buyer as of the Closing and insure fee simple title to the Owned Real Property subject only to the Permitted Encumbrances. Buyer has heretofore received as-built surveys of the land and improvements comprising the Owned Real Property (collectively, the "**Surveys**") from a registered Connecticut surveyor, which Surveys were prepared in accordance with the "Minimum Standard Detail Requirements for ALTA/NSPS Land Title Surveys" jointly established and adopted by ALTA and NSPS in 2016, and shall include Items 1, 2, 3, 4, 6(a), 6(b), 7(a), 7(b)(1), 7(c), 8, 9, 10, 11, 13, 14, 16, 17, 18, 19 and 20 of Table A thereof. The Surveys have been issued certified to Buyer, the Sellers, and the Title Company and include a surveyor's certification reasonably acceptable to Buyer and the Title Company. The legal description of the Owned Real Property described in the Commitments and the Surveys shall be used to convey title to Buyer per the special warranty deed or deeds described in Section 3.2(a).

(b) The Sellers agree to deliver any information or documentation as may be reasonably required by the Title Company under the Commitments or otherwise in connection with the issuance of Buyer's title insurance policies. The Sellers also agree to provide an affidavit of title consistent with a special warranty deed with respect to the Owned Real Property and/or such other information as the Title Company may reasonably require in order for the Title Company to insure over the "gap" (i.e., the period of time between the effective date of the Title Company's last checkdown of title to such Owned Real Property and the Closing Date) and to cause the Title Company to delete all standard exceptions (including any exception for mechanics liens related to the Owned Real Property) from the final title insurance policies. The costs of such title policy or policies (including the endorsements to such policy or policies, but

after taking into account all credits available, including any reissue credits) (the "**Title Policy Costs**") and the costs of such surveys (the "**Survey Costs**") shall be shared equally by Buyer and the Sellers in accordance with the provisions of Section 13.16 herein.

6.12 Subordination and Non-disturbance Agreements. The Sellers will use commercially reasonable efforts to deliver to Buyer at least ten (10) business days prior to the Closing Date, in a form reasonably acceptable to Buyer or such other form as may be prescribed in any Seller Lease, a commercially reasonable subordination and non-disturbance agreement (the "**SNDA**") executed by any lender with a mortgage or deed of trust on the land and improvements relating to any Leased Real Property for all Sellers.

6.13 Discharge of Indebtedness. At or before the Closing, the Sellers shall discharge all of their indebtedness, their capital lease obligations, their unfunded pension liabilities and any other indebtedness secured by any of the Assets or to which any of the Assets may be subject, including intercompany obligations.

6.14 Insurance Rating. Each of the Sellers shall take all action reasonably requested by Buyer to enable Buyer to succeed to its Workmen's Compensation and Unemployment Insurance ratings, property, automobile or any other insurance policies, deposits and other interests with respect to the operation of the Business and other ratings for insurance or other purposes established by such Seller. Buyer shall not be obligated to succeed to any such rating, insurance policy, deposit or other interest, except as it may elect to do so.

6.15 Best Efforts to Close. Each Seller shall use its reasonable best efforts to proceed toward the Closing and to cause Buyer's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Each Seller shall notify Buyer as soon as practicable of any event or matter that comes to such Seller's attention that may reasonably be expected to prevent the conditions of such Seller's obligations being met.

6.16 Notice; Efforts to Remedy. Each Seller shall promptly give notice to Buyer upon becoming aware of the impending occurrence of any event that would cause or constitute a breach of any of the representations, warranties or covenants contained or referred to in this Agreement or cause, or be likely to cause, a Material Adverse Effect and shall use its commercially reasonable efforts to prevent or promptly remedy the same.

6.17 Management Agreement. The Sellers and Manager shall have entered the Management Agreement, pursuant to which Manager shall provide services to Sellers to operate the Facilities. Sellers' obligations to provide information to Buyer relating to the operation of the Facilities from the date hereof until the Effective Date, including updating and correcting schedules pursuant to Section 13.1, shall be subject to Manager's performance of its obligations in the Management Agreement.

ARTICLE VII

COVENANTS OF BUYER PRIOR TO THE CLOSING

7.1 Governmental Approvals; Third Party Consents. Between the date of this Agreement and the Closing Date, Buyer shall (i) use commercially reasonable efforts to obtain

all governmental approvals (or exemptions therefrom) necessary or required to allow Buyer to perform its obligations under this Agreement; and (ii) assist and cooperate with the Sellers and their representatives and counsel in obtaining all governmental consents, approvals and licenses that the Sellers deem necessary or appropriate and in the preparation of any document or other material that may be required by any governmental agency as a predicate to or as a result of the transactions contemplated herein. Buyer will use commercially reasonable efforts to obtain all consents of all third parties necessary or desirable for the purpose of (i) consummating the transactions contemplated herein or (ii) enabling Buyer to operate the Facilities and the Assets in the ordinary course after the Closing.

7.2 Best Efforts to Close. Buyer shall use its reasonable best efforts to proceed toward the Closing and to cause each Seller's conditions to the Closing to be met as soon as practicable and consistent with the other terms contained herein. Buyer shall notify the Sellers as soon as practicable of any event or matter that comes to Buyer's attention that may reasonably be expected to prevent the conditions of Buyer's obligations being met.

7.3 Cooperation with Sellers to Provide Information. Buyer shall cause Manager to comply with its obligations in the Management Agreement, to the extent applicable, with respect to providing Sellers with material reports, data and other information necessary for Sellers to comply with their obligations in ARTICLE VI, Section 8.8 and Section 13.1 hereof.

ARTICLE VIII

CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.1 Governmental Approvals.

(a) All material consents, authorizations, orders and approvals of (or filings or registrations with) any government entity required in connection with the execution, delivery and performance of this Agreement, as set forth on Schedule 8.1(a), shall have been obtained, except for any documents required to be filed, or consents, authorizations, orders or approvals required to be issued, after the Closing Date.

(b) The Parties shall have received confirmation from all applicable licensure agencies, as set forth on Schedule 8.1(b), that upon the Closing all licenses required by law to operate each of the Facilities and the Assets as currently operated will be transferred to, or issued or reissued in the name of, Buyer.

8.2 Adverse Change. Since the date hereof, there shall not have occurred any event, change or occurrence that has or would reasonably be expected to have a Material Adverse Effect.

8.3 Injunctions. No injunction shall have been issued and no action or other proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the transactions herein contemplated.

8.4 Bankruptcy. None of the Sellers shall (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have been adjudicated bankrupt or (iv) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against any of the Sellers.

8.5 Closing Deliveries. The Sellers shall have made the deliveries required to be made by it under Section 3.2 hereof, other than any deliveries pursuant to Section 3.2(q).

8.6 Consents. All consents and estoppels to those certain Material Contracts set forth on Schedule 8.6 shall have been obtained.

8.7 Employee Benefit Plans and Employees. Sellers shall have (i) terminated the employment of all employees of the Facilities, effective as of the close of business on the Closing Date, and (ii) promptly paid all wages, salaries and other sums due such employees, including without limitation, severance pay and accrued leave benefits (in excess of any accrued paid time off that is included within the calculation of Sellers' Closing Net Working Capital or the maximum amount of paid time off that can be accrued under Buyer's paid time off program), through the close of business on the Closing Date.

8.8 Schedules. Subject to Section 7.3, Buyer shall have been furnished with the Schedules required to be revised pursuant to Section 13.1 that shall be updated (but not corrected) as of the Closing Date to the extent of any changes therein.

8.9 Managed Care Plans. Consent Satisfaction, that in the aggregate, together with government payment programs, self-pay and non-contracted commercial payment programs constitute no less than 90% of the Hospital's revenue for 2015, shall have been obtained.

ARTICLE IX

CONDITIONS PRECEDENT TO OBLIGATIONS OF THE SELLERS

Notwithstanding anything herein to the contrary, the obligations of the Sellers to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by the Sellers at the Closing:

9.1 Governmental Approvals. All material consents, authorizations, orders and approvals of (or filings or registrations with) any government entity required in connection with the execution, delivery and performance of this Agreement, as set forth on Schedule 8.1, shall have been obtained, except for any documents required to be filed, or consents, authorizations, orders or approvals required to be issued, after the Closing Date.

9.2 Actions/Proceedings. No injunction shall have been issued and no action or other proceeding before a court or any other governmental agency or body shall have been instituted or threatened that may reasonably be expected to prohibit the sale of the Assets or seeks damages in a material amount by reason of the consummation of the transactions herein contemplated.

9.3 Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated bankrupt, or (v) have filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state, nor shall any such petition have been filed against Buyer.

9.4 Closing Deliveries. Buyer shall have made the deliveries required to be made by it under Section 3.3 hereof, other than any deliveries pursuant to Section 3.3(i).

ARTICLE X

PARTICULAR COVENANTS OF BUYER

10.1 Employee Matters.

(a) As of the effective date of the Management Agreement, Buyer shall offer employment to the Chief Executive Officer, Chief Financial Officer and the Chief Nursing Officer of the Hospital (the "**Executives**"), provided such individuals satisfy Buyer's screening requirements (including but not limited to background checks and drug screenings), such employment effective at 12:01 a.m. on the first day following the effective date of the Management Agreement. As of the Effective Time, Buyer shall offer employment to all active employees who satisfy Buyer's screening requirements (including but not limited to background checks and drug screenings), commencing as of the Closing Date (collectively with the Executives, the "**Hired Employees**"). Buyer shall not be obligated to continue any employment relationship with any employee for any specific period of time, and the foregoing shall not affect the status of the Hired Employees as employees "at will." Nothing herein shall be deemed to affect or limit in any way normal management prerogatives of Buyer with respect to employees or to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. Within the ninety (90) days following the Effective Time, Buyer shall not take any action that would result in WARN Act liability with respect to the Hired Employees. Buyer shall recognize the existing seniority and service credit with the Sellers of all Hired Employees for purposes of determining accrued paid time off under Buyer's paid time off program.

(b) Consistent with Section 2.3(c), Buyer shall give credit to all Hired Employees for their accrued but unused paid time off, up to the maximum amount of paid time off that can be accrued under Buyer's paid time off program, and shall credit each Hired Employee with the unused extended illness benefits hours each such Hired Employee accrued while employed by the Sellers, but only to the extent disclosed on Schedules 2.3(c).

10.2 Cost Reports. Buyer shall forward to the Sellers any and all correspondence relating to the Seller Cost Reports within five (5) business days after receipt by Buyer. Buyer shall remit any receipts of funds relating to the Seller Cost Reports (without any offset or setoff of the same for any claim for indemnification under ARTICLE XII hereof) within five (5) business days after receipt by Buyer and shall forward to the Sellers any demand for payments within five (5) business days after receipt by Buyer.

ARTICLE XI

ADDITIONAL COVENANTS

11.1 Employee Matters.

(a) As of the effective date of the Management Agreement, Sellers shall terminate the Executives. As of the Closing Date, the Sellers shall terminate all of their employees providing services at the Facilities. Within the period of ninety (90) days before the Closing Date, the Sellers shall not take any action that would result in WARN Act liability.

(b) Effective as of the Closing Date, the Sellers shall (i) make or cause to be made all contributions due for all periods prior to the Closing Date, including a prorated contribution for the 2016 plan year, on behalf of all Hired Employees who are participants in the Sellers' tax-qualified retirement Benefit Plan; and (ii) fully vest all accounts of all Hired Employees who are participants in the Sellers' tax-qualified retirement Benefit Plan. With respect to the foregoing and for all other purposes, the Sellers shall amend the Benefit Plans and take any other necessary action to comply fully with the requirements under ERISA and the IRC related to Benefit Plans and other applicable law at all times.

(c) Notwithstanding anything herein to the contrary, the Sellers acknowledge and agree that Buyer does not assume or agree to discharge any liability of the Sellers for any benefits under COBRA, the Public Health Service Act or otherwise for individuals incurring a qualifying event prior to the Closing, and any such liabilities shall remain solely the responsibility of the Sellers, including any liability with respect to any M&A Qualified Beneficiaries.

(d) Effective as of the Closing Date, the Sellers shall pay out any unused paid time off that is in excess of any accrued paid time off that is included within the calculation of Sellers' Closing Net Working Capital and the limits for paid time off under Buyer's paid time off program.

11.2 Terminating Cost Reports. The Sellers, at their expense, shall prepare and file within sixty (60) days of the Closing all terminating and other cost reports required or permitted by law to be filed under Medicare, Medicaid and other third party payor programs or with DSS for periods ending on or prior to the Closing Date, or as a result of the consummation of the transactions described herein. The Sellers shall retain all rights and obligations under the Seller Cost Reports including without limitation any amounts receivable or payable or recaptured, in respect of such Seller Cost Reports or reserves relating to such Seller Cost Reports. Such rights

shall include the right to appeal any Medicare or Medicaid determinations relating to the Seller Cost Reports. Notwithstanding the foregoing, the Sellers shall not open, refile or amend any Seller Cost Report without the prior written consent of Buyer, which consent shall not be withheld unreasonably. The Sellers shall retain the originals of the Seller Cost Reports, correspondence, work papers and other documents relating to the Seller Cost Reports. The Sellers agree to furnish copies of the Seller Cost Reports, correspondence, work papers and other documents to Buyer upon request.

11.3 Trade Name Cancellation. The Sellers acknowledge and agree that Buyer will acquire as part of the Assets the exclusive right to use the name "Sharon Hospital", and any variation thereof and the goodwill associated therewith, and that none of the Sellers will use such name(s) or any derivative thereof subsequent to the Closing. Sharon further covenants and agrees to file, immediately after Closing, a Certificate of Cancellation or equivalent filing to terminate its trade name certification for "Sharon Hospital" and any similar certifications held by any Affiliates (the "**Trade Name Cancellation**").

11.4 Advisory Board of Trustees. Unless otherwise approved by the Attorney General of the State of Connecticut (the "**Attorney General**"), Newco will continue to recognize the Advisory Board of Trustees ("**Advisory Board**") currently at the Hospital. The Advisory Board is comprised of community representatives and physicians on the medical staff of the Hospital. The Advisory Board shall consist of no fewer than nine (9) members and shall be so constituted that:

(a) at least three (3) members of the Advisory Board shall be elected public officials currently holding office in the Hospital's primary service area, or their designees;

(b) at least three (3) members of the Advisory Board shall be members of the medical staff of the Hospital;

(c) at least three (3) members of the Advisory Board shall be nominated and selected by the elected public officials or their designees serving on the Advisory Board; and

(d) Newco may select two (2) additional members of the Advisory Board beyond the nine (9) set forth above.

Newco shall meet with the Advisory Board at least quarterly and will seek input of the Advisory Board with respect to various decisions affecting the Hospital, including, but not limited to, management evaluations, monitoring of clinical quality at the Hospital and the overall strategic direction of the Hospital. The Advisory Board shall establish procedures to assume maximum feasible participation in the operation, scope of services and overall strategic direction of the Hospital.

Newco agrees to consult with the Advisory Board prior to implementing material changes in the operation and management of the Hospital. Newco further agrees to consider and implement, as warranted, considerations by the Advisory Board. All recommendations to Newco by the Advisory Board shall be in writing and shall be retained by Newco for inspection by members of the public upon written notice to Newco.

11.5 Indigent and Charity Care. Unless the Attorney General provides otherwise, Newco will continue the Hospital's existing practice as of the date hereof with respect to the provision of indigent and charity care. In addition, Newco will include this covenant in any subsequent sale of the Hospital after the Closing Date.

11.6 2001 Order. Buyer agrees to comply with the obligations and requirements of Sharon that are established by that certain Final Decision, Docket No. 01-486-01, by the State of Connecticut Office of the Attorney General, dated November 26, 2001 to the extent that such obligations and requirements are required to be assigned to future owners of the Hospital by such Final Decision.

11.7 Attorney General Discussions. Sellers and Buyer acknowledge that Buyer may seek discussions with the Attorney General regarding modifying or eliminating the covenants set forth in Sections 11.4, 11.5 and 11.6. Newco shall comply with such provisions unless modified by the Attorney General in writing.

11.8 Property Transfer Law Matters.

(a) Within thirty (30) days of the date hereof, Sellers shall engage at their sole cost and expense an environmental professional licensed pursuant to Connecticut General Statutes § 22a-133v ("**Licensed Environmental Professional**") who shall render an opinion as to whether the property and Facility located at 50 Hospital Hill Road, Sharon, Connecticut (the "**Connecticut Facility**") is an "establishment" under the Property Transfer Law. If the Connecticut Facility is an "establishment" under the Property Transfer Law, then Sellers shall as promptly as reasonably practical comply with the Property Transfer Law through final LEP Verification (as defined by the Property Transfer Law) or a no further action letter from the Connecticut Department of Energy & Environmental Protection ("**CT DEEP**"), as applicable, under the Property Transfer Law. Sellers shall also cooperate with and provide CT DEEP any and all information and data requested by CT DEEP in connection with any audit undertaken by CT DEEP and take all other actions as may be properly requested by CT DEEP as follow-up to any CT DEEP audit. Sellers shall provide Buyer as soon as reasonably practicable (but in any event at least five (5) days prior to delivery), with advance copies of all documents or correspondence to be filed with CT DEEP or prepared under the Property Transfer Law and shall incorporate any reasonable substantive comments provided by Buyer into such filings. Sellers shall promptly provide to Buyer copies of correspondence and documents received from or submitted to CT DEEP. Without limiting the generality of the foregoing, with respect to the Connecticut Facility, the Sellers, at their own cost and expense, shall, as appropriate and necessary, conduct all investigation, sampling, monitoring, remediation, cleanup, removal and other corrective action or closure work necessary to comply with the Property Transfer Law and prepare and submit all documents and reports and pay all fees, costs and expenses necessary to comply with the Property Transfer Law.

(b) Subject to the terms of this Agreement, Sellers shall retain control of the actions necessary and appropriate to comply with the Property Transfer Law. Sellers expressly reserve the right to design and implement any remedial actions pursuant to which Sellers obligations under the Property Transfer Law can be satisfied in accordance with the Connecticut Remediation Standard Regulations, R.C.S.A. 22a-133k-1 through 22a-133k-3 ("**RSRs**"),

including, but not limited to, the development of alternative criteria for soil, sediment, surface water or groundwater at the Connecticut Facility, and the placement of one or more Environmental Land Use Restrictions (as defined and set forth under the RSRs) on the Connecticut Facility; provided that no such remedial action may materially interfere with Buyer's use and operation of the Connecticut Facility.

(c) Buyer shall use commercially reasonable efforts to cooperate with the Sellers in connection with their actions with respect to compliance with the Property Transfer Law, including providing access to the Connecticut Facility after the Closing Date and executing any forms necessary to allow the parties hereto to timely consummate the transactions contemplated by this Agreement in accordance with the Property Transfer Law requirements; provided, that if any obligation or liability is imposed pursuant to such forms such obligation or liability shall constitute an Excluded Liability and shall be subject to the terms and conditions of Article 12 hereof.

ARTICLE XII

INDEMNIFICATION

12.1 Indemnification by Buyer.

(a) Buyer shall indemnify and hold harmless the Sellers, and their respective officers, directors, employees and Affiliates (collectively, the "**Seller Indemnified Parties**"), from and against Damages that any Seller Indemnified Party incurs as a result of, or with respect to, (i) any misrepresentation or breach of warranty by Buyer under this Agreement or the other agreements and documents executed and delivered by Buyer pursuant to this Agreement, (ii) any breach by Buyer of any covenant or agreement of Buyer under this Agreement or the other agreements contemplated hereby or (iii) any of the Assumed Liabilities.

(b) For purposes of calculating the amount of any Damages incurred, arising out of or relating to a breach or inaccuracy for purposes of Section 12.1, no effect shall be given to any materiality or Material Adverse Effect qualification of any representation, warranty, covenant or agreement of Buyer.

12.2 Indemnification by the Sellers.

(a) Each of the Sellers, jointly and severally, shall indemnify and hold harmless Buyer, and its officers, directors, employees, stockholders, members and Affiliates (collectively, the "**Buyer Indemnified Parties**"), from and against any and all Damages that any such Buyer Indemnified Party incurs as a result of, or with respect to, (i) any misrepresentation or breach of warranty by any of the Sellers under this Agreement or the other agreements and documents executed and delivered by any or all of the Sellers pursuant to this Agreement, (ii) any breach by any of the Sellers of any covenant or agreement of any of the Sellers under this Agreement or the other agreements contemplated hereby, (iii) an erroneous interpretation or determination by Sellers or a Licensed Environmental Professional retained by Sellers that the Connecticut Facility is not an "establishment" for purposes of the Property Transfer Law or that the Property Transfer Law does not apply to the transaction covered by this Agreement for some

other or alternative reason ("**Erroneous Applicability Determination**"), or (iv) any of the Excluded Liabilities.

(b) For purposes of calculating the amount of any Damages incurred, arising out of or relating to a breach or inaccuracy for purposes of Section 12.2, no effect shall be given to (i) any materiality or Material Adverse Effect qualification of any representation, warranty, covenant or agreement of any of the Sellers or (ii) any Corrected Schedule.

12.3 Survival. Except as otherwise expressly provided in this Agreement, all representations and warranties contained in this Agreement or in any document delivered at the Closing pursuant hereto shall (i) be deemed to be material and to have been relied upon by the Parties, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, (ii) not be deemed merged into any instruments or agreements delivered at the Closing or thereafter and (iii) survive the Closing and shall be fully effective and enforceable for a period of two (2) years following the Closing Date, except for the representations and warranties set forth in (a) Sections 4.1 (Existence and Capacity), 4.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.) (other than 4.2(c)), and 4.3 (Binding Agreement) which shall survive the Closing indefinitely, (b) Sections 4.8 (Medicare Participation; Accreditation) and 4.9 (Regulatory Compliance) which shall survive until the fifth anniversary of the Closing Date, and (c) Section 4.12(a) (Title, Condition, and Sufficiency of the Assets) and Section 4.16 (Taxes) which shall survive until the expiration of the applicable statute of limitations taking into account all valid extensions.

12.4 Limitations.

(a) The Sellers shall be liable under Section 12.2(a)(i) only when total indemnification claims made under Section 12.2(a)(i) exceed One Hundred Thousand Dollars ($100,000) (the "**Indemnification Deductible**"), after which the Sellers shall be liable for the amount of Damages in excess of the Indemnification Deductible.

(b) Buyer shall be liable under Section 12.1(a)(i) only when total indemnification claims made under Section 12.1(a)(i) exceed the Indemnification Deductible, after which Buyer shall be liable for only for the amount of Damages in excess of the Indemnification Deductible.

(c) Notwithstanding the foregoing in (a) and (b), any Damages incurred by (i) a Buyer Indemnified Party as a result of an Erroneous Applicability Determination or as a result of a breach or inaccuracy of any representation or warranty made by any of the Sellers in Sections 4.1 (Existence and Capacity), 4.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.), 4.3 (Binding Agreement), 4.11 (Real Property), 4.12(a) (Title, Condition, and Sufficiency of the Assets), or 4.16 (Taxes) (collectively, the "**Seller Fundamental Representations**"), Section 4.9 (Regulatory Compliance), information disclosed on any Corrected Schedule, or information that should have been disclosed on an Updated Schedule or Corrected Schedule but was fraudulently withheld; (ii) a Seller Indemnified Party as a result of a breach or inaccuracy of any representation or warranty made by Buyer in Sections 5.1 (Existence and Capacity), 5.2 (Powers; Consents; Absence of Conflicts With Other Agreements, Etc.) or 5.3

(Binding Agreement) (collectively, the "**Buyer Fundamental Representations**"); or (iii) in the case of fraud, shall not count towards, nor be subject to, the Indemnification Deductible.

(d) The maximum aggregate liability of Sellers for indemnification under Section 12.2(a)(i) (other than with respect to breaches of the Seller Fundamental Representations, breaches of Section 4.9 (Regulatory Compliance), breaches with respect to information set forth on any Corrected Schedule, breaches with respect to information that should have been disclosed on an Updated Schedule or Corrected Schedule but was fraudulently withheld, and claims of fraud) and Buyer for indemnification under Section 12.1(a)(i), respectively (other than with respect to breaches of the Buyer Fundamental Representations and claims of fraud) shall be limited to an amount equal to Two Million Five Hundred Thousand Dollars ($2,500,000). The maximum aggregate liability of: (i) Sellers for indemnification under Section 12.2(a)(ii), for breaches of the Seller Fundamental Representations; and (ii) Buyer for indemnification under Section 12.1(a)(ii), for breaches of the Buyer Fundamental Representations, and breaches with respect to information set forth on any Corrected Schedule that causes Damages, respectively, shall be limited to an amount equal to the Purchase Price. For the avoidance of doubt, Sellers' liability for an Erroneous Applicability Determination, for breaches of Section 4.9 (Regulatory Compliance), for breaches set forth on any Corrected Schedule, and/or for breaches with respect to information that should have been disclosed on an Updated Schedule or Correct Schedule but was fraudulently withheld, that cause Damages shall not be subject to any limitation on indemnification under this Agreement.

(e) Notwithstanding anything else to the contrary in this Agreement, Sellers shall have no obligation to indemnify Buyer for any Damages relating to any events, circumstances, conditions, occurrences or changes in the Assets or Business during the term of the Management Agreement ("Change") if Buyer had knowledge of such Change in its capacity as Manager under the Management Agreement, failed to provide Sellers notice of such Change prior to Closing, and none of the individuals listed on Schedule 4.30 (other than the Executives) otherwise had knowledge of such Change

12.5 Notice and Control of Litigation. If any claim or liability is asserted in writing by a third party against a Party entitled to indemnification under this ARTICLE XII (the "**Indemnified Party**") which would give rise to a claim under this ARTICLE XII, the Indemnified Party shall notify the person giving the indemnity (the "**Indemnifying Party**") in writing of the same within ten (10) days of receipt of such written assertion of a claim or liability. The Indemnifying Party shall have the right to defend a claim and control the defense, settlement and prosecution of any litigation. If the Indemnifying Party, within ten (10) days after notice of such claim, fails to defend such claim, the Indemnified Party shall (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise or settlement of such claim on behalf of and for the account and at the risk of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise or final determination thereof. Anything in this Section 12.5 notwithstanding, (i) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense and subject to the written consent of the Indemnifying Party (which consent shall not be unreasonably withheld, conditioned or delayed), to defend, compromise and settle such claim, and (ii) the Indemnifying

Party shall not, without the written consent of the Indemnified Party (which consent shall not be unreasonably withheld, conditioned or delayed), settle or compromise any claim or consent to the entry of any judgment that does not include a term thereof the giving by the claimant to the Indemnified Party of an unconditional release from all liability in respect of such claim. All Parties agree to cooperate fully as necessary in the defense of such matters. Should the Indemnified Party fail to notify the Indemnifying Party in the time required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.6 Notice of Claim. If an Indemnified Party becomes aware of any basis for a claim for indemnification under this ARTICLE XII (except as otherwise provided for under Section 12.5), the Indemnified Party shall notify the Indemnifying Party in writing of the same within thirty (30) days after becoming aware of such claim, specifying in detail the circumstances and facts which give rise to a claim under this ARTICLE XII. Should the Indemnified Party fail to notify the Indemnifying Party within the time frame required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have nonetheless resulted had the Indemnified Party notified the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.7 Exclusive Remedy. Except (i) in cases of fraud or (ii) as set forth in Section 13.17 and Section 13.28, the sole and exclusive remedy for any breach or inaccuracy of any representation, warranty or covenant contained herein shall be the remedies provided for in this ARTICLE XII.

ARTICLE XIII

MISCELLANEOUS

13.1 Schedules and Other Instruments. Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until the Closing Date, the Sellers or Buyer shall update their Schedules, either as a result of (i) matters hereafter arising which, if existing or occurring at the date of this Agreement, would have been required to be set forth or described in such Schedules or that are necessary to correct any information in such Schedules which has been rendered materially inaccurate thereby (the "**Updated Schedules**") or (ii) matters that existed or occurred at or before the date of this Agreement and should have been set forth or described in such Schedules, but were not (the "**Corrected Schedules**"). The Schedules shall be modified and superseded as contemplated by such Updated or Corrected Schedule for all purposes hereunder. Any other provision herein to the contrary notwithstanding, each party shall deliver all Updated Schedules and Corrected Schedules, if any, shall be delivered to the other party hereto: (a) with respect to Schedules 4.8, 4.9, 4.14, and 4.25, within five (5) business days of any material changes thereto, provided that Manager has complied with Section 7.3; and (b) with respect to all other Schedules every ninety (90) days from the date hereof, to the extent preparing Party has discovered an inaccuracy of a Schedule. Notwithstanding the foregoing, in the event the information to be disclosed on an

Updated or Corrected Schedule would reasonably be considered material to the operations of the Facilities, the disclosing party must disclose within ten (10) days of discovery. If any matter described in an Updated Schedule results in any Damage to the non-disclosing Party for which such Party is entitled to indemnification pursuant to ARTICLE XII (*e.g.* such Updated Schedule would render a representation and warranty made as of the date hereof inaccurate or constitute a breach of a covenant made as of the date hereof), then the Indemnified Party shall be entitled to pursue all remedies pursuant to ARTICLE XII; provided, however, that if Buyer's Damages (x) are a result of Buyer's (or its Affiliate's) breach of the Management Agreement, (y) are a result of actions taken by or caused by the Buyer or its Affiliates or (z) are based on an inaccuracy attributable to information possessed by the Buyer and not delivered to Sellers as required by Section 7.3, Buyer shall not be entitled to pursue remedies pursuant to ARTICLE XII.

13.2 Allocation. The Parties agree that Buyer shall prepare a preliminary allocation (the "**Tax Allocation**") of the Purchase Price (and all other capitalizable costs incurred in connection with the transactions hereunder) among the Assets in accordance with Section 1060 of the IRC and the Treasury Regulations thereunder (and any similar provisions of state, local or foreign law, as appropriate). Buyer shall deliver its preliminary Tax Allocation to the Sellers within forty-five (45) days after the Purchase Price has been agreed upon or otherwise determined pursuant to Section 2.6, and the Sellers shall have forty-five (45) days after receiving the preliminary Tax Allocation (the "**Seller Review Period**") to object to the preliminary Tax Allocation. If the Sellers timely raise any such objections, Buyer and the Sellers will attempt to resolve such objections in good faith; provided, however, that if Buyer and the Sellers are unable to resolve such issues within thirty (30) days after the end of the Seller Review Period, then either Buyer and the Sellers may elect, by written notice to the other, to have the objections resolved by the Audit Firm, whose decision shall be binding on the Parties in the absence of manifest error and whose fees and expenses shall be paid fifty percent (50%) by Buyer and fifty percent (50%) by the Sellers. If the Sellers fail to object to the preliminary Tax Allocation within the Seller Review Period, then such preliminary Tax Allocation shall be deemed acceptable to the Sellers and such preliminary Tax Allocation shall be binding upon the Parties. Thereafter, Buyer, the Sellers and their respective Affiliates shall report, act and file all Tax Returns (as defined below) (including, but not limited to, Internal Revenue Service Form 8594) in all respects and for all purposes consistent with such finally determined Tax Allocation. Neither Buyer, the Sellers nor any of their respective Affiliates shall take any position (whether in audits, Tax Returns or otherwise) that is inconsistent with such Tax Allocation, unless required to do so by applicable law.

13.3 Termination Prior to Closing. Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) on or prior to the Closing, by mutual consent of the Sellers and Buyer; (ii) by Buyer or the Sellers, if the Closing shall not have taken place on or before July 31, 2017 or the first anniversary of the date hereof, whichever is later, which date may be extended by mutual agreement of Buyer and the Sellers; provided, however, that no termination may be made under this Section 13.3; (ii) by a Party if the failure to close on or prior to such date shall be caused by the failure of such Party to fully comply with its obligations under this Agreement; (iii) in the event the Sellers, on one hand, or Buyer, on the other hand, commit a material breach of any of the terms hereof and such breach would prevent a condition to Closing from being satisfied, by the non-breaching Party, provided however, if such breach is

capable of cure, then the breaching party shall have thirty (30) days to effect such cure prior to termination;(iv) by Buyer in accordance with the provisions of Section 13.31.

13.4 Post-Closing Access to Information. The Sellers and Buyer acknowledge that subsequent to the Closing each Party may need access to information or documents in the control or possession of the other Party for the purposes of concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, subject to applicable law and attorney-client privilege or other applicable privileges, the Sellers and Buyer agree that for a period of six (6) years after the Closing Date each will make reasonably available to the other's agents, independent auditors, counsel and/or governmental agencies upon written request and at the expense of the requesting Party such documents and information as may be available relating to the Business or the Assets for periods ending on or prior to the Closing Date to the extent necessary to facilitate concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

13.5 Preservation and Access to Records After the Closing. Buyer agrees to maintain all patient, medical and other records of the Facilities delivered to Buyer at the Closing in accordance with applicable law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. Section 1395(v)(l)(i)), HIPAA and applicable state requirements with respect to medical privacy and requirements of relevant insurance carriers, all in a manner consistent with the maintenance of patient records generated at the Facilities after the Closing. For purposes of this Agreement, the term "**records**" includes all documents, electronic data and other compilations of information in any form. Buyer acknowledges that as a result of entering into this Agreement and operating the Facilities it will gain access to patient and other information that is subject to rules and regulations regarding confidentiality, and agrees to abide by any such rules and regulations relating to the confidential information it acquires. Upon reasonable notice, during normal business hours, at the sole cost and expense of the Sellers and upon Buyer's receipt of appropriate consents and authorizations, Buyer will afford to the representatives of the Sellers, including their counsel and accountants, full and complete access to, and copies of, the records transferred to Buyer at the Closing (including, without limitation, access to patient records in respect of patients treated by the Sellers at the Facilities). Upon reasonable notice, during normal business hours and at the sole cost and expense of the Sellers, Buyer shall also make its officers and employees available to the Sellers at reasonable times and places after the Closing. In addition, the Sellers shall be entitled, at the Sellers' sole risk, to remove from the Facilities copies of any such patient records, but only for purposes of pending litigation involving a patient to whom such records refer, as certified in writing prior to removal by counsel retained by the Sellers in connection with such litigation and only upon Buyer's receipt of appropriate consents and authorizations. Any patient record so removed from the Facilities shall be promptly returned to Buyer following its use by the Sellers. Any access to the Facilities, their records or Buyer's personnel granted to the Sellers in this Agreement shall be upon the condition that any such access not unreasonably interfere with the business operations of Buyer.

13.6 CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the Certificate of Need statute of any state, until the appropriate governmental agencies shall have granted a Certificate

of Need or the appropriate approval or ruled that no Certificate of Need or other approval is required.

13.7 Cooperation on Tax Matters. Following the Closing, the Parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting Party, and to any Taxing Authority, all information, records or documents relating to Tax liabilities or potential Tax liabilities of the Sellers or the Buyer and any information that may be relevant to determining the amount payable under this Agreement, and shall preserve all such information, records and documents at least until the expiration of any applicable statute of limitations or extensions thereof. Upon request of Buyer, the Sellers shall use their commercially reasonable efforts to obtain any certificate or other document from any governmental authority or any other person as may be necessary to mitigate, reduce or eliminate any Taxes that could be imposed (including, but not limited to, with respect to the transactions contemplated hereby).

13.8 Misdirected Payments, Etc. Each of the Sellers and Buyer covenant and agree to remit, with reasonable promptness, to the other Party any payments received, which payments are on or in respect of accounts or notes receivable owned by (or are otherwise payable to) the other Party. In addition, in the event of a determination by any governmental or third party payor that payments to the Sellers or the Facilities resulted in an overpayment or other determination that funds previously paid by any program or plan to the Sellers or the Facilities must be repaid, including, without limitation, pursuant to a RAC audit, the Sellers shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered on or prior to the Closing Date, and Buyer shall be responsible for repayment of said monies (or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date and not arising out of the actions or policies of the Sellers. In the event that, following the Closing, Buyer suffers any offsets against reimbursement under any third party payor or reimbursement programs due to Buyer, relating to amounts owing under any such programs by the Sellers, the Sellers shall promptly upon demand from Buyer pay to Buyer the amounts so offset. Notwithstanding the foregoing, any obligation of Sellers to make any payment to the Buyer hereunder is, where the Buyer is the recipient of the notice of the audit and/or underpayment, conditioned upon the Buyer's delivery of written notice of the audit and/or underpayment to the Sellers within ten (10) business days of Buyer's receipt of the same in order that Sellers may contest the assessment should they so desire; provided, however, that should the Buyer fail to notify the Seller in the time required above, the payment with respect to the subject matter of the required notice shall be limited to the payment that would have resulted had the Buyer notified the Seller in the time requirement above after taking into account such actions the Seller could have taken had it received timely notice from the Buyer.

13.9 Tax Returns. Each of the Sellers will timely file all Tax Returns, accurately report all income and loss, and pay all Taxes due for tax years or periods ending on or before the Closing Date and shall provide a copy of each such return to Buyer upon filing. Buyer shall make any books and records necessary or helpful to the preparation of such returns available to the Sellers during normal business hours. In addition to any other indemnification obligations hereunder, each Seller shall indemnify Buyer for (A) any liability for unpaid Taxes of each Seller; and (B) any Taxes levied with respect to the Assets or Business for (i) any Tax year

ending on or before the Closing Date; and (ii) in the case of any period that begins before but does not end on the Closing Date (a "**Straddle Period**"), to the extent allocable to the portion of the Straddle Period ending on the Closing Date. The amount of any Taxes based on or measured by income, receipts or expenses for the portion of the Straddle Period ending on the Closing Date shall be determined based on an interim closing of the books as of the Closing Date, and the amount of other Taxes for a Straddle Period which relate to the portion of the period ending on the Closing date shall be deemed to be the amount of such Tax for the entire period, multiplied by a fraction, the numerator of which is the number of days in the taxable period ending on the Closing Date, and the denominator of which is the number of days in in such Straddle Period.

13.10 Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the Parties except as may be herein specifically provided to the contrary; provided, however, at the request of a Party, the other Parties shall execute such additional instruments and take such additional actions as the requesting Party may reasonably deem necessary to effectuate this Agreement. In addition and from time to time after the Closing, the Sellers shall execute and deliver such other instruments of conveyance and transfer, and take such other actions as Buyer reasonably may request, more effectively to convey and transfer full right, title, and interest to, vest in, and place Buyer in legal and actual possession of, any and all of the Assets. The Sellers shall also furnish Buyer with such information and documents in their possession or under their control, or which the Sellers can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Facilities or the Assets. Additionally, the Sellers shall cooperate and use their best efforts to have their present directors, officers and employees cooperate with Buyer on and after the Closing in furnishing information, evidence, testimony and other assistance in connection with any action, proceeding, arrangement or dispute of any nature with respect to matters pertaining to all periods ending on or prior to the Closing Date in respect of the items subject to this Agreement.

13.11 Consented Assignment. Anything contained herein to the contrary notwithstanding, this Agreement shall not constitute an agreement to assign any claim, right, contract, license, lease, commitment, sales order or purchase order if an attempted assignment thereof without the consent of the other party thereto would constitute a breach thereof or in any material way affect the rights of the Sellers thereunder, unless such consent is obtained. Each of the Sellers shall use commercially reasonable efforts to obtain any third party consents to the transactions contemplated by this Agreement. If such consent is not obtained, or if an attempted assignment would be ineffective or would materially affect the rights thereunder of the Sellers so that Buyer would not in fact receive all such rights, the Sellers and Buyer shall cooperate in good faith in any reasonable arrangement designed to provide for Buyer the benefits under any such claim, right, contract, license, lease, commitment, sales order or purchase order, including, without limitation, enforcement of any and all rights of the Sellers against the other party or parties thereto arising out of the breach or cancellation by such other party or otherwise.

13.12 Consents, Approvals and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a Party, or whenever a Party must or may exercise discretion, the Parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

13.13 Legal Fees and Costs. In the event there is a dispute between the Parties and a Party elects to incur legal expenses to enforce or interpret any provision of this Agreement by judicial proceedings, the prevailing Party will be entitled to recover such legal expenses, including, without limitation, reasonable attorneys' fees, costs and necessary disbursements at all court levels, in addition to any other relief to which such Party shall be entitled.

13.14 Choice of Law; Mediation.

(a) The Parties agree that this Agreement shall be governed by and construed in accordance with the laws of the State of New York without regard to conflict of laws principles.

(b) In the event that any disagreement, dispute, controversy or claim arising out of or relating solely to this Agreement (a "**Legal Dispute**") arises between the Parties arising out of or relating to this Agreement, the matter shall first be submitted to non-binding mediation. The mediation process shall be initiated by either Party giving written notice to the other party of its desire to mediate. Within thirty (30) days of such written notice, the Parties shall agree on a mediator, or, if the Parties are unable to agree, the mediator shall be selected by the American Health Lawyers Association (the "**AHLA**"), and in that event, the mediation shall be administered by the AHLA under its Rules of Procedure for Arbitration and Mediation. The mediator shall be a practicing attorney who has experience with mediating controversies involving complex commercial transactions or the subject matter of the particular dispute involved. The mediation shall be held at a neutral site mutually agreed upon by the Parties, provided, however, that if the Parties cannot agree on such site within fifteen (15) days after written notice of mediation, then the site shall be the location selected by the mediator.

Each Party shall bear its own costs and expenses and an equal share of the mediator's fees and administrative fees of mediation, if any. If at any time more than five (5) hours into the mediation conference the mediator determines that the controversy cannot be settled in mediation, the mediator may declare an impasse and the mediation process shall end at that point. The mediation shall be held within thirty (30) days after selection or appointment of the mediator.

(c) In the event that a Legal Dispute arises between the Parties arising out of or relating to this Agreement, and following declaration of an impasse by the mediator pursuant to Section 13.14(b), either Party may pursue whatever legal or equitable remedies as are available.

(d) Nothing in this Section 13.14 shall preclude either Party from seeking interim or provisional relief, including a temporary restraining order, preliminary injunction or other interim equitable relief concerning a Legal Dispute, either prior to or during any mediation hereunder, if necessary to protect the interests of such Party. This Section 13.14(d) shall be specifically enforceable.

13.15 Benefit/Assignment. Subject to provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, successors and permitted assigns. Neither the Sellers, on one hand, nor Buyer, on

the other hand, may assign this Agreement without the prior written consent of the other Party. Notwithstanding the foregoing, either Party may collaterally assign and grant a security interest in, all of its rights hereunder in favor of one or more lenders in connection with any credit facility, whether now existing or hereafter entered into, to which such Party or any Affiliate is or becomes a party.

13.16 Cost of Transaction. Whether or not the transactions contemplated hereby shall be consummated, the Parties agree as follows: (i) the Sellers shall pay the fees, expenses and disbursements of the Sellers and their agents, representatives, accountants and legal counsel incurred in connection with the subject matter hereof and any amendments hereto; (ii) Buyer shall pay the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and legal counsel incurred in connection with the subject matter hereof and any amendments hereto; and (iii) the Sellers shall pay one-half and Buyer shall pay one-half of all costs of any title search, title commitment, title policy, surveys and endorsements to title policies, as well as all transfer and recording taxes and fees, relating to the Owned Real Property and incurred in connection with the transactions contemplated by this Agreement, provided that Buyer shall pay for any zoning reports and all fees and expenses related thereto.

13.17 Confidentiality. It is understood by the Parties that any information provided by another Party (the "**Providing Party**") concerning such Providing Party obtained, directly or indirectly, from the Providing Party in connection with the transactions contemplated by this Agreement ("**Confidential Information**"), and the documents and other written information delivered to a receiving Party (the "**Receiving Party**"), or its stockholders, members, Affiliates, officers, employees or agents (collectively, "**Agents**"), are of a confidential and proprietary nature. To the extent permitted by law, the Receiving Party agrees that it will, and will use its reasonable best efforts to cause the Agents to, maintain the confidentiality of all such Confidential Information, and will only disclose such Confidential Information to Agents as necessary to effect the transactions contemplated hereby. Notwithstanding the foregoing, the Sellers may provide the Confidential Information to their or their Affiliates' debt or equity financing sources and investors who sign a customary confidentiality agreement. The parties further agree that if the transactions contemplated hereby are not consummated, the Receiving Party will return, and will use its reasonable best efforts to cause its Agents to return, all documents and other written information acquired from the Providing Party or its Affiliates and all copies thereof in their possession to the Providing Party. Each of the Parties hereto recognizes that any breach of this Section 13.17 would result in irreparable harm to the other Parties to this Agreement and their Affiliates and that therefore either the Sellers or Buyer shall be entitled to an injunction to prohibit any such breach or anticipated breach, without the necessity of posting a bond, cash, or otherwise, in addition to all of its other legal and equitable remedies. Nothing in this Section 13.17, however, shall prohibit the use of such Confidential Information, documents or information for such governmental filings as in the opinion of the Sellers' counsel or Buyer's counsel are required by law or governmental regulations or are otherwise required to be disclosed pursuant to applicable law. The foregoing restrictions in this Section 13.17 shall not apply to any information that (i) is on the date hereof or hereafter becomes generally available to the public other than as a result of a disclosure, directly or indirectly, by the Receiving Party or its Agents, (ii) was in the possession of the Receiving Party on a non-confidential basis prior to its disclosure or (iii) becomes available to the Receiving

Party on a non-confidential basis from a source other than the Providing Party or its representatives, which source was not itself bound by a confidentiality agreement.

13.18 Public Announcements. No Party hereto shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the other Parties, except for information and filings reasonably necessary to be directed to governmental agencies to fully and lawfully effect the transactions herein contemplated or as required by law. Notwithstanding the foregoing, the Sellers, in consultation with Buyer, may make periodic announcements to their employees regarding the transactions contemplated by this Agreement. Notwithstanding the foregoing, in the event a Party hereto determines that the terms hereof will be the subject of discovery in any litigation involving such Party, such Party shall promptly notify the other Parties hereto of such determination and if Sellers, on one hand, and Buyer, on the other hand, conclude that such disclosure through discovery is inevitable, then (i) the Parties shall make a public announcement of the terms hereof prior to such discovery taking place, (ii) such public announcement shall be made in a manner and at a time mutually agreed by the Parties and (iii) the Parties shall be represented at, and permitted to participate in, such announcement.

13.19 Waiver of Breach. The waiver by any Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to constitute, a waiver of any subsequent breach of the same or any other provision hereof.

13.20 Notice. Any notice, demand, or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered, when received by overnight delivery or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

The Sellers:	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital c/o RegionalCare Hospital Partners, Inc. 103 Continental Place, Suite 410 Brentwood, TN 37027 Attention: General Counsel Email: howard.wall@regionalcare.net
With simultaneous copies to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, Tennessee 37219 Attention: George W. Bishop III, Esq. Email: george.bishop@wallerlaw.com

Buyer:	Health Quest Systems, Inc. 1351 Route 55, Suite 200 Lagrangeville, NY 12540 Attention: Michael Holzhueter, Senior Vice President and General Counsel Email: mholzhue@health-quest.org
With a simultaneous copy to:	McDermott, Will & Emery LLP 227 West Monroe Street, Suite 4700 Chicago, Illinois 60606-5096 Attention: John M. Callahan, Esq. Email: jcallahan@mwe.com

or to such other address, and to the attention of such other person or officer as any Party may designate, with copies thereof to the respective counsel thereof as notified by such Party.

13.21 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be and remain in full force and effect, enforceable in accordance with its terms.

13.22 Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

13.23 Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Agreement.

13.24 Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

13.25 Accounting Date. The transactions contemplated hereby shall be effective for accounting purposes as of 12:01 a.m. on the day following the Closing Date (the "**Effective Time**"), unless otherwise agreed in writing by the Sellers and Buyer.

13.26 No Inferences. Inasmuch as this Agreement is the result of negotiations between sophisticated parties of equal bargaining power represented by counsel, no inference in favor of,

or against, either Party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such Party.

13.27 No Third Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of Buyer and the Sellers and their respective successors and permitted assigns, and it is not the intention of the Parties to confer, and this Agreement shall not confer, third party beneficiary rights upon any other person or entity.

13.28 Enforcement of Agreement. The Parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement was not performed in accordance with its specific terms or was otherwise breached. It is accordingly agreed that the Parties shall be entitled to an injunction or injunctions (without the need to post bond or other security) to prevent breaches of this Agreement and to enforce specifically the terms and provisions hereof in any court of competent jurisdiction, this being in addition to any other remedy to which they are entitled at law or in equity.

13.29 Entire Agreement/Amendment. This Agreement, together with its Schedules, Exhibits and documents delivered at the Closing, supersedes all previous contracts or understandings, including any offers, letters of intent, proposals or letters of understanding, and constitutes the entire agreement of whatsoever kind or nature existing between or among the Parties with respect to the subject matter hereof. As between or among the Parties, no oral statements or prior written material not specifically incorporated herein shall be of any force and effect. The Parties specifically acknowledge that in entering into and executing this Agreement, the Parties are relying solely upon the representations and agreements contained in this Agreement and its Schedules and Exhibits, and no others. No changes in, or additions to, this Agreement shall be recognized unless and until made in writing and signed by all Parties hereto.

13.30 Counterparts. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. Facsimile signatures on this Agreement and signatures sent by PDF shall be deemed to be original signatures for all purposes.

13.31 Risk of Loss. The risk of loss in respect to casualty to the Assets shall be borne by the Sellers until the Closing, and by Buyer on and after the Closing. Notwithstanding the foregoing, if any material part of the Hospital is damaged so as to be rendered unusable or destroyed prior to the Closing, Buyer may elect to terminate this Agreement for a period of thirty (30) days after the expiration of the cure period set forth below and all obligations of the parties hereunder; provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction within forty-five (45) days following such event. In the event the Assets are destroyed or damaged, but such destruction or damage does not entitle Buyer or Buyer does not elect to terminate this Agreement, and provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction, then Buyer shall be entitled to all insurance proceeds paid prior to the Closing in respect of such damage or destruction prior to the Closing. Following the Closing, in the event insurance proceeds are not paid prior to the Closing and provided that such damage, destruction or loss is not cured by the Sellers to Buyer's reasonable satisfaction, Buyer shall be entitled to receive all proceeds payable in respect of such damage or destruction and the Sellers shall use their commercially reasonable efforts to obtain all

such proceeds that may be payable pursuant to their insurance policies with respect to such matters. This Section 13.31 shall survive the Closing.

13.32 RCHP Guarantee. RCHP hereby unconditionally and irrevocably guarantees, as a primary obligor and not only a surety (the "**RCHP Guarantee**"), the prompt and complete payment and performance (not just collection) of any and all of the Sellers' obligations to the Buyer Indemnified Parties under this Agreement, the Escrow Agreement or any Collaboration Agreement executed and delivered by any or all of the Sellers pursuant to this Agreement (the "**Obligations**"), if, as, when and to the extent that such Obligations are required to be performed pursuant to such agreements. If a Seller does not perform an Obligation, RCHP shall promptly perform the Obligation. The obligations of RCHP under the RCHP Guarantee are independent of the obligations of the Sellers under the Agreement and a separate action or actions may be brought against RCHP, whether action is brought against the Sellers or whether the Sellers are joined in any such action or actions; provided, however, as a condition precedent to the commencement of any action against RCHP, (i) Sellers shall have first failed to satisfy an Obligation in the time specified in the Agreement, taking into account any notice and cure periods, and (ii) Buyer (and its Affiliates) shall have an ongoing duty to provide to Sellers any notices required under this Agreement. Except as set forth in this Section 13.32, RCHP hereby waives all rights and defenses of a surety under applicable law. Notwithstanding the foregoing, RCHP shall be entitled to assert as a defense to any claim under this Section 13.32, (i) that the Obligations in respect of which a demand has been made are not yet due under the terms of this Agreement, (ii) that such Obligations have been previously performed in full, and (iii) any claims, defenses, counter claims, setoffs or circumstances excusing payment or performance which the Sellers would be entitled to assert under this Agreement. Except as specifically set forth in this Section 13.32, the RCHP Guarantee is an absolute, irrevocable, primary, continuing, unconditional, and unlimited guaranty of performance and payment subject to and within the limitations of this Agreement. The RCHP Guarantee shall remain in full force and effect (and shall remain in effect notwithstanding any amendment to this Agreement) for RCHP until all of the obligations of the Sellers have been paid, observed, performed, or discharged in full.

13.33 Limited Recourse. Notwithstanding anything in this Agreement to the contrary except for Section 13.32 which shall remain fully binding on RCHP, all Damages arising out of this Agreement and the transactions contemplated hereby will be limited to the Parties to this Agreement and the Management Agreement, no Non-Recourse Party will have any liability hereunder or with respect to the transactions contemplated hereby. For the purpose of this Section 13.33, "Non-Recourse Party" means, with respect to a Party to this Agreement, any of such Party's former, current and future equity holders, controlling Persons, directors, officers, employees, agents, representatives, Affiliates, members, managers, general or limited partners (or any former, current or future equity holder, controlling Person, director, officer, employee, agent, representative, Affiliate, member, manager, general or limited partner, or assignee of any of the foregoing), other than the Manager; provided, that, for the avoidance of doubt, neither RCHP nor any Party to this Agreement will be considered a Non-Recourse Party.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

REGIONAL HEALTHCARE ASSOCIATES, LLC,

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

HEALTH QUEST SYSTEMS, INC.

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

TRI STATE WOMEN'S SERVICES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF SECTIONS 13.32 and 13.33 OF THIS AGREEMENT:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

REGIONAL HEALTHCARE ASSOCIATES, LLC,

By:_____

Name:_____

Title:_____

HEALTH QUEST SYSTEMS, INC.

By:_____

Name: Robert Friedberg

Title: President

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF SECTIONS 13.32 and 13.33 OF THIS AGREEMENT:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____

Name:_____

Title:_____

TRI STATE WOMEN'S SERVICES, LLC

By:_____

Name:_____

Title:_____

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name: Robert Friedberg

Title: President

ASSET PURCHASE AGREEMENT

AMONG

HEALTH QUEST SYSTEMS, INC.,

VASSAR HEALTH CONNECTICUT, INC.,

ESSENT HEALTHCARE OF CONNECTICUT, INC.,

SHARON HOSPITAL HOLDING COMPANY.

REGIONAL HEALTHCARE ASSOCIATES, LLC,

TRI STATE WOMEN'S SERVICES, LLC

AND

REGIONALCARE HOSPITAL PARTNERS, INC.,

(solely for the limited purpose of Section 13.32 and 13.33 therein)

September 9, 2016

Attached to and forming a part of that certain Asset Purchase Agreement dated as of September 13, 2016 (the "Agreement"), by and among Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("Sharon" or the "Hospital"), Sharon Hospital Holding Company, a Delaware corporation ("SHHC"), Regional Healthcare Associates, LLC, a Delaware limited liability company ("RHA"), Tri State Women's Services, LLC, a Delaware limited liability company ("TSWS" and collectively with Sharon, SHHC, and RHA, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("VHC" and, collectively with Health Quest, the "Buyer") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("RCHP"), solely for the purposes of Sections 13.32 and 13.33 therein, are these Schedules. The Schedules shall be organized to correspond to the section numbers used for the Sellers' representations and warranties in the Agreement, and disclosures contained therein shall provide the information contemplated by, or otherwise qualify, the representations and warranties of the Sellers set forth in the corresponding section or subsection of the Agreement; provided that, any exception or qualification set forth in the Schedules with respect to a particular representation or warranty contained in the Agreement shall be deemed to be an exception or qualification with respect to all other applicable representations and warranties contained in the Agreement to the extent the relevance of such disclosure to such other representations and warranties is reasonably apparent on its face. Nothing in the Schedules shall broaden the scope of any representation or

warranty contained in this Agreement or create any covenant. Matters reflected in the Schedules do not represent a determination that such matters are material or establish a standard of materiality, do not and shall not represent a determination that any such matters did not arise in the ordinary course of business, and shall not constitute, or be deemed to be, an admission to any third party concerning such matter or an admission of default or breach under any agreement or document.

SCHEDULES

#	Title
2.1(a)	Owned Real Property
2.1(b)	Leased Real Property
2.1(c)	Personal Property
2.1(h)	Tenant Leases
2.1(i)	Seller Leases
2.1(k)	Pending Approvals
2.2	Excluded Assets
2.2(e)	Excluded Contracts
2.2(i)	Amounts Due to Sellers
2.3(c)	Accrued PTO
2.4(c)	Excluded Liabilities
4.1(d)	Subsidiaries
4.2(b)	Sellers' Required Consents
4.4(a)	Financial Statements; GAAP Exceptions
4.5	Certain Post-Balance Sheet Results
4.6	Licenses
4.7	Applications
4.8	Medicare Participation; Accreditation
4.9	Regulatory Compliance
4.10	Equipment
4.11	Permitted Encumbrances
4.11(a)	Property Violations
4.11(b)	Zoning
4.11(d)	Real Property Actions
4.11(g)	Rent Roll
4.11(h)	Notice of Modifications
4.11(i)	Encroachments
4.11(j)	Third Party Rights
4.11(k)	Construction
4.11(l)	Tenant Improvement
4.12	Condition of the Assets
4.13(a)	Benefit Plans
4.13(c)	ERISA
4.14	Litigation
4.16	Tax Returns
4.16(a)	Tax Extensions
4.16(b)	Tax Audits
4.16(c)	Tax Partnerships
4.17(a)	Employees
4.17(b)	Employment Claims
4.17(c)(i)	Employment Contracts

#	Title
4.17(c)(ii)	Employment Loss
4.18	Material Contracts
4.19(d)	Assumed Contract Consents
4.19(e)	Assignment Penalties
4.21	Insurance
4.22	Cost Reports
4.23	Medical Staff Matters
4.25	Compliance Program
4.26	Environmental Matters
4.26(f)(i)	Underground Storage Tanks
4.26(g)	Environmental Proceedings
4.26(j)	Connecticut Transfer Act
4.27(a)	Owned Intellectual Property
4.27(b)	Other Intellectual Property
4.27(d)	Patents, Copyrights and Trademarks
4.29	Sellers' Brokers
4.30	Knowledge Parties
5.2(b)	Buyer Required Consents
5.5	Buyer Brokers
6.4(j)	Sellers' Negative Covenants
8.1	Governmental Approvals
8.6	Material Contract Consents

Schedule 2.1(a)
Owned Real Property

Tract I - 48 & 50 Hospital Hill Road
Assessor Map 28
Lot 7-1

All that certain piece or parcel of land, together with the buildings and improvements thereon, situated in the Town of Sharon, County of Litchfield and State of Connecticut and shown on a map entitled: "Site Plan Prepared for Sharon Hospital, Inc. Hospital Hill Road & King Hill Road Sharon, Connecticut Scale 1" = 50' July 22, 1991 Total Area = 16.133 ± Acres Peter A. Lamb R.L.S. #7764 Sharon, Connecticut From the Office of: Lamb-Kiefer Land Surveyors, Sharon, Connecticut", and more particularly bounded and described as follows:

Beginning at a point in the southerly street line of King Hill Road which point marks the northeast corner of the herein described parcel and the northwest corner of land now or formerly of Richard Debrowsky & Melanie Aakjar; thence running S 06° 13' 00" W a distance of 185.30 feet along land now or formerly of Richard Debrowsky & Melanie Aakjar to a point; thence running S 84° 08' 00" E a distance of 271.50 feet to an iron pipe; thence S 06° 17' 00" W a distance of 109.85 feet to a point; the last two courses and distances being along land now or formerly of Richard Debrowsky and Melanie Aakjar and August Prause and St. Bernard's Roman Catholic Church, Inc., in part by each; thence running N 84° 14' 00" W a distance of 39.25 feet to a point; thence S 06° 34' 03" W a distance of 110.00 feet to an iron pipe; the last two courses and distances being along land now or formerly of Thomas A. & Violet E. Cunningham; thence N 84° 14' 00" W a distance of 302.21 feet to an iron pipe along land now or formerly of Florence C. Gobillot and Eugene B. & Florence C. Gobillot, in part by each; thence running S 05° 54' 00" W a distance of 149.20 feet to a point; thence S 84° 06' 00" E a distance of 65.20 feet to an iron pipe, the last two courses and distances being along land now or formerly of Eugene B. & Florence C. Gobillot; thence S 06° 32' 00" W a distance of 321.87 feet along land now or formerly of Alma & Gertrude King to a point on the northerly street line of Hospital Hill Road; thence N 82° 38' 00" W a distance of 353.533 feet to a point; thence along the arc of a curve to the right having a radius of 150.00 feet, a delta of 48° 22' 00", a tangent of 673.602 feet and a length of 126.623 feet to a point; thence N 34° 06' 00" W a distance of 723.598 feet to an iron pipe the last three courses and distances being along Hospital Hill Road; thence N 60° 20' 00" E a distance of 81.90 feet along land now or formerly of Patricia A. Lynehan to an iron pipe; thence N 10° 52' 00" W a distance of 239.30 feet along land now or formerly of Patricia A. Lynehan and Barbara Heili, in part by each, to a point on the southerly street line of King Hill Road; thence S 83° 10' 55" E a distance of 944.824 feet along King Hill Road to the point or place of beginning.

Tract II - 1 Low Road
Assessor Map 29
Lot 7

PARCEL TWO: All that certain tract or parcel of land with all buildings thereon standing and all appurtenances thereto belonging, lying northerly of Route #41, so-called, in the Town of Sharon, County of Litchfield, and State of Connecticut, bounded and described as follows:

NORTHERLY	by lands now or formerly of Patricia Gillette and lands now or formerly of Mabel Hotaling, each in part;
EASTERLY	by Low Street, so-called, by lands now or formerly of Mabel Hotaling, by lands now or formerly of Kenneth L. and Margaret Bartram, and by lands now or formerly of Iva N. Stine, each in part;
SOUTHERLY	by highway leading from Sharon to Lakeville (Route #41); and
WESTERLY	by lands now or formerly of Arthur W. Lamb and by lands now or formerly of L. H. Bartram, each in part.

Tract III - 25 Hospital Hill Road
Assessor Map 26
Lot 40-2

All that certain piece or parcel of land, with all improvements thereon situated on the southerly side of the highway leading from Sharon Town Street to Sharon Valley in the Town of Sharon, County of Litchfield and State of Connecticut, bounded and described as follows: viz:

BEGINNING at an iron pipe in the southerly line of said highway at the northwest corner of land of I. Harry Bartram and being the northeast corner of the parcel herein conveyed; thence along the westerly line of land of said Bartram S. 18° 48' W. 259.1 feet to an iron pipe in line of other lands owned by Laura R. Hamlin; thence along line of other land of said Laura R. Hamlin N. 70° 38' W. 132.0 feet to an iron pipe, being the southeast corner of land now or formerly of Pete, Ida and Louise Hansen; thence along said Hansen land N. 18° 48' E. 261.1 feet to an iron pipe in the southerly line of said highway; thence along the southerly line of said highway S. 69° 48' E. 132.0 feet to the iron pipe and place of beginning. Containing .787 of an acre, more or less.

Tract IV - 29 Hospital Hill Road & 40 Amenia Road
Assessor Map 26
Lot 40-3

All that certain piece or parcel of land with all improvements thereon, situated on the northerly side of the highway leading from Sharon, Connecticut to Amenia, New York, in the Town of Sharon, County of Litchfield, State of Connecticut, bounded and described as follows:

BEGINNING at an iron pin in the southwesterly corner of the piece herein described and running the following courses and distances North 20° 49' East 10.8 feet to an iron pin; North 8° 23' East 521.6 feet to an iron pin; North 4° 26' East 390.6 feet to an iron pin; thence running South 70° 26' East 132.2 feet to an iron pin; thence running South 17° 36' West 97.5 feet to an iron pin; then running the following courses and distances: South 70° 38' East 133.65 feet to an iron pin; South 70° 38' East 132.0 feet to an iron pin; South 70° 38' East 253.85 feet to an iron pin; thence running South 20° 52' West 239.2 feet to an iron pin; thence running North 72° 37' West 131.4 feet to an iron pin; thence running the following courses and distances: South 15° 08' East 266.6 feet to an iron pin; South 7° 47' East 77.6 feet to an iron pin; South 1° 11' West 79.95 feet to an iron pin; South 4° 04' West 186.1 feet to an iron pin; thence running the following courses and distances: North 70° 53' West 99.6 feet to a Connecticut Highway Department monument; North 70° 53' West 159.0 feet to an iron pin; thence running North 15° 10' East 200.3 feet to an iron pin; thence running North 70° 53' West 180.0 feet to an iron pin; thence running South 15° 10' West 200.3 feet to an iron pin; thence running along the northerly line of the Sharon, Connecticut to Amenia, New York highway the following courses and distances: North 70° 53' West 102.9 feet to a Connecticut Highway Department monument; North 88° 30' West 38.21 feet to an iron pin which marks the point and place of beginning.

Containing 9.35 acres, more or less.

Reference is made to a map entitled "Map Showing Property of Laura Hamlin in the Town of Sharon, Conn. Scale 1 inch = 40 feet, by H. Knickerbocker, Land Surveyor, Salisbury, Conn., dated March 10, 1958.

Excepting from the above-described parcel the property described in the following deeds:

(a) Quit Claim Deed dated April 30, 1990 from West Sharon Corporation to Sharon Corporation recorded in Volume 113, Page 331 of the Sharon Land Records; however, the property referenced in the Quit Claim Deed dated September 1, 1991 from Sharon Corporation

to West Sharon Corporation recorded in Volume 115, Page 495 is not excepted from the above described Parcel 4. Reference is made to Map 1611 and Map 1640.

(b) Warranty Deed dated August 21, 1992 from West Sharon Corporation to Sharon Medical Office Building Limited Partnership recorded in Volume 117, Page 708 of the Sharon Land Records. Reference is made to Map 1657.

(c) Statutory Form Warranty Deed dated May 31, 2001 from Sharon Health Care, Inc. to United Methodist Home of Sharon, Inc. recorded in Volume 141, Page 256 of the Sharon Land Records. Reference is further made to a Quit Claim Deed dated September 30, 1991 from West Sharon Corporation to Sharon Corporation recorded in Volume 115, Page 491 of the Sharon Land Records. Reference is made to Map 1693.

(d) Warranty Deed dated May 1, 2014 from Essent Healthcare of Connecticut, Inc. to Jean C. Hodouin recorded in Volume 195, Page 201 of the Sharon Land Records. Reference is made to Map 2129.

Tract V - 33 Hospital Hill Road
Assessor Map 26
Lot 40-1

All that certain piece or parcel of land, situated in the Town of Sharon, County of Litchfield and State of Connecticut more particularly bounded and described as follows: Beginning at the Northeast corner of the property herein described; thence in line of West Main Street, westerly four rods to a corner bound; thence south 18 degrees 56 minutes 05 seconds west, 262.054 feet to an iron pipe; thence easterly about four rods to an iron pipe; thence northerly along land now or formerly of Clarence Bassett to the place of beginning. Shown as 0.398 more or less acre on a map entitled Map Prepared for Sharon Hospital, Inc., Hospital Hill Road, Sharon, Connecticut dated May 5, 1985, prepared by Peter A. Lamb and on file in the Office of the Town Clerk of Sharon as Map No. 1429.

Schedule 2.1(b)
Leased Real Property

TENANT	LANDLORD	ADDRESS/ LOCATION
Essent Healthcare of Connecticut, Inc.	Anu Properties Corp.	17 Hospital Hill Road (Residential Unit) Sharon, CT
Regional Healthcare Associates, LLC	Kenmil Realty, LLC	64 Maple St. Kent, CT
Regional Healthcare Associates, LLC	Candlewood Properties, LLC	120 Park Lane Road, New Milford, CT
Regional Healthcare Associates, LLC	Anu Properties, LLC	17 Hospital Hill Road (Office Space) Sharon, CT

Schedule 2.1(c)
Personal Property

See attached.

Schedule 2.1(h)
Tenant Leases

AGREEMENT	TENANT	LANDLORD	ADDRESS/ LOCATION	EFFECTIVE DATE (current term)
Lease Agreement	David R. Kurish, M.D.	Essent Healthcare of Connecticut, Inc.	Suite 1200 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT.	11/1/16
Medical Office Lease	Torrington Winsted Pediatric Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1600 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	12/7/16
Lease Agreement	Connecticut GI, P.C., successor in interest to Litchfield County Gastroenterology Associates, LLC	Essent Healthcare, Inc.	Suite 1700 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	11/1/16
Physician Space Occupancy Agreement	Westwood Ear Nose & Throat, P.C.	Essent Healthcare of Connecticut, Inc.	Certain space in Suite 1900 Sharon Medical Arts Center 29 Hospital Hill Rd Sharon, CT	10/1/16
Clinical Space Rental Agreement	Hanger Prosthetics & Orthotics, Inc.	Essent Healthcare of CT, Inc. d/b/a Sharon Hospital	Examination Rooms Nos. 5 and 162 50 Hospital Hill Road Sharon, CT	6/1/16
Retail Thrift Store Lease Agreement	Tri-State Communications, LLC	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	Space on the 1st Floor "Bargain Barn" 3 Low Road Sharon, CT	1/1/16

Schedule 2.1(i)
Seller Leases

AGREEMENT	TENANT	LANDLORD	ADDRESS/ LOCATION	EFFECTIVE DATE (current term)
Connecticut Residential Lease Agreement	Essent Healthcare of Connecticut, Inc.	Anu Properties Corp.	17 Hospital Hill Road (Residential Unit) Sharon, CT	7/15/2016
Commercial Lease	Regional Healthcare Associates, LLC	Kenmil Realty, LLC	64 Maple St. Kent, CT	8/1/2016
Medical Office Lease Agreement	Regional Healthcare Associates, LLC	Candlewood Properties, LLC	120 Park Lane Road, New Milford, CT	5/5/2016
Medical Office Lease Agreement	Regional Healthcare Associates, LLC	Anu Properties, LLC	17 Hospital Road (Office Space) Sharon, CT	5/5/2016

Schedule 2.1(k)
Pending Approvals

	Program	Provider No.	Comments
1.	NY Medicaid Provider Number (Hospital)	02255392	NY Medicaid is currently processing the hospital's revalidation application filed in October 2015. Still in process per phone call to NY Medicaid on 6/10/16 (218 days in process). Per 8/19/16 phone call to NY Medicaid, the revalidation is still in process and NY Medicaid has no timeline in place for processing revalidations. Tracking ID: 153090248.

Schedule 2.2
Excluded Assets

1. All monies for Medicare and Medicaid MU incentives related to the period prior to Closing.
2. All monies for the period prior to Closing related to CT State Supplemental Payment program
3. All monies for "Sales / Use Tax Refund", as further described in Schedule 4.16(b).
4. Assignment interest in the Sok life insurance contract. The total assignment interest is $544,278.00.
5. Hospital's ownership of Connecticut Hospital Laboratory Network, LLC, including any payments to the Hospital in connection with a potential dissolution.

Schedule 2.2(e)
Excluded Contracts

1. Services Agreement between Essent Healthcare facilities of Southwest Regional Medical Center, Merrimack Valley Hospital, Nashoba Valley Medical Center and Sharon Hospital and Cardon Healthcare Network, Inc., dated January 1, 2011
2. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated 07/31/2015
3. Professional Services Agreement by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 05/01/2012
4. Professional Services Agreement for On Call Coverage by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 01/01/2012, as assigned to Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
5. Billing and Collection Services Agreement by and between Women's Health Connecticut and Tri State Women's Services, dated 05/01/2012
6. EMR Agreement by and between Tri State Women's Services LLC and Women's Health Connecticut, Inc., dated 05/01/2012
7. Timeshare Lease Agreement by and between Tri State Women's Services, LLC and Bruce Janelli, M.D., dated 08/01/2012
8. Physician Space Lease Occupancy Agreement by and between Tri State Women's Services, LLC and Orlito Trias, M.D., dated 11/01/2015
9. Lease Agreement by and between Winsted Health Center, Inc. and Tri State Women's Services, LLC, dated 09/01/2013
10. Equipment Lease Agreement by and between Tri State Women's Services and Physician's for Women's Health, dated 05/01/2012
11. Lease by and between Tri State Women's Services and Sharon Medical Office Building, dated 05/31/2012
12. Services Agreement by and between Sharon Hospital Holding Company and Tri State Women's Services, LLC, dated 10/01/2014
13. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated 10/01/2006
14. Merchant Processing Application and Agreement by and between Tri State Women's Services LLC and First Data Merchant Services, dated 2012
15. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated 01/01/2011
16. Participating Provider Agreement by and between Harvard Pilgrim Health Care of Connecticut, Inc. and Tri-State Women's Services, dated July 1, 2014.
17. Bill of Sale by and between Physicians for Women's Health LLC and Tri State Women's Services, dated 05/30/2012
18. Any other agreement not listed on this Schedule 2.2(e) between any Seller and New Milford Orthopedics
19. Any other agreement not listed on this Schedule 2.2(e) between Tri State Women's Services, LLC (as the only Seller party to such agreement) and any third party

Schedule 2.2(i)
Amounts Due to the Sellers

All amounts due to the Sellers from Affiliates of the Sellers as of the Closing Date.

Schedule 2.3(c)
Accrued PTO

Accrued PTO

$1,030,640.93

Unrecorded Extended Illness Benefits

$483,000

Schedule 2.4(c)
Excluded Liabilities

1. All liabilities relating to the State of Connecticut's audit of the Hospital's Sales and Use Tax, as further described in Schedule 4.16(b).
2. All liabilities of Connecticut Hospital Laboratory Network, LLC that are attributable to the Hospital's ownership interest.
3. All liabilities relating to the assignment interest in the Sok life insurance contract.

Schedule 4.1(d)
Subsidiaries

1. SHHC owns 100% of the outstanding capital stock of Sharon.
2. Essent Healthcare of Connecticut, Inc. holds the following ownership interest in Connecticut Hospital Laboratory Network, LLC. Ownership percentage (as of September 30, 2016): 4.7619047%.

Schedule 4.2(b)
Sellers' Required Consents

1. Connecticut Office of Health Care Access
2. CT Hospital License
3. CT Controlled Substance Registration
4. CDPH Lab Registration
5. CDPH Blood Bank Lab Registration
6. NY State Lab Permit
7. PA Lab Registration Letter
8. CDEEP Certificate of Use
9. CDEEP Certificate of Use
10. CDEEP RAM Registration Confirmation
11. CDEEP RAM Registration Confirmation
12. DEA Registration
13. CLIA Certificate of Accreditation
14. CLIA Certificate of Waiver (RHA 17 Hosp Hill Rd)
15. CLIA Certificate of Waiver (RHA 50 Hosp Hill Rd)
16. CLIA Certificate of PPMP (New Milford OB/GYN)
17. CLIA Certificate of PPMP (RHA 29 Hosp Hill Rd, Ste. 1400)
18. CLIA Waiver (RHA 64 Maple St)
19. CLIA Waiver (RHA 120 Park Lane)
20. CAP Accreditation
21. US Nuclear Regulatory Commission Materials License
22. FDA Mammography Facility Certification
23. ACR Accreditation (Mammographic Imaging)
24. ACR Accreditation (Computed Tomography)
25. ACR Accreditation (MRI Services)
26. ACR Accreditation (SBBI Services)
27. ACR Accreditation (Nuclear Medicine)
28. ACR Accreditation (Ultrasound Services)
29. ACR Accreditation (Breast Ultrasound Imaging)
30. ACR Accreditation (Breast MRI)
31. AIUM Accreditation
32. The Joint Commission
33. FCC Radio Station Authorization
34. FCC Radio Station Authorization
35. FCC Radio Station Authorization

36. Connecticut Property Transfer Form

Schedule 4.4(a)
Seller Financial Statements; GAAP Exceptions

See attached.

GAAP Exceptions:

1. The Financial Statements do not contain year-end notes as would be required for auditing/issuance in accordance with GAAP.
2. The asset related to a key man life insurance policy for James Sok is not recorded on the Balance Sheet as would be required if material in accordance with GAAP.
3. There is no income tax provision prepared or recorded in the Financial Statements.
4. Certain obligations are accounted for on an intercompany basis with RegionalCare Hospital Partners, Inc. (e.g. certain insurance reserves, executive bonuses, etc.)

Schedule 4.5
Certain Post Balance Sheet Results

None.

Schedule 4.6
Licenses

	License Issuer	License No.	Expiration Date
1.	State of Connecticut Department of Public Health License	#0071	Expires: 03/31/2018
2.	State of Connecticut Department of Consumer Protection Controlled Substance Registration for Hospitals	CSP.0000875-HOSP (3367)	Expires: 02/28/2019
3.	CDPH Approved Public Health Laboratory	HP-0317	Expires: 03/31/2018
4.	CDPH Registration and Approval Blood Bank Laboratory	BB-1046	Expires: 03/31/2018
5.	NY State Department of Health Clinical Laboratory Permit	3367	Expires: 06/30/2018
6.	PA Department of Health Lab Registration Letter	31767	Expires: ongoing
7.	CDEEP RMI Confirmation of Registration	0302	Expires: 12/31/2017
8.	CDEEP DTX Confirmation of Registration	4480	Expires: 04/30/2018
9.	Sharon Department of Health	Food Establishment License (Gazebo/Café)	Expires: 07/31/2018
10.	Sharon Department of Health	Food Establishment License (Healthcare/Institutional Food Service/Café)	Expires: 07/31/2018
11.	Controlled Substance Registration Certificate United States Department of Justice Drug Enforcement Administration	BE7740562	Expires: 08/31/2019
12.	CLIA Certificate of Accreditation (Hospital)	07D0644532	Expires: 01/02/2019
13.	CLIA Waiver (RHA 64 Maple St)	07D2027246	Expires: 07/19/2019
14.	CLIA Waiver (RHA 50 Hosp Hill Rd)	07D1099947	Expires: 05/26/2019
15.	CLIA PPMP (New Milford OB/GYN)	07D0868377	Expires: 08/31/2018
16.	CLIA PPMP (RHA 29 Hosp Hill Rd, Ste. 1400)	07D1106899	Expires: 09/08/2018
17.	CLIA Waiver (RHA 17 Hosp	07D0093351	Expires: 01/23/2018

	License Issuer	License No.	Expiration Date
	Hill Rd)		
18.	CLIA Waiver (RHA 120 Park Lane)	07D0100407	Expires: 08/29/2018
19.	The College of American Pathologists Accreditation	1185501	Expires: 01/07/2018
20.	United States Nuclear Regulatory Commission	06-08020-02	Expires: 06/30/2025
21.	Food and Drug Administration Certified Mammography Facility	ID: 149658	Expires: 5/13/2020
22.	American College of Radiology Mammographic Imaging	MAP# 00552-05	Expires: 5/13/2020
23.	American College of Radiology Computed Tomography	CTAP# 00311-02	Expires: 03/29/2019
24.	American College of Radiology Magnetic Resonance Imaging Services	MRAP# 01764-03	Expires: 10/29/2019
25.	American College of Radiology Stereotactic Breast Biopsy Imaging Services	SBBAP# 00984-02	Expires: 12/22/2018
26.	American College of Radiology Nuclear Medicine Services	NMAP# 00296-01	Expires: 09/17/2017
27.	American College of Radiology Ultrasound Services	UAP# 02130	Expires: 11/28/2018
28.	American College of Radiology Breast Ultrasound Imaging Services	BUAP# 00083	Expires: 11/28/2018
29.	American College of Radiology Breast Magnetic Resonance Imaging Services	BMRAP# 50771-01	Expires: 02/10/2019
30.	AIUM Accreditation	New Milford OB/GYN	Expires: 10/15/2018
31.	The Joint Commission	5691	Expires: 01/08/2018
32.	Federal Communications Commission Radio Station Authorization	WPDJ523	Expires: 10/06/2018
33.	Federal Communications Commission Radio Station Authorization	WPRG957	Expires: 09/20/2025
34.	Federal Communications Commission Radio Station Authorization	WQUW310	Expires: 10/29/2024
35.	State of Connecticut Division of Construction Services Boiler Operating Certificate	# 014047	Next Inspection Date: 01/08/2018
36.	State of Connecticut Division of	# 014048	Next Inspection Date:

	License Issuer	License No.	Expiration Date
	Construction Services Boiler Operating Certificate		10/10/2017
37.	State of Connecticut Division of Construction Services Boiler Operating Certificate	# 014049	Next Inspection Date: 10/05/2017
38.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0001	Expires: 02/01/2018
39.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0005	Expires: 07/21/2018
40.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0004	Expires: 07/21/2018
41.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0010	Expires: 03/30/2018
42.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0013	Expires: 05/07/2018
43.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0014	Expires: 05/07/2018
44.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0009	Expires: 03/30/2018
45.	State of Connecticut Elevator Certificate of Operation	Elevator #125-0002	Expires: 07/21/2018
46.	CDEEP Bureau of Air Management	Registration# 162-0007-FPLPE	Expires: 11/08/2020
47.	CDEEP Underground Storage Tank – Notice of Application	Facility ID: 125-2170 Application No.: 2199113	Expires: 10/08/2017
48.	CT Airport Authority	License No. HR171	Expires: 11/15/2017
49.	CLIA Waiver (TSWS 115 Spencer St.)	07D0950433	Expires: 08/24/2018
50.	CLIA Waiver (TSWS 76 Church St.)	07D0950424	Expires: 11/26/2018
51.	CLIA Compliance (TSWS 50 Amenia Rd.)	07D0674765	Expires: 03/10/2019

Schedule 4.7
Applications

Certificate of Need:

State Health Agency	Determination No.	Comments
State of Connecticut Department of Health	Determination # 11-31720-DTR	Certificate of Need not required for merger between Essent Health and RegionalCare Hospital Partners, Inc. 09/09/2011

Schedule 4.8
Medicare Participation; Accreditation

	Program	Provider No.	Comments
1.	Medicare Part A CCN (Hospital)	07-0004	
2.	Medicare Part A CCN (Psych Unit)	07-S004	
3.	Medicare Part B PTAN (Regional Healthcare Associates LLC)	C03779	
4.	Medicare Part B PTAN (Tri State Women's Services LLC)	D100070627	
5.	Railroad Medicare PTAN (Regional Healthcare Associates LLC)	DO7964	
6.	Railroad Medicare PTAN (Tri State Women's Services LLC)	DT3319	
7.	CT Medicaid Provider Number (Hospital)	004221800; 004221818	
8.	CT Medicaid Provider Number (Regional Healthcare Associates LLC)	008024284; 008016129; 008008233; 008024296; 008024286; 008062872; 008064785; 008024424	
9.	CT Medicaid Provider Number (Tri State Women's Services LLC)	1285903526	
10.	NY Medicaid Provider Number (Hospital)	02255392	NY Medicaid is currently processing the hospital's revalidation application filed in October 2015. Still in process per phone call to NY Medicaid on 6/10/16 (218 days in process). Per 8/19/16 phone call to NY Medicaid, the revalidation is still in process and NY Medicaid has no timeline in place for processing revalidations. Tracking ID: 153090248.
11.	NY Medicaid Provider Number (Regional Healthcare Associates LLC)	03597211	
12.	NY Medicaid Provider Number (Tri State Women's Services	03461832	

	Program	Provider No.	Comments
	LLC)		
13.	NPI (Hospital)	1235131442	
14.	NPI (Psych Unit)	1306960596	
15.	NPI (RHA)	1043390156	
16.	NPI (Tri State Women's Services)	1285903526	

Schedule 4.9
Regulatory Compliance

None.

Schedule 4.10
Equipment

See attached.

Schedule 4.11
Permitted Encumbrances

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting installation of a pass-through door to finalize the pharmacy renovations.

2. Real estate taxes to Town of Sharon for the year 2016 and subsequent years.

3. As to Parcel 1: Matters shown ALTA/ACSM Land Title Survey; located at Hospital Hill Road and King Hill Road; Sharon, Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and recorded as Map 1860B in the Sharon Town Clerk's office:

   a. Note regarding non-conforming building side yard on easterly property line;
   b. Underground sanitary sewer lines along Hospital Hill Road;
   c. Notes regarding zoning;
   d. Utility poles and lines along King Hill Road;
   e. Telephone line and electric lines along southerly boundary;
   f. Front, rear and sideyard setback lines.

4. As to Parcel 2: Easement dated August 5, 1895 from Albert J. Bostwick to Sharon Water Company recorded in Volume 40, Page 112 of the Sharon Land Records.

5. As to Parcel 2: Rights described in a Warranty Deed dated March 26, 1964 from Ronald B. Wike and Mary Jane Paavola to Iva N. Stine recorded in Volume 76, Page 249 of the Sharon Land Records. Reference is made to Map 628.

6. As to Parcel 2: Release of rights as described in a Quit Claim Deed dated May 27, 1966 from Ronald B. Wike and Mary Jane Paavola to Patricia P. Gillette recorded in Volume 78, Page 478 of the Sharon Land Records.

7. As to Parcel 2: Riparian rights of others in and to Beardsley Park Brook.

8. As to Parcel 2: The following matters shown on a map entitled ALTA/ACSM Land Title Survey; located at Low Road, Lovers Lane, and Gay Street; Sharon Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and on file as Map No. 1861 in the Sharon Town Clerk's Office:

   a. Water Service lines;
   b. Variance between property lines and lines of fencing
   c. Setback lines;
   d. ROW of New Posts over Property Line.

9. As to Parcels 3, 4 and 5: Easement dated July 6, 1966 from Frank Lovallo and Phyllis K. Lovallo to The Hartford Electric Light Company recorded in Volume 78, Page 517 of the Sharon Land Records. Reference is made to Map 691.

10. As to Parcels 3, 4 and 5: Easement dated April 20, 1989 from West Sharon Corporation to Roger W. Elwood and Jane M. Elwood recorded in Volume 111, Page 607 of the Sharon Land Records.

11. As to Parcels 3, 4 and 5: Right of way set forth in a Quit Claim Deed dated April 30, 1990 from West Sharon Corporation to Sharon Corporation recorded in Volume 113, Page 331; as modified, extended and affected by terms set forth in a Statutory Form Warranty Deed dated May 31, 2001 from Sharon Health Care, Inc. to United Methodist Home of Sharon, Inc. recorded in Volume 141, Page 256 of the Sharon Land Records. Reference is made to Map 1611 and Map 1693.

12. As to Parcels 3, 4 and 5: Rights of way as set forth in a Quit Claim Deed dated September 30, 1991 from West Sharon Corporation to Sharon Corporation recorded in Volume 115, Page 491. Reference is made to Map 1640.

13. As to Parcels 3, 4 and 5: Reciprocal Easement Agreement dated as of July 30, 2002 recorded in Volume 148, Page 47 of the Sharon Land Records.

14. As to Parcels 3, 4 and 5: The following matters shown on Sheet 3 of maps entitled ALTA/ACSM Land Title Survey; located at Hospital Hill Road and Amenia Road; Sharon, Connecticut; prepared for Sharon Corporation dated October 5, 2001, prepared by Martin and Martin Engineering and Land Surveyors, and recorded as Map 1860C in the Sharon Town Clerk's office:

    a. Building setback lines;
    b. Parking Limits over Subdivision Lot Line;
    c. Drainage flow onto east side;
    d. Sanitary sewer line;
    e. Underground electric and telephone lines.

15. As to Parcel 4: A condition set forth in a Warranty Deed dated December 30, 1969 that no part of the (premises) shall be used as a "drive-in" type of restaurant and containing a reversion for any breach of said condition; from Laura Hamlin to Frank Lovallo and Phyllis K. Lovallo recorded in Volume 82, Page 590 of the Sharon Land Records.

16. As to Parcel 4: Easement dated September 29, 1970 from Frank Lovallo and Phyllis K. Lovallo to The Hartford Electric Light Company recorded in Volume 83, Page 493 of the Sharon Land Records. Reference is made to Map 813.

17. As to Parcel 4: Easement dated January 12, 1984 from Frank Lovallo and Phyllis K. Lovallo to The Connecticut Light and Power Company recorded in Volume 101, Page 324 of the Sharon Land Records. Reference is made to Map 1359.

18. As to Parcel 4: Grant of Easement dated September 30, 1991 from West Sharon Corporation to First Church of Christ (Congregational) recorded in Volume 115, Page 496 of the Sharon Land Records. Reference is made to Map 1640.

19. As to Parcel 4: Easement dated August 7, 1992 from West Sharon Corporation to Sharon Medical Office Building Limited Partnership recorded in Volume 117, Page 715 of the Sharon Land Records. Reference is made to Map 1657.

20. As to Parcel 4: Easement dated April 18, 1994 from West Sharon Corporation to Sharon Health Care, Inc. recorded in Volume 122, Page 810 of the Sharon Land Records. Reference is made to Map 1693.

Schedule 4.11(a)
Property Violations

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting installation of a pass-through door to finalize the pharmacy renovations. Once the door is installed, the contractor will contact the Connecticut Department of Public Health for approval.

Schedule 4.11(b)
Zoning

None.

Schedule 4.11(d)
Real Property Actions

None.

Schedule 4.11(g)
Rent Roll

TENANT	LANDLORD	PREMISES (ADDRESS)	EFFECTIVE DATE	TERM & RENEWALS	RENT/ CHARGES /SEC DEP	EXPIRES	ARREARS/ PREPD
David R. Kurish, M.D.	Essent Healthcare of Connecticut, Inc.	Suite 1200 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	11/1/16	1 year Automatic 1-year renewal terms	$1,270.00 per month No security deposit	10/31/17	None as of July 17, 2017
Torrington Winsted Pediatric Associates, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1600 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	12/7/16	1 year May renew for one 1-year term	$4,584.67 per month No security deposit	12/31/17	None as of July 17, 2017
Connecticut GI, P.C.	Essent Healthcare of Connecticut, Inc.	Suite 1700 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	11/1/16	1 year Automatic 1-year renewal terms	$1,704.56 per month No security deposit	10/31/17	None as of July 17, 2017
Westwood Ear Nose & Throat, P.C.	Essent Healthcare of Connecticut, Inc.	Certain space in Suite 1900 Sharon Medical Arts Center 29 Hospital Hill Rd. Sharon, CT	10/1/16	1 year No renewal options	$1,083.33 per month No security deposit	9/30/17	None as of July 17, 2017
Hanger Prosthetics & Orthotics, Inc.	Essent Healthcare of CT, Inc. d/b/a Sharon Hospital	Examination Rooms Nos. 5 and 162 50 Hospital Hill Road Sharon, CT	6/1/11	1 year Automatic 1 year renewal terms	$263.00 per month No security deposit	6/1/18	None as of July 17, 2017
Tri-State Communications, LLC	Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	Space on the 1st Floor ("Bargain Barn") 3 Low Road Sharon, CT	1/1/16	3 years Tenant has option to renew for 1 additional 3 year term	$1,129.06 per month No security deposit	12/31/18	None as of July 17, 2017

Schedule 4.11(h)
Notice of Modification

None.

Schedule 4.11(i)
Encroachments

1. Encroachment of 2 story wood frame building over building setback line on Parcel IV.

2. Encroachment of 1 story wood frame building over building setback line on Parcel I.

3. Encroachment of 1 story masonry building over building setback line on Parcel II.

Schedule 4.11(j)
Third Party Rights

None.

Schedule 4.11(k)
Construction

1. The Connecticut Department of Public Health/Centers for Medicare and Medicaid Services determined that renovations performed at Pharmacy USP 797 took place without formal authorization. An action plan was submitted and subsequently accepted. The Hospital is awaiting installation of a pass-through door to finalize the pharmacy renovations. Once the door is installed, the contractor will contact the Connecticut Department of Public Health for approval.

Schedule 4.11(l)
Tenant Improvement

None.

Schedule 4.12
Condition of the Assets

1. The 20,000 gallon underground storage tank, as further described in Schedule 4.27(f), is nearing its "end-of-life" and must be replaced by 2018.
2. On March 13, 2017, a fire occurred at a maintenance barn that housed tractors and other equipment. None of the equipment inside the structure was materially harmed; however, the barn has a hole in the roof as a result from the fire. Quotes have been obtained to repair the barn, but repairs have not been commenced to date.

Schedule 4.13(a)
Benefit Plans

1. RCCH Healthcare Partners Health and Welfare Plan. This particular plan covers the following types of benefits:
    a. Medical and Dental
    b. Flexible Benefits (health and dependent care flexible spending arrangement)
    c. Life and Accidental Death and Dismemberment Plan
    d. Short-Term Disability Plan
    e. Long-Term Disability Plan
    f. Health Reimbursement Account
    g. Health Savings Account
    h. Voluntary Vision
    i. Voluntary Accident and Critical Illness Plans
2. RCCH Healthcare Partners Deferred Compensation Plan
3. Paid Time Off (Vacation)
4. RCCH Healthcare Partners 401(k) Plan
5. Tuition Reimbursement Program
6. Sharon Hospital Retiree Plan

Schedule 4.13(c)
ERISA

None.

Schedule 4.14
Litigation

Orders

1. Final Decision, Docket No. 01-486-01, by the State of Connecticut Office of the Attorney General, dated November 26, 2001, as amended by the Order, dated January 9, 2002, of the State of Connecticut Office of the Attorney General.

2. Final Decision, Docket No. 01-486-01, by the Office Of Health Care Access ("OHCA"), dated October 17, 2001, as amended by the Revised Final Decision, Docket No. 01-486-01R, by OHCA, dated December 14, 2001.

Potential/Threatened Litigation

Name	Claim Filed	Attorney	Progress/Status
Dr. Ari Namon	N/A	Jackson Lewis P.C.	Unfiled dispute regarding discourse between Dr. Namon and previous Hospital CEO. Settlement discussions in progress.
Nannette R. Pizzoni, Conservator of the Estate of Nicole R. Pizzoni	Connecticut Superior Court (Litchfield)	Deakin, Edwards & Clark LLP	Compliant filed August 11, 2016 regarding a medical malpractice claim against Dr. David Kurish, Essent Healthcare of Connecticut, Inc. and RegionalCare Hospital Partners, Inc.

Schedule 4.16
Tax Returns

None.

Schedule 4.16(a)
Tax Extensions

The tax extensions below relate to Essent Healthcare of Connecticut, Inc. and to Sharon Hospital Holding Company.

1. Tax Year 2016

   (a) Federal Form 1120, U.S. Corporation Income Tax Return
      (i) Extended to October 15, 2017

   (b) Connecticut Form CT-1120, Connecticut Business Tax Return
      (i) Extended to November 1, 2017

Schedule 4.16(b)
Tax Audits

State of Connecticut:

1. Essent Healthcare of Connecticut, Inc. - Sales Tax, April 1, 2011 through June 30, 2014.

Schedule 4.16(c)
Tax Partnerships

1. Essent Healthcare of Connecticut, Inc. holds the following ownership interest in Connecticut Hospital Laboratory Network, LLC. Ownership Percentage (as of September 30, 2016): 4.7619047%

2. Regional Healthcare Associates, LLC is treated as a S-corporation for federal and applicable state income tax purposes.

3. Tri State Women's Services, LLC is treated as a partnership for federal and applicable state income tax purposes.

Schedule 4.17(a)
Employees

Independent Contractor Physician/Physician Group Agreements

1. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and David Kurish, M.D., dated 08/01/2005
2. Professional Services Agreement (General Surgery) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Peter Reyelt, M.D., dated 08/18/2008
3. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
4. Medical Director Agreement by and between Essent Healthcare, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., dated 01/01/2010 (and Amendment to Medical Director Agreement and Release of Claims, dated 09/04/2012)
5. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 08/01/2005
6. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 02/01/2012
7. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Howard G. Mortman, M.D., dated 01/01/2011
8. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
9. Agreement for Radiology Department Coverage [Group Coverage] by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Hudson Valley Radiologists, P.C., dated 06/18/2015
10. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
11. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated 10/09/2014, as amended
12. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated 10/01/2006
13. Professional Services Agreement for On Call Coverage for Individual Physician by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Abdulmasih Zarif, M.D., dated 05/12/2016, as amended
14. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated 06/01/2016
15. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated 07/31/2015

16. Pathology Services Agreement by and between RCHP d/b/a Sharon Hospital and Consultants in Pathology, P.C., dated 01/01/2012
17. Lithotripsy Services Agreement by and between UMS Connecticut Lithotripsy, LP and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated 06/08/2006
18. Professional Services Agreement for Physician Group by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Associated Northwest Urology, PC, dated 05/02/2016
19. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Douglas A. Finch, M.D., dated September 30, 2016
20. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Lisa Haut, APRN, dated November 1, 2016
21. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Pamela Cipriano, APRN, dated November 9, 2016
22. Professional Services Agreement by and between Regional Healthcare Associates, LLC and I-Hsun Liang, M.D., dated January 16, 2017
23. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Amy Tocco, M.D., dated September 30, 2016
24. Agreement for Anesthesiology Department Coverage by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and North American Partners in Anesthesia (Connecticut), PC, dated January 30, 2017
25. Professional Services Agreement by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 05/01/2012
26. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Denis Tereb, M.D., dated May 27, 2016, as amended
27. Professional Services Agreement for On Call Coverage by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 01/01/2012, as assigned to Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
28. Billing and Collection Services Agreement by and between Women's Health Connecticut and Tri State Women's Services, dated 05/01/2012
29. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Suzanne Lefebvre, M.D., dated July 19, 2017
30. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated January 1, 2011

Other Clinical Agreements

1. Memorandum of Agreement for Organ/Tissue/Eye Procurement by and between Sharon Hospital and LifeChoice Donor Services, Inc., dated May 1, 2012.
2. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010

Supplies Agreements

1. Instrument Service Agreement by and between Trinity Biotech and Sharon Hospital, dated May 27, 2016
2. Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 8, 2008
3. Local Service Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 27, 2015
4. Equipment Lease Agreement by and between Tri State Women's Services and Physician's for Women's Health, dated 05/01/2012

Facilities Services

1. Transaction Schedule by and between Sharon Hospital and General Electronic Company, dated May 1, 2009
2. Contract Agreement by and between Connecticut Peer Review Organization d/b/a Qualidigm and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated February 1, 2016
3. Medicaid Eligibility Services Agreement by and between The Collection Bureau of Hudson Valley, Inc., Healthcare Billing Services, NY, Inc. and Sharon Hospital-RegionalCare Hospital Partners, dated January 6, 2012
4. Peak Performance Service Agreement No. PM114 by and between D & E Technologies and Sharon Hospital, dated January 1, 2016
5. Engagement Letter Agreement by and between Sharon Hospital and Updike, Kelly & Spellacy, PC, dated November 19, 2015
6. Services Agreement by and between Haytel Cardiac Services d/b/a Remote Cardiac Services and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated April 20, 2015
7. Rental Customer Order and Support Customer Order by and between CareFusion Solutions, LLC and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated January 11, 2016
8. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013
9. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
10. Pharmacy Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Cardinal Health Solutions, Inc., dated October 1, 2007
11. Cyracom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
12. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated April 1, 2014
13. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
14. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
15. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011

16. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
17. Service Solution Proposal by and between Tyco SimplexGrinnell and Sharon Hospital, dated 06/01/2014
18. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
19. Agreement by and between Essent Healthcare of Connecticut, Inc. dba Sharon Hospital and Agile Consulting Group, Inc., dated July 19, 2013
20. Masimo Pulse Oximetry Supply Agreement Deferred Equipment Purchase Plan by and between Masimo Americas, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated May 9, 2014
21. Business Electricity Authorization Connecticut Large Commercial Sales Standard Product Agreement by and between Essent Healthcare of CT dba Sharon Hospital and NextEra Energy Services, dated June 2, 2016
22. 2016 Environmental Compliance Master Services Agreement by and between Fuss & O'Neill and Sharon Hospital, dated January 15, 2016
23. Security Service Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Apollo Security International, Inc., dated May 1, 2016
24. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
25. Consulting Services Agreement by and between Sharon Hospital and Diamond Healthcare Corporation, dated March 8, 2017

IT Agreements

1. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
2. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
3. Grant Consulting Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and SpectraCorp Technologies Group Inc., dated July 8, 2013
4. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013
5. Support Agreement by and between Clinical Computer Systems, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated September 1, 2010
6. Master Agreement and Customer Order by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
7. EMR Agreement by and between Tri State Women's Services LLC and Women's Health Connecticut, Inc., dated May 1, 2012
8. Merchant Processing Application and Agreement by and between Tri State Women's Services LLC and First Data Merchant Services, dated 2012
9. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc.

d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016

10. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
11. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
12. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013
13. Service Agreement by and between MSDS Source and Sharon Hospital, dated December 1, 2004

Miscellaneous

1. Services Agreement by and between Sharon Hospital Holding Company and Regional Healthcare Associates, LLC, dated February 25, 2014
2. Services Agreement by and between Sharon Hospital Holding Company and Tri State Women's Services, LLC, dated October 1, 2014
3. There are no employees of Tri State Women's Services, LLC. All non-provider employees are employees of Sharon OBGYN or Physicians for Women's Health. All physicians are employees or independent contractors of Sharon OBGYN or Physicians for Women's Health

Schedule 4.17(b)
Employment Claims

None.

Schedule 4.17(c)(i)
Employment Contracts

1. Each of the Agreements listed in Schedule 4.17(a) is incorporated herein, except those Employment Agreements between RCHP Management Company, Inc. and individuals.
2. Agreement for Hospice General Inpatient Level Care in a Hospital by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Salisbury Visiting Nurse Association, Inc., dated July 1, 2016
3. Non-Exclusive Professional Services Agreement by and between Sharon Hospital and Sharon Healthcare, dated April 1, 2012
4. Non-Exclusive Professional Services Agreement by and between Sharon Hospital and Geer Nursing and Rehabilitation, dated April 1, 2012
5. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended
6. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and A. Martin Clark, Jr., M.D., dated 09/24/2012, as amended
7. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Kristin Newton, M.D., dated 07/06/2015
8. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Leonard Astrauskas, M.D., dated 10/08/2015, as amended
9. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Michelle Apiado, M.D., dated 07/22/2015
10. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and John Sussman, M.D., dated 04/01/2013
11. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Tracey Sheedy, PA, dated 02/09/2016
12. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Mark J. Marshall, D.O. dated September 30, 2016
13. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Jesse Cohen, M.D. dated October 4, 2016
14. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Brandy Stepney, APRN dated September 30, 2016
15. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Larry Atlas, APRN dated March 9, 2017
16. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Mustafa Ugurlu, M.D., dated October 24, 2016

Schedule 4.17(c)(ii)
Employment Loss

None.

Schedule 4.18
Material Contracts

(a)

Employment Agreements

1. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended
2. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and A. Martin Clark, Jr., M.D., dated 09/24/2012, as amended
3. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Kristin Newton, M.D., dated 07/06/2015
4. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Leonard Astrauskas, M.D., dated 10/08/2015, as amended
5. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Michelle Apiado, M.D., dated 07/22/2015
6. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Josh Sussman, M.D., dated 04/01/2013
7. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Tracey Sheedy, PA, dated 02/09/2016
8. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Mark J. Marshall, D.O. dated September 30, 2016
9. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Jesse Cohen, M.D. dated October 4, 2016
10. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Brandy Stepney, APRN dated September 30, 2016
11. Mid-Level Practitioner Employment Agreement by and between Regional Healthcare Associates, LLC and Larry Atlas, APRN dated March 9, 2017
12. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Mustafa Ugurlu, M.D., dated October 24, 2016

Independent Contractor Agreements

1. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and David Kurish, M.D., dated 08/01/2005
2. Professional Services Agreement (General Surgery) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Peter Reyelt, M.D., dated 08/18/2008
3. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
4. Hospital Professional Services Agreement (Diagnostic Test Interpretation Services) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 08/01/2005

5. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Howard G. Mortman, M.D., dated 01/01/2011
6. Medical Director Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Michael Parker, M.D., dated 02/01/2012
7. Medical Director Agreement by and between Essent Healthcare, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., dated 01/01/2010 (and Amendment to Medical Director Agreement and Release of Claims, dated 09/04/2012)
8. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated January 1, 2011
9. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
10. Agreement for Radiology Department Coverage [Group Coverage] by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Hudson Valley Radiologists, P.C., dated 06/18/2015
11. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
12. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated October 9, 2014, as amended
13. Nurse Midwife Lease Agreement by and between Essent Healthcare of CT, Inc. d/b/a Sharon Hospital and Physicians for Women's Health, LLC d/b/a Sharon Obstetrics & Gynecological Associates, dated October 1, 2006
14. Professional Services Agreement for On Call Coverage for Individual Physician by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Abdulmasih Zarif, M.D., dated 5/12/2016
15. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated June 1, 2016
16. Non-Exclusive Professional Services Agreement for Interpretations of Diagnostic Tests by and between Mountainside Treatment Center and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 8, 2016
17. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut, Inc., d/b/a Sharon Hospital, Tri-State, a division of Physicians for Women's Health and Bhavana Daruvuri, DO, dated July 31, 2015
18. Pathology Services Agreement by and between RCHP d/b/a Sharon Hospital and Consultants in Pathology, P.C., dated 01/01/2012
19. Lithotripsy Services Agreement by and between UMS Connecticut Lithotripsy, LP and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated 06/08/2006
20. Professional Services Agreement for Physician Group by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Associated Northwest Urology, PC, dated May 2, 2016
21. Professional Services Agreement by and between Tri State Women's Services LLC and Physicians for Women's Health, dated 05/01/2012

22. Professional Services Agreement for On Call Coverage by and between Tri State Women's Services LLC and Physicians for Women's Health, dated January 1, 2012, as assigned to Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital
23. Billing and Collection Services Agreement by and between Women's Health Connecticut and Tri State Women's Services, dated 05/01/2012
24. EMR Agreement by and between Tri State Women's Services LLC and Women's Health Connecticut, Inc., dated May 1, 2012
25. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016
26. Agreement for Hospice General Inpatient Level Care in a Hospital by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Salisbury Visiting Nurse Association, Inc., dated July 1, 2016
27. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Douglas A. Finch, M.D., dated September 30, 2016
28. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Lisa Haut, APRN, dated November 1, 2016
29. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Pamela Cipriano, APRN, dated November 9, 2016
30. Professional Services Agreement by and between Regional Healthcare Associates, LLC and I-Hsun Liang, M.D., dated January 16, 2017
31. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Amy Tocco, M.D., dated September 30, 2016
32. Agreement for Anesthesiology Department Coverage by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and North American Partners in Anesthesia (Connecticut), PC, dated January 30, 2017
33. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Denis Tereb, M.D., dated May 27, 2016, as amended
34. Professional Services Agreement by and between Regional Healthcare Associates, LLC and Suzanne Lefebvre, M.D., dated July 19, 2017

Lease Agreements

1. Office Lease Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Saint Francis Medical Group, Inc., dated 04/18/2014
2. Medical Office Lease Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Torrington Winsted Pediatric Associates, P.C., dated 12/07/2015
3. Lease Agreement between Essent Healthcare of Connecticut d/b/a Sharon Hospital and David R. Kurish, M.D., dated 1/28/2009
4. Physician Space Occupancy Agreement (Suite 1900) by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Westwood Ear Nose & Throat, P.C., dated 10/02/2013

5. Lease Agreement by and between Essent Healthcare of Connecticut and Litchfield County Gastroenterology Associates, LLC, dated 11/01/2008, as assigned to Connecticut GI, P.C.
6. Connecticut Residential Lease Agreement by and between Essent Healthcare of Connecticut and Anu Properties, dated 10/27/2008
7. Physician Space Occupancy Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Arthritis and Allergy Associates P.C., dated 06/01/2013
8. Timeshare Lease Agreement by and between Tri State Women's Services, LLC and Bruce Janelli, M.D., dated 08/01/2012
9. Physician Space Lease Occupancy Agreement by and between Tri State Women's Services, LLC and Orlito Trias, M.D., dated 11/01/2015
10. Lease Agreement by and between Winsted Health Center, Inc. and Tri State Women's Services, LLC, dated 9/1/2013
11. Equipment Lease Agreement by and between Tri State Women's Services and Physician's for Women's Health, dated 05/01/2012
12. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and Candlewood Properties, LLC dated 05/05/2016
13. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and ANU Properties, LLC dated 05/05/2016
14. Lease by and between Tri State Women's Services and Sharon Medical Office Building, dated 05/31/2012
15. Commercial Lease by and between Regional Health Care Associates, LLC and Kenmil Realty LLC, dated 08/01/2016

(b)

1. Contract by and between Sharon Hospital and Torrington Area Health District, dated July 14, 2015
2. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
3. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013
4. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
5. Cyracom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
6. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated April 1, 2014
7. Proposal by and between Sharon Hospital and Upcountry Services of Sharon, Inc., dated November 1, 2014
8. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011
9. Master Lease Agreement (Quasi) by and between Essent Healthcare of Connecticut, Inc. and General Electric Capital Corporation, dated January 29, 2013, including all related schedules
10. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011

11. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
12. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
13. Grant Consulting Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and SpectraCorp Technologies Group Inc., dated July 8, 2013
14. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013
15. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010
16. Physician Recruitment Agreement by and between Essent Healthcare of Connecticut d/b/a Sharon Hospital and Bhavana Daruvuri, D.O., dated October 1, 2015
17. Local Service Agreement by and between Unitex Textile Rental Services and Sharon Hospital, dated May 27, 2015
18. Support Agreement by and between Clinical Computer Systems, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated September 1, 2010
19. Service Solution Proposal by and between Tyco SimplexGrinnell and Sharon Hospital, dated 06/01/2014
20. Consulting Services Agreement by and between Sharon Hospital and Diamond Healthcare Corporation, dated March 8, 2017
21. Service Agreement by and between MSDS Source and Sharon Hospital, dated December 1, 2004

(c)

Managed Care Agreements

1. Hospital Services Agreement by and between Aetna Health Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated April 1, 2014, as amended.
2. Facility Agreement by and between Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield and Sharon Hospital Inc., dated August 1, 2013, as amended.
3. Hospital Managed Care Agreement by and between CIGNA Healthcare of Connecticut, Inc. and Sharon Hospital, dated September 1, 1999, as amended.
4. Hospital Agreement by and between ConnectiCare Inc. and Essent-Sharon Hospital, dated April 1, 2008, as amended.
5. Facility Agreement by and between Empire HealthChoice HMO, Inc. d/b/a Empire BlueCross BlueShield HMO and Empire HealthChoice Assurance, Inc. d/b/a Empire BlueCross BlueShield and Sharon Hospital, dated November 1, 2014, as amended.
6. Standard Hospital Provider Agreement 2.0 by and between New York State Catholic Health Plan, Inc. d/b/a Fidelis Care New York and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated December 17, 2012, as amended.
7. Hospital Agreement by and between MVP Health Plan, Inc., MVP Health Services Corp., MVPHP PA, Inc. and MVP Select Care, Inc. and Sharon Hospital, dated January 1, 1999, as amended.

8. Facility Participation Agreement by and between UnitedHealthcare Insurance Company and Essent Healthcare of Connecticut Inc., dba Sharon Hospital, dated June 1, 2009, as amended.

(d)

1. Master Agreement and Customer Order by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
2. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
3. Services Agreement by and between Sharon Hospital Holding Company and Regional Healthcare Associates, LLC, dated February 25, 2014
4. Services Agreement by and between Sharon Hospital Holding Company and Tri State Women's Services, LLC, dated October 1, 2014
5. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
6. Security Service Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Allied Universal Security Services f/k/a Apollo Security International, Inc., dated May 1, 2016
7. 2016 Environmental Compliance Master Services Agreement by and between Fuss & O'Neill and Sharon Hospital, dated January 15, 2016
8. Business Electricity Authorization Connecticut Large Commercial Sales Standard Product Agreement by and between Essent Healthcare of CT dba Sharon Hospital and NextEra Energy Services, dated June 2, 2016
9. Product Sale Agreement by and between Sharon Hospital and Airgas East, Inc., dated July 13, 2011
10. Agreement by and between Essent Healthcare of Connecticut, Inc. dba Sharon Hospital and Agile Consulting Group, Inc., dated July 19, 2013
11. Masimo Pulse Oximetry Supply Agreement Deferred Equipment Purchase Plan by and between Masimo Americas, Inc. and Essent Healthcare of Connecticut d/b/a Sharon Hospital, dated May 9, 2014
12. Engagement Letter Agreement by and between Sharon Hospital and Updike, Kelly & Spellacy, PC, dated November 19, 2015
13. Medicaid Eligibility Services Agreement by and between Sharon Hospital - RegionalCare Hospital Partners and The Collection Bureau Hudson Valley and Healthcare Billing Services, NY, Inc., dated January 6, 2012
14. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
15. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
16. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013
17. Annual Plan by and between One Eleven Group and Sharon Hospital, dated January 3, 2017

Schedule 4.19(d)
Assumed Contract Consents

Real Estate Leases:

1. Connecticut Residential Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Anu Properties Corp., dated July 15, 2012, as amended by First Amendment dated April 21, 2014, and further amended by Second Amendment dated June 29, 2015
2. Commercial Lease by and between Regional Healthcare Associates, LLC and Kenmil Realty LLC, dated 08/01/2016
3. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and Candlewood Properties, LLC dated 05/05/2016
4. Medical Office Lease Agreement by and between Regional Healthcare Associates, LLC and ANU Properties, LLC dated 05/05/2016

Material Contracts:

1. Healthcare Management Services Agreement by and between Sharon Hospital and Aramark Healthcare Support Services, Inc., dated October 1, 2004
2. Support and Maintenance Agreement by and between Sharon Hospital and Merge Healthcare, dated July 15, 2012
3. Maintenance Contract by and between Sharon Hospital and Otis Elevator Company, dated May 1, 2013, as amended by that certain Addendum to Contract by and between Sharon Hospital and Otis Elevator Company, dated July 1, 2015
4. Lease Agreement # 234103 by and between Sharon Hospital and Johnson & Johnson Finance Corporation, dated July 12, 2012
5. Proposal by and between Sharon Hospital and SimplexGrinnell LP, dated June 1, 2014
6. Pharmacy Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Cardinal Health Solutions, Inc., dated October 1, 2007, as amended
7. CyraCom International Service Agreement by and between Sharon Hospital and CyraCom International, Inc., dated February 19, 2007
8. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Haytel Cardiac Services, Inc., d/b/a Remote Cardiac Services, dated 4/9/15
9. Master Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and CareFusion Solutions, LLC, dated March 30, 2015
10. Master Lease Agreement by and between Essent Healthcare of Connecticut, Inc. and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
11. Print Management Agreement by and between Sharon Hospital and Konica Minolta Business Solutions U.S.A., Inc., dated January 31, 2011
12. Order Form and Terms and Conditions by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and ChimeNet, Inc., dated April 14, 2015
13. Amendment to the Support Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Clinical Computer Systems, Inc., dated September 1, 2014
14. Dell Cloud Clinical Archive Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Dell Marketing, L.P., dated July 9, 2013

15. Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and EmCare, Inc., dated October 9, 2014, as amended
16. Master Lease Agreement (Quasi) by and between Essent Healthcare of Connecticut, Inc. and General Electric Capital Corporation, dated January 29, 2013, including all related schedules
17. Clinical Wound Care with Hyperbaric Oxygen Therapy Management and Support Services Agreement by and between Essent Healthcare of CT Inc. dba Sharon Hospital and Diversified Clinical Services, Inc., dated October 27, 2010
18. Charge Description Master Maintenance Services by and between Essent Healthcare and The Wellington Group, LLC, dated September 1, 2006
19. Professional Services Agreement (Supplemental Call Coverage) by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and New Milford Orthopedics, dated January 1, 2011
20. Comprehensive Gastroenterology Call Coverage Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Connecticut GI, P.C., dated 09/25/2015
21. Professional Services Agreement for Travel Clinic Services by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Douglas A. Finch, M.D., LLC, dated 01/01/2010
22. Telestroke Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital and Yale-New Haven Health System, dated 01/01/2014
23. Memorandum of Agreement for Organ/Tissue/Eye Procurement by and between Sharon Hospital and LifeChoice Donor Services, Inc., dated 05/01/2012
24. Physician Employment Agreement by and between Regional Healthcare Associates, LLC and Joseph Catania, M.D., dated 10/17/2008, as amended
25. Each of the Managed Care Contracts listed on Schedule 4.18(c) is incorporated herein.
26. Professional Services Agreement by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, Regional Healthcare Associates, LLC and Onsite Neonatal, P.C., dated June 1, 2016
27. Non-Exclusive Professional Services Agreement for Interpretations of Diagnostic Tests by and between Mountainside Treatment Center and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 8, 2016
28. meridianEMR, EMR Software License, Hardware Purchase and Business Services Agreement by and between Associated Northwest Urology and IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, dated August 20, 2008 as assigned by that certain Assignment and Assumption Agreement by and between IntrinsiQ Specialty Solutions, Inc. d/b/a IntrinsiQ Software, Associated Northwest Urology and Regional Healthcare Associates, LLC, dated August 23, 2016
29. Agreement by and between Essent Healthcare d/b/a Sharon Hospital and UpToDate, Inc., dated July 7, 2016
30. Application Service Provider Agreement by and between Standing Stone Inc. and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, dated May 31, 2011
31. Maintenance Agreement and Service Agreement Terms and Conditions by and between Hologic, Inc. and Sharon Hospital, dated July 3, 2013

Schedule 4.19(e)
Assignment Penalties

None.

Schedule 4.21
Insurance

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
Combined Specialty; 02-877-91-90	12/3/2016-12/3/2017	$32,000,000	D&O: $150,000 Employment Practices: $150,000 Fiduciary: $0 Employed Lawyers: $10,000 All Crimes: $50,000	National Union Fire Ins. Co. of Pittsburg	AON
Excess D&O; 1000057537161	12/3/2016-12/3/2017	$10,000,000; excess of $10,000,000	N/A	Starr Indemnity & Liability Company	AON
Excess D&O; G25543440 002	12/3/2016-12/3/2017	$10,000,000; excess of $20,000,000	N/A	Chubb	AON
Excess D&O; DOX10009086401	12/3/2016-12/3/2017	$10,000,000; excess of $30,000,000	N/A	Endurance Risk Solutions Assurance Co.	AON
D&O - Excess Side A; EPG0016257	12/3/2016-12/3/2017	$10,000,000; excess of $40,000,000	N/A	RLI Insurance Company	AON
Special Crime; UKA3009239.16	12/3/2016-12/3/2017	Control Risks Fees and Expenses: Unlimited Per Insured Event: $1,250,000 Ransom, Transit, Additional Expenses, Legal Liability: $1,000,000 Personal Accident-Per Person: $250,000	N/A	Hiscox Insurance Company	AON
Automobile; BAP582254403	10/1/2016-10/1/2017	$1,000,000 per Accident	$1,000 Comprehensive $1,000 Collision	Zurich American Insurance Co.	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
Non-Owned Aircraft Liability; BA-15-10-0073	10/1/2016-10/1/2017	$10,000,000 Combined Single Limit Bodily Injury and Property Damage Liability $10,000,000 Personal Injury Liability Each Offense and in the Aggregate $10,000,000 Aviation Premises Liability Each Occurrence $25,000 Medical Expense Any One Person	$0	StarNet Insurance Co.	Willis
Healthcare Umbrella Liability; EN017833	10/1/2016-10/1/2017	$25,000,000 Specific Loss Unit $25,000,000 Aggregate $25,000,000 Professional Liability Aggregate Limit	Professional Liability - $2,000,000 Each Medical Incident SIR General Liability and EBL - $2,000,000 Occurrence SIR Retained Limit all other coverages - $100,000	National Fire & Marine/MedPro Group	Willis
Excess Healthcare Liability; BM00030264LI16A	10/1/2016-10/1/2017	$25,000,000 Per Medical Incident/Aggregate Excess of $25,000,000 $2,000,000 SIR	N/A	XL Bermuda, Ltd.	Willis
Excess Healthcare Liability; C033183/001	10/1/2016-10/1/2017	$25,000,000 Each Occurrence/Aggregate Excess of $50,000,000 $2,000,000 SIR	N/A	AWAC	Willis
Pollution Liability; PPIG28170397	10/1/2016-10/1/2017	$20,000,000 Each Pollution Condition or Indoor Environmental Condition	$25,000 per Pollution Condition; 3 days Deductible for BI Loss	Illinois Union Ins. Co./Chubb	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
		$21,000,000 Aggregate	$25,000 Applies to 9 UST's $100,000 Applies to 5 UST's $250,000 Applies to 1 UST		
Property; GM863	10/1/2016-10/1/2017	$500,000,000 - Buildings, Personal Property, Business Income Limit	$100,000 Deductible All other Perils Other deductibles apply for Flood, EQ and Named Storm	Affiliated FM	Willis
Workers Compensation; WC583354504	10/1/2016-10/1/2017	Workers Compensation - Statutory Bodily Injury by Accident: $1,000,000 per accident Each Employee Bodily Injury by Disease: $1.,000,000 Policy Limit, Bodily Injury by Disease: $1,000,000	$500,000 Per Occurrence $4,423,000 Estimated Annual Deductible Aggregate	American Zurich Insurance Co.	Willis
Privacy and Network Liability (Cyber); 0310-1202	4/29/2017-4/29/2018	$10,000,000 Privacy, Network Security or Media Wrongful Acts $10,000,000 Breach Consultant Services $10,000,000 Breach Response Services Coverage $10,000,000 Supplemental Privacy Coverage	$250,000 N/A Breach Consultant Services	Allied World Assurance Company (U.S.), Inc.	Willis

Description; Policy No.	Term	Limits	Deductible	Insurance Company	Agency
		$10,000,000 Policy Aggregate			
1st Excess Privacy and Network Liability (Cyber); MTE 9033485	4/29/2017-4/29/2018	$10,000,000 Aggregate Limit of Liability Excess of $10,000,000	N/A	Indian Harbor Ins. Co.	Willis
2nd Excess Privacy and Network Liability (Cyber); EO5NABAX8P001	4/29/2017-4/29/2018	$10,000,000 Aggregate Limit of Liability Excess of $20,000,000	N/A	Liberty Surplus Insurance Corp.	Willis
3rd Excess Privacy and Network Liability (Cyber); SPR0298226-00	4/29/2017-4/29/2018	$10,000,000 Aggregate Limit of Liability Excess of $30,000,000	N/A	Zurich/Steadfast Insurance Co.	Willis

Schedule 4.22
Cost Reports

	FYE		Status	NOPR Date	Filed	Finalized	Reopening NOPR Date	Reopening Settlement
Medicare								
	9/30/2013		Audited	6/16/2015	2/28/2014	6/16/2015	N/A	N/A
	9/30/2014		Audited	3/3/2017	2/28/2015	3/3/2017	N/A	N/A
	9/30/2015		Filed	N/A	2/29/2016	N/A	N/A	N/A
	9/30/2016		Filed	N/A	2/28/2017	N/A	N/A	N/A
Medicaid								
	9/30/2013		Audited	7/2/2015	2/28/2014	N/A	N/A	N/A
	9/30/2014		Audited	2/28/2015	N/A	N/A	N/A	N/A
	9/30/2015		Filed	N/A	6/30/2016	N/A	N/A	N/A
	9/30/2016		N/A - no longer required by Medicaid					

Schedule 4.23
Medical Staff Matters

None.

Schedule 4.25
Compliance Program

(a) None.

(b) None.

(c) None.

(d) None.

Schedule 4.26
Environmental Matters

The specific matters set forth below in Schedules 4.26(a) through 4.26(j) as more fully described in the following reports.

1. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 2016 (including all reports contained or referenced therein) ("Document 1"). (Provided by Buyer.)

2. *Phase I Environmental Site Assessment, 1 and 3 Low Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 2016 (including all reports contained or referenced therein) ("Document 2"). (Provided by Buyer.)

3. *Limited Environmental Compliance Review, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated July 20, 2016 (including all reports contained or referenced therein) ("Document 3"). (Provided by Buyer.)

4. *Limited Environmental Compliance Review, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by RPS GaiaTech, dated August 10, 2016 (including all reports contained or referenced therein) ("Document 4"). (Provided by Buyer.)

5. *Asbestos Sampling Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated May 10, 2012 (including all reports contained or referenced therein) ("Document 5"). (Provided in Data Room.)

6. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated July 22, 2011 (including all reports contained or referenced therein) ("Document 6"). (Provided in Data Room; Included in Document 1.)

7. *Interim Remedial Action Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by Berkshire Environmental Services & Technology, LLC, dated June 19, 2009 (including all reports contained or referenced therein) ("Document 7"). (Included in Document 1.)

8. *Phase I Environmental Site Assessment, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Paratus Group, LLC, dated December 7, 2006 (including all reports contained or referenced therein) ("Document 8"). (Provided in Data Room; Included in Document 1.)

9. *Quarterly Groundwater Monitoring Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by ATC Associates, Inc. for The Paratus Group, LLC, dated June 5, 2006 (Paratus cover letter dated June 7, 2006) (including all reports

contained or referenced therein) ("Document 9"). (Provided in Data Room; Included in Document 1.)

10. *Environmental Review of Four Hospitals of Essent Healthcare, Inc.* (relating to Sharon Hospital, Sharon, Connecticut), prepared by Environ International Corporation, dated October 2004 (including all reports contained or referenced therein) ("Document 10"). (Provided in Data Room; Included in Document 1.)

11. *Groundwater Monitoring Well Installation and Sampling Report, Sharon Hospital, 50 Hospital Hill Road, Sharon, Connecticut*, prepared by The Nicks Group, Inc., dated March 15, 2004 (including all reports contained or referenced therein) ("Document 11"). (Included in Document 1.)

(a) Noncompliance; Permits and Governmental Authorizations

1. The specific interior and exterior spills and releases involving petroleum and chemicals described in Document 1, pages ii, iii, iv, 8, 9, 11, 13, 14, 15, 16-17, 18, 19, 20, 21, 22, 24, 25, 31, 32, 36, 37 and Document 10, page II-2.
2. The specific historical on-site UST related release incidents described in Document 1, pages iii, 17, 18, 19, 20, 21, 22, 24, 25, 36; Document 9, pages 1-4, figures, table, and appendix; Document 10, pages II-2, V-3, V-5, V-7, V-8, V-9; and Document 11, pages 1-13.
3. Potential for impact to on-site stormwater pathways specifically described in Document 1, pages iv, 9, 17, 31, 36-37 and Document 10, pages II-4
4. Historical on-site waste incinerator. (*See* Document 1, pages iv, 9, 12, 33, 35, 37.)
5. A minor quantity of petroleum contaminated soil was left in place at 50 Hospital Hill Road, Sharon, Connecticut after removal of an underground storage tank due to proximity to a building foundation. (*See* Document 6, pages 4, 32, 36; Document 7, pages 1-14, figures, tables, and appendices; Document 8, pages 3, 24, 27, 28; Document 10, pages II-2, V-3, V-8; and Document 11, pages 1-13 for more details.)

(b) Materials of Environmental Concern on the Properties

1. A minor quantity of petroleum contaminated soil was left in place at 50 Hospital Hill Road, Sharon, Connecticut after removal of an underground storage tank due to its proximity to a building foundation. (*See* Document 6, pages 4, 32, 36; Document 7, pages 1-14, figures, tables, and appendices; Document 8, pages 3, 24, 27, 28; Document 10, pages II-2, V-3, V-8; and Document 11, pages 1-13 for more details.)

(c) Pending or Threatened Environmental Claims

None.

(d) Materials of Environmental Concern at Off-Site Locations

1. In 1999, Sharon was identified as a potentially responsible party for the Amenia Town Landfill. In 2002, Sharon paid $340,000 and entered into a settlement agreement to resolve its liability for this matter. (*See* Document 4, page 8; Document 10, pages II-5, VII-7.)

(e) Liability or Obligations of Third Parties

None.

(f)(i) Underground Storage Tanks

The following underground storage tanks are present on the property at 50 Hospital Hill Road, Sharon Connecticut:

1. Location: Sharon Hospital
   - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
   - Tank ID #: UG-1
   - Tank Size: 20,000
   - Tank Type: UST
   - Construction: Steel
   - Contents: Fuel Oil
   - Install Date: 1988
   - Retro Date: N/A
   - Leak Detection: CPIC
   - Overfill Protection: None
   - Spill Containment: None
   - AST Diking: N/A
   - AST Base Const.: N/A
   - Piping Const.: DW
   - Piping Leak Det.: None

2. Location: Sharon Hospital
   - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
   - Tank ID #: UG-2
   - Tank Size: 10,000
   - Tank Type: UST
   - Construction: Fiberglass
   - Contents: Kerosene/Diesel
   - Install Date: 1994
   - Retro Date: N/A
   - Leak Detection: IM
   - Overfill Protection: AL
   - Spill Containment: None

- AST Diking: N/A
- AST Base Const.: N/A
- Piping Const.: DW
- Piping Leak Det.: None

3. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: Not Issued
    - Tank Size: 1,950
    - Tank Type: UST
    - Construction: Steel
    - Contents: Propane
    - Install Date: 2006
    - Retro Date: N/A
    - Leak Detection: None
    - Overfill Protection: None
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A
    - Piping Const.: N/A
    - Piping Leak Det.: N/A

4. Location: Sharon Hospital
    - Address: 50 Hospital Hill Road, P.O. Box 789, Sharon, CT 06069
    - Tank ID #: Not Issued
    - Tank Size: 1,000
    - Tank Type: UST
    - Construction: Steel
    - Contents: Propane
    - Install Date: 1994
    - Retro Date: N/A
    - Leak Detection: None
    - Overfill Protection: None
    - Spill Containment: None
    - AST Diking: N/A
    - AST Base Const.: N/A
    - Piping Const.: N/A
    - Piping Leak Det.: N/A

(f)(ii) Asbestos-Containing Materials

1. Potential asbestos in buildings on site. (*See* Document 1, page 21; Document 2, pages ii, 3, 14, 15; Document 3, pages 3, 14-15; Document 4, pages 2, 13-14; Document 5, pages

1-8, appendices A - D; Document 6, pages 4, 33, 36; Document 8, pages 3, 25, 27, 28; Document 10, pages II-6, VII-11, VII-34.)

(f)(iii) Polychlorinated Biphenyls (PCBs)

1. Hazardous wastes generated at the site have included PCB-containing wastes. (*See* Document 1, page 15; Document 10, pages V-3, VII-11, VII-12.)
2. Pad-mounted or other transformers. (*See* Document 1, page 35; Document 2, page 14; Document 3, page 15; Document 4, page 14; Document 6, pages 31, 35; Document 8, pages 23, 27; Document 10, page VII-35.)

(g) Properties Encumbered Under Environmental Laws

None.

(h) Noncompliance with Medical Waste Laws

None.

(i) Environmental Reports Not Provided

1. *Phase I Environmental Site Assessment*, prepared by The Nicks Group, Inc., August 2002. (Referred to in Document 1, page 17; Document 10, pages I-3, V-2, but not in the possession, custody or control of Sellers.)
2. *Groundwater* Monitoring Reports, beginning after March 15, 2004. (Referred to in Document 1, page 17; Document 10, page 13, but not in the possession, custody or control of Sellers.)

(j) Connecticut Transfer Act

1. To the extent applicable to the transaction covered by the Agreement, Sharon shall file the appropriate Property Transfer Form (with all applicable accompanying forms) with the Connecticut Department of Energy & Environmental Protection following Closing in accordance with the Connecticut Transfer Act.

Schedule 4.27(a)
Owned Intellectual Property

Mark	Goods/Services	Registration Number & Registration Date
	Healthcare	Registration No. 4981620; Registration Date: June 21, 2016

Trade Names

Sharon Hospital (Town of Sharon, Connecticut)

Domain Names

http://sharonhospital.com/

Schedule 4.27(b)
Other Intellectual Property

No.	Solution/Application	Service Provided
1.	3M	Clinical Documentation Improvement
		CPT Lookup
		ICD-9 Lookup
		MS-DRG Lookup & Grouping
		OP Coding
		RCS Medicare
2.	Abbott	Lab POC
3.	Acmeware, Inc	Meaningful Use Metrics
		Report Writing
4.	ADP HRB	HR - Benefits
5.	Agilum	ERP Reporting
6.	Animas Corporation	Lab POC
7.	AthenaHealth	Practice Management & EHR
8.	Cadwell	EEG
		Sleep Study
9.	CCSI	Fetal Monitoring System/Perinatal Documentation
10.	Checkpoint Software Technologies	Firewall
11.	Clinicalpharmacology.com	Pharmacy Drug Interactions
12.	Datacard Corporation	Employee Badge ID System
13.	DCS Global - AuditLogix	Insurance Eligibility Verification
		Insurance Verification/Medical Necessity
14.	Dell	Offsite Image Archive
15.	DigitalTechnology LLC	Pathology dictation/transcription
16.	Dr. First	ePrescribing
17.	eClinicalWorks	SAAS Interface Engine
18.	ElSevier	Emergency Department Discharge Instructions
19.	EVS Guard	Maternity Security - video cameras
20.	Forward Advantage	Meditech Outbound Interface
21.	GE	Cardiology ECG
		Holter Monitor system
		Stress Test monitor
22.	HealthLine Systems, Inc	Credentialing
23.	HealthStream	Employee Education & Certification
24.	Hologic	Mammography Diagnostic Viewing Station
25.	HUGS	Infant Security
26.	Intelligent Medical Objects	Nomenclature Mapping
27.	Interbit Data	Faxing Software
28.	Johnson Controls	Temperature/AC Controls

No.	Solution/Application	Service Provided
29.	KRONOS	HR - Time and Attendance
30.	LabCorp	Reference Lab
31.	Maintenance Connection	Work Order & Maintenance Management System
32.	McKesson	Case Management
		Nurse Scheduling
33.	MedAllies	Practice Management & EHR
		Transition of Care
34.	Meditech	Accounts Payable
		Admission/Registration
		Billing Accounts Receivable
		Budgeting & Forecasting
		Case Mix Abstracting
		Data Repository
		EDIS
		Executive Support System
		General Ledger
		HRIS - HR & Payroll
		Lab (LIS)
		Lab Anatomic Pathology
		Lab Blood Bank
		Lab Microbiology
		Materials Management
		Medical Records
		Nursing Documentation
		Order Entry
		Pharmacy
		Pharmacy-Bedside Med Admin
		Physician Care Manager
		Physician Documentation
		Radiology (RIS)
		Scheduling & Referral Management
35.	Meditech/paper	Surgery Documentation
		Surgery Scheduling
36.	Merge (AMICAS)	PACS
37.	Micromedex	ED Discharge Instructions
		Patient Education
38.	Milt	Medication packaging system
		Pharmacy Labeling system
39.	Morgan Scientific	Pulmonary Function Testing
40.	MRS	Mammography Reporting System
41.	Nuance	Dictation/Transcription
42.	Occurrence Insight	Incident Reporting system

No.	Solution/Application	Service Provided
43.	Optum LYNX (ePoint)	ED Coding/Leveling
44.	Perceptive Lexmark (ImageNow)	Patient Scanning & Archiving System
45.	PrecisionWeb	QC for Abbott POC
46.	Press Ganey	Patient Satisfaction
47.	Provider Trust	Background checking website
48.	Pyxis	Pharmacy Dispense
49.	Quest	Lab Reference Lab
50.	RelayHealth	Patient Portal
51.	RepTrax	Vendor Credentialing & Badge Printing
52.	Sage	Fixed Assets
53.	SAI Global	Contract Management
54.	Sentri7	Clinical Surveillance, RPH documentation
		Infection Control
		Pharmacy Decision Support and Surveillance
55.	Sonic Wall	Guest wireless content filtering and support
56.	Sorna	Imaging CD Burner
		Radiology CD burner
57.	SpaceLabs	Automatic BP cuff
58.	Standing Stone	Coumadin clinic
59.	Symantec	A/V & Malware Protection
60.	The Advisory Board	Crimson Quality Management
61.	The SSI Group	Claim Scrubbing
62.	TrackVia	Investigation Tracking system
63.	Truven Health Analytics	Core Measures
64.	Uptodate	Clinical Decision Support
65.	UtiliPro	HR and Payroll
66.	Vitrea	CT 3D Reconstruction
67.	Whitecloud	Analytics Solution
68.	Wolters Kluwer	Pharmacy Formulary Content
69.	Women's Health	Practice Management & EHR
70.	Xeleris	Stress Test - nuclear medicine

Schedule 4.27(d)
Patents, Copyrights and Trademarks

None.

Schedule 4.29
Sellers' Brokers

None.

Schedule 4.30
Sellers' Knowledge

Name	Organization	Title
Peter Cordeau	Sharon Hospital	Chief Executive Officer
Christian Bergeron	Sharon Hospital	Chief Financial Officer
Cliff Hedges	Sharon Hospital	Ethics and Compliance Officer
Lori Puff	Sharon Hospital	Chief Nursing Officer
Martin Rash	RegionalCare Hospital Partners, Inc.	Chairman and Chief Executive Officer
Michael Browder	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Financial Officer
Rob Jay	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Operating Officer
Howard Wall	RegionalCare Hospital Partners, Inc.	Executive Vice President, Chief Administrative Officer, General Counsel and Secretary

Schedule 5.2(b)
Buyer Required Consents

Refer to matters set forth on Schedule 8.1(a).

Schedule 5.5
Buyer's Brokers

1. Cain Brothers.

Schedule 6.4(j)
Sellers' Negative Covenants

Peter Cordeau	Sharon Hospital	Chief Executive Officer
Christian Bergeron	Sharon Hospital	Chief Financial Officer
Cliff Hedges	Sharon Hospital	Ethics and Compliance Officer
Lori Puff	Sharon Hospital	Chief Nursing Officer

Schedule 8.1
Governmental Approvals

(a)

1. Certificate of Need Review/Hospital Transfer of Ownership – Office of Health Care Access (Conn. Gen. Stat. § 19a-630 et seq.)

2. Certificate of Need Review/Large Group Practice Transfer of Ownership – Office of Health Care Access (Conn. Gen. Stat. § 19a-630 et seq.)

3. Acute Care General Hospital Licensure – Department of Public Health (Conn. Gen. Stat. § 19a-493)

4. Public Health Laboratory License(s) – Department of Public Health (Conn. Gen. Stat. §19a-30)

5. Blood Collection Facility License(s) – Department of Public Health (Conn. Gen. Stat.§19a-30)

6. Office of Attorney General and Department of Public Health Group Practice Notifications (Conn. Gen. Stat. § 19a-486i).

7. Office of Attorney General Hospital System Affiliation Notification (Conn. Gen. Stat. § 19a-486i).

(b)

1. Acute Care General Hospital Licensure – Department of Public Health (Conn. Gen. Stat. § 19a-493)

Schedule 8.6
Material Contract Consents

None.

Exhibit A

Facility List

Owned Property

1. Medical Arts Center located at 29 Hospital Hill Rd, Sharon, Connecticut 06069.

2. Community Health Building located at 1 Low Rd (with accompanying Thrift Shop at 3 Low Rd), Sharon, Connecticut 06069, used for community outreach.

3. Building used for Hospital storage located at 33 Hospital Hill Rd, Sharon, Connecticut.

Leased Property

1. Kent Primary Care located at 64 Maple Street, Kent, Connecticut 06757.

2. Time share office space at 75 Church Street, Canaan, Connecticut.

3. Time share office space at 9 Aspetuck Avenue, New Milford, Connecticut.

4. New Milford OB/GYN located at 2 Old Park Lane, New Milford, Connecticut 06776.

5. Associated Northwest Urology and apartment for on-call staff located at 17 Hospital Hill Road, Sharon Connecticut.

6. Winstead Health Center located at 115 Spencer Street, Winsted, Connecticut.

7. Tri State Women's Services located at 50 Amenia Road, Sharon, Connecticut.

8. Associated Northwest Urology located at 120 Park Lane Road, New Milford, Connecticut

ESCROW AGREEMENT

This Escrow Agreement (this "**Agreement**"), dated as of July 31, 2017 (to be effective as of 12:01 a.m. on August 1, 2017 (the "**Effective Date**")), is made and entered into by and among **Health Quest Systems, Inc.**, a New York non-profit corporation, not individually but solely in its capacity as representative of the Buyer (as defined below) (the "**Buyer Representative**"), RegionalCare Hospital Partners, Inc., a Delaware corporation, not individually but solely in its capacity as representative of the Sellers (as defined below) (the "**Seller Representative**"), and **Wells Fargo Bank, National Association**, a national banking association, as escrow agent (the "**Escrow Agent**"). The Buyer Representative and the Seller Representative are referred to collectively herein as the "**Parties**" and each individually as a "**Party**."

WITNESSETH:

WHEREAS, Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), and Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**" and together with Sharon, SHHC, and RHA, the "**Sellers**"), the Buyer Representative, Vassar Health Connecticut, Inc., a Connecticut non-profit corporation ("**VHC**" and together with the Buyer Representative, the "**Buyer**"), and the Seller Representative, solely for the purposes of Sections 13.32 and 13.33 of the Purchase Agreement, entered into that certain Asset Purchase Agreement dated as of September 13, 2016 (the "**Purchase Agreement**"), pursuant to which Buyer agreed to purchase from the Sellers substantially all of the assets, real and personal, tangible and intangible, constituting the Facilities (as defined in the Purchase Agreement) and assume the Assumed Liabilities (as defined in the Purchase Agreement), subject to the terms and conditions set forth in the Purchase Agreement;

WHEREAS, pursuant to Section 2.5 of the Purchase Agreement, the Parties have agreed that the Buyer Representative shall deliver Five Hundred Thousand Dollars ($500,000) (the "**Escrow Amount**") to the Escrow Agent on the date of this Agreement pursuant to the terms of this Agreement, which Escrow Amount shall be held in an account deemed the "**Escrow Account**";

WHEREAS, the Parties desire to engage the Escrow Agent so that the Escrow Amount can be held, invested, administered and distributed by the Escrow Agent, all in accordance with the terms set forth in this Agreement;

WHEREAS, the Parties desire that the Escrow Agent serve as escrow agent on the terms and conditions provided in this Agreement;

WHEREAS, capitalized terms used in this Agreement but not otherwise defined herein shall have the respective meanings given to them in the Purchase Agreement; *provided, however*, that the Escrow Agent will not be responsible to determine or to make inquiry into any term, capitalized or otherwise, not defined herein;

WHEREAS, the Parties acknowledge that the Escrow Agent is not a party to, is not bound by, and has no duties or obligations under, the Purchase Agreement, that all references in this Agreement to the Purchase Agreement are for convenience, and that the Escrow Agent shall have no implied duties beyond the express duties set forth in this Agreement; and

WHEREAS, Schedule I to this Agreement sets forth the wire transfer instructions (or payment instructions) for the Parties.

NOW, THEREFORE, in consideration of the mutual covenants of the parties set forth in this Agreement and the Purchase Agreement and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

AGREEMENT

1. Appointment of Escrow Agent. The Buyer Representative (on behalf of the Buyer) and the Seller Representative (on behalf of the Sellers) hereby appoint the Escrow Agent as their agent to hold, invest, and disburse the Escrow Amount and all interest and other income, and interest earned on such interest and other income related to the Escrow Amount ("**Escrow Interest**" and, together with the Escrow Amount, the "**Escrow Funds**") in accordance with the terms of this Agreement.

2. Appointment of the Seller Representative.

(a) The Sellers have appointed the Seller Representative as the designated representative of both of the Sellers and have authorized the Seller Representative to take or cause to be taken all action in furtherance of the Sellers' rights and obligations with respect to the Escrow Funds.

(b) Each of the Escrow Agent and the Buyer Representative shall be entitled to rely on all action taken by the Seller Representative and shall have no liability with respect to its reliance thereon. The Seller Representative is serving in that capacity solely for purposes of administrative convenience. Notwithstanding anything to the contrary contained in this Agreement, the Seller Representative, absent fraud or intentional misconduct, shall not have any liability under this Agreement in excess of its pro rata share of the collective liability of all of the Sellers.

3. Appointment of the Buyer Representative.

(a) The Buyer has appointed the Buyer Representative as the designated representative of the entities comprising the Buyer and has authorized the Buyer Representative to take or cause to be taken all action in furtherance of the Buyer's rights and obligations with respect to the Escrow Funds.

(b) Each of the Escrow Agent and the Seller Representative shall be entitled to rely on all action taken by the Buyer Representative and shall have no liability with respect to its reliance thereon. The Buyer Representative is serving in that capacity solely for purposes of administrative convenience.

4. Delivery of Funds to Escrow Agent. Pursuant to Section 2.5 of the Purchase Agreement, the Buyer Representative shall deposit the Escrow Amount with the Escrow Agent on the Effective Date. The Escrow Agent shall hold the Escrow Funds on behalf of the Buyer Representative and each of the Sellers under the terms of this Agreement and distribute the Escrow Funds in accordance with Section 8 or Section 9 hereto.

5. Investment.

(a) The Escrow Agent shall invest any and all of the Escrow Funds as directed in writing jointly by the Parties in obligations issued or guaranteed by the United States of America or any agent or instrumentality thereof or a mutual fund which invests solely in such obligations.

(b) In the absence of complete joint written investment instructions from the Parties, the Escrow Agent shall deposit and invest the Escrow Funds in the Money Market Deposit Account, certain aspects of which are further described on Exhibit A attached hereto. The Parties acknowledge that each has read and understands Exhibit A.

(c) The Escrow Agent shall have the right to liquidate any investments held in order to provide funds necessary to make required payments under this Agreement. The Parties may direct in writing the Escrow Agent as to which investments to liquidate to make such required payments. The Escrow Agent, in its capacity as escrow agent hereunder, shall not have any liability for any loss sustained as a result of any investment made pursuant to the instructions of the Parties or as a result of any liquidation of any investment prior to its maturity or for the failure of the Parties to give the Escrow Agent instructions to invest or reinvest the Escrow Funds.

(d) The Escrow Agent shall have no responsibility or liability for any loss that may result from any investment or sale of investment made pursuant to this Agreement. The Escrow Agent is hereby authorized, in making or disposing of any investment permitted by this Agreement, to deal with itself or with any one or more of its affiliates, whether it or any such affiliate is acting as agent of the Escrow Agent or for any third person or dealing as principal for its own account. The Parties acknowledge that the Escrow Agent is not providing investment supervision, recommendations, or advice.

6. Monthly Statements. As soon as reasonably practicable following each month during the term of this Agreement, the Escrow Agent shall deliver to the Parties a statement setting forth (a) the value of the Escrow Funds as of such date, (b) the amount of Escrow Interest during the period covered by such statement, (c) the amount of payments and distributions made during the period covered in such statement and the payee thereof and (d) confirmations of permitted investment transactions, to the extent applicable. The Parties agree that confirmations of permitted investments are not required to be issued by the Escrow Agent for each month in which a monthly statement is rendered. No statement need be rendered for any fund or account if no activity occurred in such fund or account during such month.

7. Payment of Taxes.

(a) Consistent with proposed Treasury Regulation section 1.468B-8, the Buyer Representative shall be treated as the owner of the Escrow Funds for federal income tax purposes and shall be responsible for paying all foreign, federal, state, and local income taxes payable on the Escrow Funds, and all interest and other income, and interest earned on such interest and other income related to the Escrow Funds (any such taxes being herein called "**Income Taxes**") until the amount of and parties entitled to the distribution of the Escrow Funds (or portion thereof) are determined and the Income Taxes shall thereafter be the responsibility of the Buyer Representative, on the one hand, and the Sellers, on the other hand, in accordance with their respective interests in the amount of the Escrow Funds subject to distribution consistent with proposed Treasury Regulations section 1.468B-8. Each of the Parties shall file all tax returns in a manner consistent with the foregoing, and the responsible Party shall pay the taxes directly to the taxing authority. The Parties agree that, for tax reporting purposes, all interest or other income earned on the investment of the Escrow Funds shall, as of the end of each calendar year and to the extent required by the Internal Revenue Service, be reported as having been earned by the Buyer Representative, whether or not such income was disbursed during such calendar year. Notwithstanding anything in this Agreement to the contrary, each responsible Party shall pay on its own behalf all such Income Taxes at or before the time any such Income Taxes become due and payable (taking into account any extension of the due date thereof) after any distribution of the Escrow Funds to such Party.

(b) The Escrow Agent shall have no responsibility under this Section 7 for the payment of Income Taxes or the filing of any returns in connection therewith other than to provide the Parties with copies of such records in the Escrow Agent's possession as are reasonably requested by the Parties in connection with the filing of any such returns.

(c) For certain payments made pursuant to this Agreement, the Escrow Agent may be required to make a "reportable payment" or "withholdable payment" and in such cases the Escrow Agent shall have the duty to act as a payor or withholding agent, respectively, that is responsible for any tax withholding and reporting required under Chapters 3, 4, and 61 of the United States Internal Revenue Code of 1986, as amended (the "**Code**"). The Escrow Agent shall have the sole right to make the determination as to which payments are "reportable payments" or "withholdable payments." The Parties shall provide an executed IRS Form W-9 or appropriate IRS Form W-8 (or, in each case, any successor form) to the Escrow Agent prior to the date hereof, and shall promptly update any such form to the extent such form becomes obsolete or inaccurate in any respect. The Escrow Agent shall have the right to request from any Party, or any other person or entity entitled to payment hereunder, any additional forms, documentation or other information as may be reasonably necessary for the Escrow Agent to satisfy its reporting and withholding obligations under the Code. To the extent any such forms to be delivered under this Section 6.5(c) are not provided prior to the date hereof or by the time the related payment is required to be made or are determined by the Escrow Agent to be incomplete and/or inaccurate in any respect, the Escrow Agent shall be entitled to withhold (without liability) a portion of any interest or other income earned on the investment of the Escrow Amount or on any such payments hereunder to the extent withholding is required under Chapters 3, 4, or 61 of the Code, and shall have no obligation to gross up any such payment.

(d) To the extent that the Escrow Agent becomes liable for the payment of any taxes in respect of income derived from the investment of the Escrow Funds, the Escrow

Agent shall satisfy such liability to the extent possible from the Escrow Funds. The Parties shall indemnify, defend, and hold the Escrow Agent harmless jointly and severally from and against any tax, late payment, interest, penalty, or other cost or expense that may be assessed against the Escrow Agent on or with respect to the Escrow Funds and the investment thereof that is the responsibility of the Sellers or the Buyer Representative, as the case may be, hereunder unless such tax, late payment, interest, penalty, or other expense was directly caused by the gross negligence or willful misconduct of the Escrow Agent. The indemnification provided by this paragraph shall survive the resignation or removal of the Escrow Agent and the termination of this Agreement.

8. Delivery of Escrow Funds by Escrow Agent. The Escrow Agent shall hold the Escrow Funds until instructed or otherwise required to deliver the same or any portion thereof in accordance with Section 9 hereto.

9. Distributions.

(a) Indemnification Claims. Subject to the terms, conditions and limitations set forth in Article XII of the Purchase Agreement, if at any time prior to the second (2nd) anniversary of the Closing Date (the "**Indemnification Claims Cutoff Date**"), the Buyer Representative delivers to the Escrow Agent and the Seller Representative a certificate in substantially the form of Exhibit B attached hereto (an "**Indemnification Claim Certificate**") instructing the Escrow Agent to distribute all or a portion of the Escrow Funds to the Buyer Representative in satisfaction of any unpaid indemnification claim (a "**Claim**") asserted by the Buyer Representative pursuant to Article XII of the Purchase Agreement, then the Escrow Agent shall pay to the Buyer Representative the amount of Escrow Funds from the Escrow Account set forth in the Indemnification Claim Certificate in accordance therewith on the first (1st) business day after the thirtieth (30th) calendar day after it receives the Indemnification Claim Certificate; *provided, however*, that if the Escrow Agent receives from the Seller Representative a certificate in the form of Exhibit C attached hereto (an "**Indemnification Objection Notice**"), pursuant to which the Seller Representative objects to all or any portion of such Claim in specific detail, including the dollar amount in dispute and a specific written description of the reason(s) for the dispute, then (x) the Escrow Agent shall hold the amount disputed (the "**Disputed Amount**"), as set forth in the Indemnification Objection Notice, until receipt of notice of a Final Order (as defined below) in the form of Exhibit D attached hereto or joint notification in the form of Exhibit E attached hereto, and (y) the Escrow Agent shall as soon as reasonably practicable pay the amount, if any, not disputed to the Buyer Representative in accordance with the Indemnification Claim Certificate. The Buyer Representative shall deliver its Indemnification Claim Certificate to the Seller Representative at or prior to delivery of such Indemnification Claim Certificate to the Escrow Agent. In the event the Seller Representative fails to deliver an Indemnification Objection Notice to the Escrow Agent within such thirty (30) calendar day period, the Escrow Agent shall pay to the Buyer Representative the amount of the Escrow Funds set forth in the Indemnification Claim Certificate.

(b) In the event that an arbitration award, final judgment, or decree of any court of competent jurisdiction has been entered or awarded, in accordance with the Purchase Agreement, when the time for appeal, if any, shall have expired and no appeal shall have been taken or when all appeals taken shall have been finally determined (the "**Final Order**"), relating

to a Claim in favor of the Buyer Representative or any other the Buyer Representative Indemnified Party, in the case of Section 9(a) above, then the Buyer Representative shall deliver to the Escrow Agent and the Seller Representative, promptly after the issue of any such Final Order, a written notice in substantially the form of Exhibit D attached hereto, executed by the Buyer Representative, instructing the Escrow Agent to deliver to the Buyer Representative the Escrow Funds in accordance with Section 9(a) above in the amount of such judgment or award. Such notice shall state the amount of the Escrow Funds in accordance with Section 9(a) above, as appropriate, which the Escrow Agent shall deliver and the date upon which such delivery shall be made (which shall be no earlier than the date set forth in the next sentence) and be accompanied by a true and correct copy of the Final Order. The Escrow Agent shall deliver the stated amount of Escrow Funds in accordance with Section 9(a) above on the fifth (5^{th}) business day after it receives such notice or such later date as set forth in accordance with such notice. The Escrow Agent shall not be liable to the Seller Representative or the Buyer Representative or any other person in the event that the Escrow Agent makes a payment hereunder pursuant to a Final Order and such Final Order is subsequently reversed, modified, annulled, set aside, or vacated. Any Final Order shall be accompanied by an opinion of counsel for the presenting Party that such order is final and non-appealable and from a court of competent jurisdiction upon which opinion the Escrow Agent shall be entitled to conclusively rely without further investigation.

(c) In the event the Buyer Representative and the Seller Representative mutually agree to settle any claim for indemnification or other matter relating to the Purchase Agreement, then the Buyer Representative and the Seller Representative shall deliver to the Escrow Agent a written notice in substantially the form of Exhibit E attached hereto, duly executed by the Buyer Representative and the Seller Representative, instructing the Escrow Agent to deliver to the Buyer Representative all or a portion of such Escrow Funds. Such joint notice shall state the amount of the Escrow Funds which the Escrow Agent shall deliver to recipient and the date upon which such delivery shall be made.

(d) On the business day immediately following the Indemnification Claims Cutoff Date, or such earlier time that the Buyer Representative and the Seller Representative shall jointly instruct the Escrow Agent in writing, the Escrow Agent shall promptly deliver to the Seller Representative (for the benefit of the Sellers) from the Escrow Funds the amount, if any, by which (i) the remaining Escrow Funds exceed (ii) the sum of all Disputed Amounts then held by Escrow Agent payable pursuant to any unresolved Indemnification Claim Certificates that were delivered in accordance with Section 9(a) prior to the Indemnification Claims Cutoff Date. The Escrow Agent shall continue to hold Disputed Amounts until such Disputed Amounts are resolved in accordance with this Agreement.

(e) If any portion of a Disputed Amount remains undistributed after all Claims for disbursement are paid and resolved, the Escrow Agent shall, upon the receipt of written direction from the Seller Representative (with a copy to the Buyer Representative), if the Buyer Representative does not object in writing to the Escrow Agent (with a copy to the Seller Representative) within five (5) business days of such written direction, in accordance with the notice and delivery requirements set forth in Section 21 hereto, deliver such amount, if any, to the Seller Representative (for the benefit of the Sellers) within one (1) business day following the later of such resolution or payment.

(f) No release to the Seller Representative of Escrow Funds hereunder shall limit the Buyer Representative's right to seek indemnification, which shall only be limited as described in the Purchase Agreement. The Escrow Funds held pursuant to this Agreement are intended to provide a non-exclusive source of funds to the Buyer Representative for the payment of any amounts which may become payable with respect to indemnification claims asserted by the Buyer Representative pursuant to Article XII of the Purchase Agreement.

10. Security Procedure for Funds Transfers. The Escrow Agent shall confirm each funds transfer instruction received in the name of a Party by means of the security procedure selected by such Party and communicated to the Escrow Agent through a signed certificate in the form of Exhibit G-1 or Exhibit G-2 attached hereto, which upon receipt by the Escrow Agent shall become a part of this Agreement. Once delivered to the Escrow Agent, Exhibit G-1 or Exhibit G-2 may be revised or rescinded only by a writing signed by an authorized representative of the Party. Such revisions or rescissions shall be effective only after actual receipt and following such period of time as may be necessary to afford the Escrow Agent a reasonable opportunity to act on it. If a revised Exhibit G-1 or Exhibit G-2 or a rescission of an existing Exhibit G-1 or Exhibit G-2 is delivered to the Escrow Agent by an entity that is a successor-in-interest to such Party, such document shall be accompanied by additional documentation satisfactory to the Escrow Agent showing that such entity has succeeded to the rights and responsibilities of the Party under this Agreement.

The Parties understand that the Escrow Agent's inability to receive or confirm funds transfer instructions pursuant to the security procedure selected by such Party may result in a delay in accomplishing such funds transfer, and they agree that the Escrow Agent shall not be liable for any loss caused by any such delay.

11. Duties of Escrow Agent. The Escrow Agent hereby accepts its obligations under this Agreement and represents that it has the legal power and authority to enter into this Agreement and perform its obligations hereunder. The Escrow Agent further agrees that all Escrow Funds held by the Escrow Agent hereunder shall be segregated from all other property held by the Escrow Agent and shall be identified as being held in connection with this Agreement. Segregation may be accomplished by appropriate identification on the books and records of the Escrow Agent. The Escrow Agent agrees that its documents and records with respect to the transactions contemplated hereby will be available for examination by authorized representatives of the Buyer Representative and the Seller Representative during normal business hours of the Escrow Agent upon not less than two (2) business days' prior written notice and at the requesting Party's expense. Any fees charged by the Escrow Agent shall be paid equally by the Buyer Representative on the one hand, and the Seller Representative (on behalf of the Sellers), on the other hand. The fees of the Escrow Agent are attached hereto as Exhibit F and initial escrow fees shall be paid on the Effective Date. The Escrow Agent shall have, and is hereby granted, a prior lien upon the Escrow Funds with respect to its unpaid fees, non-reimbursed expenses, and unsatisfied indemnification rights, superior to the interests of any other persons or entities. The Escrow Agent shall be entitled and is hereby granted the right to set off and deduct any unpaid fees, non-reimbursed expenses, and unsatisfied indemnification rights from the Escrow Funds.

12. No Other Duties. Notwithstanding any provision to the contrary, the Escrow Agent is obligated only to perform the duties specifically set forth in this Agreement, which shall be deemed purely ministerial in nature. Under no circumstance will the Escrow Agent be deemed to be a fiduciary to the Buyer Representative, the Seller Representative or any other person under this Agreement. The Escrow Agent shall not have any duties or responsibilities hereunder except as expressly set forth herein. References in this Agreement to any other agreement, instrument, or document are for the convenience of the Buyer Representative and the Seller Representative, and the Escrow Agent has no duties or obligations with respect thereto.

13. Reliance on Documentary Evidence by the Escrow Agent. The Escrow Agent shall be entitled to rely upon any notice, certificate, affidavit, letter, document, or other communication that is reasonably believed by the Escrow Agent to be genuine and to have been signed or sent by the proper Party or Parties, and the Escrow Agent may rely on statements contained therein without further inquiry or investigation. Concurrently with the execution of this Agreement, the Buyer Representative and the Seller Representative shall deliver to the Escrow Agent Exhibit G-1 or Exhibit G-2 attached hereto, which contain authorized signer designations in Part I thereof. The Parties represent and warrant that each person signing this Escrow Agreement are duly authorized and has legal capacity to execute and deliver this Escrow Agreement, along with each exhibit, agreement, document, and instrument to be executed and delivered by the Parties to this Escrow Agreement.

14. Attorneys and Agents. The Escrow Agent shall be entitled to rely on and, except in the case of its own gross negligence or willful misconduct, shall not be liable for any action taken or omitted to be taken by the Escrow Agent in accordance with the advice of competent counsel or other competent professionals retained or consulted by the Escrow Agent. The Escrow Agent shall not be responsible for the negligence or misconduct of agents or attorneys appointed by it with reasonable care.

15. Liability of the Escrow Agent. The Escrow Agent shall not be liable for any action taken in accordance with the terms of this Agreement, including, without limitation, any release or distribution of Escrow Funds in accordance with Section 8 or Section 9 hereto. THE ESCROW AGENT SHALL NOT BE LIABLE, DIRECTLY OR INDIRECTLY, FOR ANY DAMAGES, LOSSES, OR EXPENSES ARISING OUT OF THE SERVICES PROVIDED HEREUNDER, OTHER THAN DAMAGES, LOSSES, OR EXPENSES THAT HAVE BEEN FINALLY ADJUDICATED TO HAVE DIRECTLY RESULTED FROM THE ESCROW AGENT'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT. THE ESCROW AGENT SHALL NOT BE LIABLE, DIRECTLY OR INDIRECTLY, FOR SPECIAL, PUNITIVE, INDIRECT, OR CONSEQUENTIAL DAMAGES OR LOSSES OF ANY KIND WHATSOEVER (INCLUDING, WITHOUT LIMITATION, LOST PROFITS), EVEN IF THE ESCROW AGENT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH LOSSES OR DAMAGES AND REGARDLESS OF THE FORM OF ACTION.

16. Indemnification of the Escrow Agent. The Buyer Representative and the Seller Representative hereby agree to jointly and severally indemnify the Escrow Agent, and defend and hold the Escrow Agent harmless, from and against any and all claims, costs, expenses, demands, judgments, losses, damages, and liabilities (including, without limitation, reasonable attorneys' fees and disbursements) ("**Escrow Damages**") arising out of or in connection with the

Escrow Agent's performance of its duties pursuant to this Agreement, except such Escrow Damages as may be finally adjudicated to have been directly caused by the gross negligence or willful misconduct of the Escrow Agent. The provisions of this Section 16 shall survive the termination of this Agreement and the resignation or removal of the Escrow Agent. Solely as between the Buyer Representative and Seller Representative, each of the Buyer Representative, on the one hand, and the Seller Representative, on the other hand, shall have a right of contribution from the other parties (other than Escrow Agent) in any action in which the Escrow Agent claims indemnification pursuant to this Agreement in the event such Party or Parties fail(s) to pay its or their pro rata share of such claim. No provision of this Agreement shall require the Escrow Agent to risk or advance its own funds or otherwise incur any financial liability or potential financial liability in the performance of its duties or the exercise of its rights hereunder.

17. Resignation or Removal of the Escrow Agent. The Escrow Agent may at any time resign by giving not less than thirty (30) calendar days' prior written notice of such resignation to the Buyer Representative and the Seller Representative. The Escrow Agent may be removed as escrow agent hereunder if both the Buyer Representative and the Seller Representative agree to such removal and give not less than thirty (30) calendar days' prior written notice thereof to the Escrow Agent. The Escrow Agent shall not be discharged from its duties and obligations hereunder until a successor escrow agent shall have been jointly designated by the Buyer Representative and the Seller Representative, and shall have executed and delivered an escrow agreement in substantially the form of this Agreement, and all Escrow Funds then held by the Escrow Agent hereunder, less any fees and expenses then due and owing to the Escrow Agent, shall have been delivered to such successor escrow agent. If the Buyer Representative and the Seller Representative have failed to appoint a successor escrow agent prior to the expiration of thirty (30) calendar days following the delivery of such notice of resignation or removal, the Escrow Agent may petition any court of competent jurisdiction for the appointment of a successor escrow agent or for other appropriate relief, and any such resulting appointment shall be binding upon the Buyer Representative and the Seller Representative.

18. Interpleader. If the Buyer Representative and the Seller Representative shall disagree about the interpretation of this Agreement, or about the rights and obligations or the propriety of any action contemplated by the Escrow Agent hereunder, or the Escrow Agent shall be uncertain how to act in a situation presented hereunder, the Escrow Agent may, in its discretion, refrain from taking action until directed in writing jointly by the Buyer Representative and the Seller Representative or, after sixty (60) calendar days' notice to the Parties of its intention to do so, file an action of interpleader in the appropriate court of competent jurisdiction and deposit all of the Escrow Funds with such court. Upon the filing of such action, the Escrow Agent shall be relieved of all liability as to the Escrow Funds and shall be entitled to recover reasonable attorneys' fees, expenses, and other costs incurred in commencing and maintaining any such interpleader action unless such costs, fees, charges, disbursements, or expenses shall have been finally adjudicated to have directly resulted from the willful misconduct or gross negligence of the Escrow Agent.

19. Merger or Consolidation. Any corporation or association into which the Escrow Agent may be converted or merged, or with which it may be consolidated, or to which it may sell

or transfer all or substantially all of its corporate trust business and assets as a whole or substantially as a whole, or any corporation or association resulting from any conversion, sale, merger, consolidation, or transfer to which the Escrow Agent is a party, shall be and become the successor escrow agent under this Agreement and shall have and succeed to the rights, powers, duties, immunities, and privileges as its predecessor, without the execution or filing of any instrument or paper or the performance of any further act, any provision herein to the contrary notwithstanding.

20. Attachment of Escrow Funds; Compliance with Legal Orders. In the event that any of the Escrow Funds shall be attached, garnished, or levied upon by any court order, or the delivery thereof shall be stayed or enjoined by an order of a court, or any order, judgment, or decree shall be made or entered by any court with respect to the Escrow Funds, the Escrow Agent is hereby expressly authorized, in its sole discretion, to respond as it reasonably deems appropriate or to comply with all writs, orders, or decrees so entered or issued, or which it is advised by legal counsel of its own choosing is binding upon it, whether with or without jurisdiction. In the event that the Escrow Agent obeys or complies with any such writ, order, or decree, it shall not be liable to the Buyer Representative, the Seller Representative, or to any other person, firm, or corporation, should, by reason of such compliance notwithstanding, such writ, order, or decree be subsequently reversed, modified, annulled, set aside, or vacated.

21. Notices. All notices and communications (including certificates and notices delivered pursuant to Section 9 hereto) by the Buyer Representative or the Seller Representative to the Escrow Agent shall be delivered contemporaneously to the other Party in the same manner as provided to the Escrow Agent. All notices and other communications under this Agreement shall be in writing and shall be deemed effectively given when personally delivered, when received by overnight delivery or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to the Buyer Representative: Health Quest Systems, Inc.
1351 Route 55, Suite 200
Lagrangeville, NY 12540
Attention: Michael Holzhueter, Senior Vice President and General Counsel

With a Copy to: McDermott Will & Emery LLP
28 State Street
Boston, MA 02109-1775
Attention: Charles Buck

If to the Seller Representative: RegionalCare Hospital Partners, Inc.
103 Continental Place, Suite 410
Brentwood, TN 37027
Attention: General Counsel

With a Copy to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, TN 37219 Attention: George W. Bishop III
If to Escrow Agent:	Wells Fargo Bank, National Association 150 East 42nd Street 40th Floor Corporate, Escrow, and Municipal Solutions New York, NY 10017 Attention: Kweku Asare Phone: 917.260.1551 Facsimile: 917.260.1592 E-mail: kweku.a.asare@wellsfargo.com

or to such other address, and to the attention of such other person or officer as any party may designate, with copies thereof to the respective counsel thereof as notified by such party.

22. Assignment. This Agreement shall not be assigned by any party without the written consent of the other parties and any attempted assignment without such written consent shall be null and void and without legal effect. This Agreement shall be binding upon and inure to the benefit of the respective parties hereto and, if any consent required by this Section 22 is properly secured, the successors and assigns of such party. Nothing herein is intended or shall be construed to give any other person any right, remedy, or claim under, in or with respect to this Agreement or any property held hereunder.

23. Waivers and Amendments. This Agreement may be amended, modified, extended, superseded, canceled, renewed, or extended, and the terms and conditions hereof may be waived, only by a written document signed by the Buyer Representative, the Seller Representative, and the Escrow Agent or, in the case of a waiver by the Buyer Representative or the Seller Representative, by the Party or Parties waiving compliance. No delay on the part of the Buyer Representative or the Seller Representative in exercising any right, power or privilege hereunder shall operate as a waiver thereof nor shall any waiver on the part of the Buyer Representative or the Seller Representative of any right, power, or privilege hereunder nor any single or partial exercise of any right, power, or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, power, or privilege hereunder.

24. Governing Law. All issues and questions concerning the construction, validity, interpretation, and enforceability of this Agreement and the exhibits and schedules hereto shall be governed by, and construed in accordance with, the laws of the State of New York, without giving effect to any choice of law or conflict of law rules or provisions (whether of the State of New York or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of New York.

25. Resolution of Disputes; Court Proceedings; Attorneys' Fees and Costs. The parties to this Agreement shall act in good faith to resolve any dispute or other controversy arising under this Agreement. Absent agreement resolving a dispute within ten (10) calendar days after the dispute has arisen, any party shall have the right to seek to settle the matter by

court action or, if the parties agree at the time, by arbitration. If any party should institute legal proceedings to enforce such party's rights under this Agreement, or otherwise with respect to the subject matter of this Agreement, the prevailing party or parties shall recover, in addition to all other costs and damages awarded, and the losing party or parties shall pay, the reasonable attorneys' fees and costs at trial, on appeal, upon petition for review, or in any bankruptcy proceeding, of the prevailing party or parties, whether or not such fees and costs are prescribed by statute, and shall pay the fees and costs of the Escrow Agent incurred in connection with such dispute, including reimbursement to the prevailing party of such fees and costs previously paid, in each case as determined by the court at trial or upon any appeal. Any lawsuit or proceeding permitted by the terms of this Agreement to be filed in a court, which lawsuit or proceeding is brought to enforce, challenge, or construe the terms or making of this Agreement and any claims arising out of or related to this Agreement, shall be exclusively brought and litigated exclusively in a state or federal court having subject matter jurisdiction and located in the State of New York. For the purpose of any lawsuit or proceeding instituted with respect to any claim arising out of or related to this Agreement, each party hereby irrevocably submits to the exclusive jurisdiction of the state or federal courts having subject matter jurisdiction and located in the State of New York. Each party hereby irrevocably waives any objection or defense which it may now or hereafter have of improper venue, forum non conveniens, or lack of personal jurisdiction.

26. Waiver of Jury Trial. AS A SPECIFICALLY BARGAINED INDUCEMENT FOR EACH OF THE PARTIES TO ENTER INTO THIS AGREEMENT (EACH PARTY HAVING HAD OPPORTUNITY TO CONSULT COUNSEL), EACH PARTY EXPRESSLY WAIVES THE RIGHT TO TRIAL BY JURY IN ANY LAWSUIT OR PROCEEDING RELATING TO OR ARISING IN ANY WAY FROM THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREIN.

27. Counterparts. This Agreement may be executed in two or more counterparts, and by different parties hereto on separate counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or electronic mail in PDF or similar format shall be effective as delivery of a mutually executed counterpart to this Agreement.

28. Termination. This Agreement shall terminate upon the earlier of: (a) one-hundred twenty (120) days after Escrow Agent's delivery of all the Escrow Funds, or (b) the joint written instructions of the Buyer Representative and the Seller Representative; except that the provision of Sections 7, 15, 16, 25, and 26 shall survive the termination of this Agreement.

29. Severability. Whenever possible, each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is held to be prohibited by or invalid under applicable law, such provision shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement, and the parties hereto shall amend or otherwise modify this Agreement to replace any prohibited or invalid provision with an effective and valid provision that gives effect to the intent of the parties to the maximum extent permitted by applicable law.

30. Force Majeure. The Escrow Agent shall not be responsible or liable for any failure or delay in the performance of its obligation under this Agreement arising out of or caused, directly or indirectly, by circumstances beyond its reasonable control, including, without limitation, acts of God; earthquakes; fire; flood; wars; acts of terrorism; civil or military disturbances; sabotage; epidemic; riots; interruptions, loss or malfunctions of utilities, computer (hardware or software) or communications services; accidents; labor disputes; acts of civil or military authority or governmental action; it being understood that the Escrow Agent shall use commercially reasonable efforts that are consistent with accepted practices in the banking industry to resume performance as soon as reasonably practicable under the circumstances.

31. Publication; Disclosure. By executing this Agreement, the parties acknowledge that this Agreement (including related attachments) contains certain information that is sensitive and confidential in nature and agree that such information needs to be protected from improper disclosure, including the publication or dissemination of this Agreement and related information to individuals or entities not a party to this Agreement. The parties hereto further agree to take reasonable measures to mitigate any risks associated with the publication or disclosure of this Agreement and information contained therein, including, without limitation, the redaction of the manual signatures of the signatories to this Agreement, or, in the alternative, the publication of a conformed copy of this Agreement. If a party must disclose or publish this Agreement or information contained therein pursuant to any stock exchange request or any regulatory, statutory, or governmental rule or requirement, as well as any judicial or administrative order, subpoena, or discovery request, it shall notify in writing the other parties at the time of execution of this Agreement of the legal requirement to do so. If any party hereto becomes aware of any threatened or actual unauthorized disclosure, publication, or use of this Agreement, such party shall promptly notify in writing the other parties and shall be liable for any unauthorized release or disclosure.

[SIGNATURE PAGES FOLLOW]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the Effective Date.

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By: _____
Name: Robert Friedberg
Title: President

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the Effective Date.

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

ESCROW AGENT:

WELLS FARGO BANK, NATIONAL ASSOCIATION, solely in its capacity as Escrow Agent hereunder

By:_____
Name: Matthew Sherman
Title: Vice President

EXHIBIT A

Agency and Custody Account Direction
For Cash Balances
Wells Fargo Money Market Deposit Accounts

Directions to use the following Wells Fargo Money Market Deposit Accounts for Cash Balances for the escrow account (the "Account") established under the Escrow Agreement to which this Exhibit A is attached.

In the absence of complete, joint written investment instructions from the Parties, the Escrow Agent is hereby directed to deposit, as indicated below, or as the Parties shall direct further in writing from time to time, all cash in the Account in the following money market deposit account of Wells Fargo Bank, National Association:

Wells Fargo Money Market Deposit Account ("MMDA")

The Parties understand that amounts on deposit in the MMDA are insured, subject to the applicable rules and regulations of the Federal Deposit Insurance Corporation ("FDIC"), in the basic FDIC insurance amount of $250,000 per depositor, per insured bank. This includes principal and accrued interest up to a total of $250,000. The Parties understand that deposits in the MMDA are not secured.

The Parties acknowledge that the Parties collectively have full power to direct investments of the Account.

The Parties understand that the Parties may jointly change this direction at any time and that it shall continue in effect until revoked or modified by the Parties by joint written notice to the Escrow Agent.

EXHIBIT B

Indemnification Claim Certificate

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Indemnification Claim Certificate is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement. This is to notify you, as the Escrow Agent, and the Seller Representative, of a Claim under the Purchase Agreement for $_____ out of the Escrow Funds.

Unless you receive from the Seller Representative an Indemnification Objection Notice in response to this Indemnification Claim Certificate on or before the thirtieth (30th) calendar day after your receipt hereof, you are hereby instructed to deliver on the first (1st) business day after the thirtieth (30th) calendar day after your receipt hereof the sum of $_____ out of Escrow Funds from the Escrow Account to the Buyer Representative by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

cc: RegionalCare Hospital Partners, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.

Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT C

Indemnification Objection Notice

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Indemnification Objection Notice is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

The undersigned hereby objects to $_____ (the "**Disputed Amount**") of the Claim that the Buyer Representative asserted in the Indemnification Claim Certificate. Accordingly, you are hereby instructed not to deliver the Disputed Amount to the Buyer Representative.

The reasons for this dispute are as follows (or are attached): _____
_____
_____
_____
_____
_____.

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

cc: Health Quest Systems, Inc.
Vassar Health Connecticut, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT D

Notice of a Final Order

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku AsarePhone: 917.260.1551
Facsimile: 917.260.1592
E-mail: Kweku.a.asare@wellsfargo.com

This Notice of a Final Order ("**Notice**") is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

The undersigned hereby certifies that: (a) a Final Order exists with respect to a Claim; (b) a true and correct copy of the Final Order or other evidence of the Final Order accompanies this certificate,; and (c) the undersigned is entitled to receive Escrow Funds from the Escrow Account in accordance with the Purchase Agreement and said Escrow Agreement.

You are hereby instructed to deliver payment on the fifth (5th) business day after your receipt of this Notice $_____ of Escrow Funds from the Escrow Account to the Buyer Representative, by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

cc: RegionalCare Hospital Partners, Inc.
Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.
Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT E

Joint Notification

To: Wells Fargo Bank, National Association
150 East 42nd Street 40th Floor
Corporate, Escrow, and Municipal Solutions
New York, NY 10017
Attention: Kweku Asare
Phone: 917.260.1551
Facsimile: 917.260.1592
E-mail: kweku.a.asare@wellsfargo.com

This Joint Notification is issued pursuant to that certain Escrow Agreement, dated as of [_____], 2017, by and among the Buyer Representative, the Seller Representative, and you, as Escrow Agent. Capitalized terms herein shall have the meaning ascribed to them in said Escrow Agreement.

You are hereby instructed to deliver **[immediately] [on date]** $_____ of Escrow Funds to the Buyer Representative, by wire transfer to the following account:

_____(Bank)

_____(Account)

_____(Routing Number)

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By:_____
Name:_____
Title:_____

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

cc: Essent Healthcare of Connecticut, Inc.
Sharon Hospital Holding Company
Vassar Health Connecticut, Inc.
Regional Healthcare Associates, LLC
Tri State Women's Services, LLC

EXHIBIT F

Escrow Agent Fees

See attached.

Corporate Trust Services

Schedule of fees to provide escrow agent services
Health Quest Systems, Inc. / RegionalCare Hospital Partners, Inc.
(Sale of Sharon Hospital) - Indemnity Escrow Account
Approximate size: $500,000

Exhibit C

Acceptance fee — **Waived**

A one-time fee for our initial review of governing documents, account set-up and customary duties and responsibilities related to the closing. This fee is payable at closing.

Annual administration fee — **$3,500**

An annual fee for customary administrative services provided by the escrow agent, including daily routine account management; cash management transactions processing (including wire and check processing), disbursement of funds in accordance with the agreement, tax reporting for one entity, and providing account statements to the parties. The administration fee is payable annually in advance per escrow account established. The first installment of the administrative fee is payable at closing.

Out-of-pocket expenses — **At cost**

Out-of- pocket expenses will be billed as incurred at cost at the sole discretion of Wells Fargo.

Extraordinary services — **Standard rate**

The charges for performing services not contemplated at the time of execution of the governing documents or not specifically covered elsewhere in this schedule will be at Wells Fargo's rates for such services in effect at the time the expense is incurred. The review of complex tax forms, including by way of example but not limited to IRS Form W-8IMY, shall be considered extraordinary services.

Assumptions

This proposal is based upon the following assumptions with respect to the role of escrow agent:

- Number of escrow accounts to be established: 1
- Amount of escrow: $500,000
- Term of escrow: 36 -48 months
- Number of tax reporting parties: 1
- Number of parties to the transaction: 3
- Number of cash transactions (deposits/disbursements): 2 deposits/5 disbursements
- Fees quoted assume all transaction account balances will be held uninvested or invested in select Wells Fargo deposit products.
- Disbursements shall be made only to the parties specified in the agreement. Any payments to other parties are at the sole discretion and subject to the requirements of Wells Fargo and shall be considered extraordinary services.

Terms and conditions

- The recipient acknowledges and agrees that this proposal does not commit or bind Wells Fargo to enter into a contract or any other business arrangement, and that acceptance of the appointment described in this proposal is expressly conditioned on (1) compliance with the requirements of the USA Patriot Act of 2001, described below, (2) satisfactory completion of Wells Fargo's internal account acceptance procedures, (3) Wells Fargo's review of all applicable governing documents and its confirmation that all terms and conditions pertaining to its role are satisfactory to it and (4) execution of the governing documents by all applicable parties.

Together we'll go far

Corporate Trust Services
Schedule of fees to provide escrow agent services
Health Quest Systems, Inc. / RegionalCare Hospital Partners, Inc.
(Sale of Sharon Hospital) - Indemnity Escrow Account
Approximate size: $500,000

- Should this transaction fail to close or if Wells Fargo determines not to participate in the transaction, any acceptance fee and any legal fees and expenses may be due and payable.
- Legal counsel fees and expenses, any acceptance fee and any first year annual administrative fee are payable at closing.
- Any annual fee covers a full year or any part thereof and will not be prorated or refunded in a year of early termination.
- Should any of the assumptions, duties or responsibilities of Wells Fargo change, Wells Fargo reserves the right to affirm, modify or rescind this proposal.
- The fees described in this proposal are subject to periodic review and adjustment by Wells Fargo.
- Invoices outstanding for over 30 days are subject to a 1.5% per month late payment penalty.
- This fee proposal is good for 90 days.

Important information about identifying our customers

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person (individual, corporation, partnership, trust, estate or other entity recognized as a legal person) for whom we open an account.

What this means for you: Before we open an account, we will ask for your name, address, date of birth (for individuals), TIN/EIN or other information that will allow us to identify you or your company. For individuals, this could mean identifying documents such as a driver's license. For a corporation, partnership, trust, estate or other entity recognized as a legal person, this could mean identifying documents such as a Certificate of Formation from the issuing state agency.

Date: June 20, 2017

EXHIBIT G-1

Buyer Representative Security Agreement

The Buyer Representative certifies that the names, titles, telephone numbers, e-mail addresses, and specimen signatures set forth in Parts I and II of this Exhibit G-1 identify the persons authorized to provide direction and initiate or confirm transactions, including funds transfer instructions, on behalf of the Buyer Representative, and that the option checked in Part III of this Exhibit G-1 is the security procedure selected by the Buyer Representative for use in verifying that a funds transfer instruction received by the Escrow Agent is that of the Buyer Representative.

The Buyer Representative has reviewed each of the security procedures and has determined that the option checked in Part III of this Exhibit G-1 best meets its requirements given the size, type, and frequency of the instructions it will issue to the Escrow Agent. By selecting the security procedure specified in Part III of this Exhibit G-1, the Buyer Representative acknowledges that it has elected to not use the other security procedures described and agrees to be bound by any funds transfer instruction, whether or not authorized, issued in its name and accepted by the Escrow Agent in compliance with the particular security procedure chosen by the Buyer Representative.

NOTICE: The security procedure selected by the Buyer Representative will not be used to detect errors in the funds transfer instructions given by the Buyer Representative. If a funds transfer instruction describes the beneficiary of the payment inconsistently by name and account number, payment may be made on the basis of the account number even if it identifies a person different from the named beneficiary. If a funds transfer instruction describes a participating financial institution inconsistently by name and identification number, the identification number may be relied upon as the proper identification of the financial institution. Therefore, it is important that the Buyer Representative takes such steps as it deems prudent to ensure that there are no such inconsistencies in the funds transfer instructions it sends to the Escrow Agent.

Part I

Name, Title, Telephone Number, Electronic Mail ("e-mail") Address, and Specimen Signature for person(s) designated to provide direction, including but not limited to funds transfer instructions, and to otherwise act on behalf of the Buyer Representative

Name	Title	Telephone Number	E-mail Address	Specimen Signature

[list more if desired]

Part II

Name, Title, Telephone Number and E-mail Address for person(s) designated to confirm funds transfer instructions

Name	Title	Telephone Number	E-mail Address

[list more if desired]

Part III

Means for delivery of instructions and/or confirmations

The security procedure to be used with respect to funds transfer instructions is checked below:

☒ *Option 1. Confirmation by telephone call-back.* The Escrow Agent shall confirm funds transfer instructions by telephone call-back to a person at the telephone number designated on Part II above. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-1.

☒ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by telephone call-back, the Escrow Agent may, at its discretion, confirm by e-mail, as described in Option 2.

☐ *Option 2. Confirmation by e-mail.* The Escrow Agent shall confirm funds transfer instructions by e-mail to a person at the e-mail address specified for such person in Part II of this Exhibit G-1. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-1. The Buyer Representative understands the risks associated with communicating sensitive matters, including time sensitive matters, by e-mail. The Buyer Representative further acknowledges that instructions and data sent by e-mail may be less confidential or secure than instructions or data transmitted by other methods. The Escrow Agent shall not be liable for any loss of the confidentiality of instructions and data prior to receipt by the Escrow Agent.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by e-mail, the Escrow Agent may, at its discretion, confirm by telephone call-back, as described in Option 1.

☐ **Option 3. Delivery of funds transfer instructions by password protected file transfer system only - no confirmation.* The Escrow Agent offers the option to deliver funds transfer instructions through a password protected file transfer system. If the Buyer Representative wishes to use the password protected file transfer system, further instructions will be provided by the Escrow Agent. If the Buyer Representative chooses this Option 3, they agree that no further confirmation of funds transfer instructions will be performed by the Escrow Agent.

☐ **Option 4. Delivery of funds transfer instructions by password protected file transfer system with confirmation.* Same as Option 3 above, but the Escrow Agent shall confirm funds transfer instructions by ☐ telephone call-back or ☐ e-mail (must check at least one, may check both) to a person at the telephone number or e-mail address designated on Part II above. By checking a box in the prior sentence, the party shall be deemed to have agreed to the terms of such confirmation option as more fully described in Option 1 and Option 2 above.

**The password protected file system has a password that expires every 60 days. If you anticipate having infrequent activity on this account, please consult with your Escrow Agent before selecting this option.*

Dated this 28th day of July, 2017.

BUYER REPRESENTATIVE:

HEALTH QUEST SYSTEMS, INC.

By: _____

Name: Robert Friedberg

Title: President

EXHIBIT G-2

Seller Representative Security Agreement

The Seller Representative certifies that the names, titles, telephone numbers, e-mail addresses and specimen signatures set forth in Parts I and II of this Exhibit G-2 identify the persons authorized to provide direction and initiate or confirm transactions, including funds transfer instructions, on behalf of the Seller Representative, and that the option checked in Part III of this Exhibit G-2 is the security procedure selected by the Seller Representative for use in verifying that a funds transfer instruction received by the Escrow Agent is that of the Seller Representative.

The Seller Representative has reviewed each of the security procedures and has determined that the option checked in Part III of this Exhibit G-2 best meets its requirements given the size, type, and frequency of the instructions it will issue to the Escrow Agent. By selecting the security procedure specified in Part III of this Exhibit G-2, the Seller Representative acknowledges that it has elected to not use the other security procedures described and agrees to be bound by any funds transfer instruction, whether or not authorized, issued in its name and accepted by the Escrow Agent in compliance with the particular security procedure chosen by the Seller Representative.

NOTICE: The security procedure selected by the Seller Representative will not be used to detect errors in the funds transfer instructions given by the Seller Representative. If a funds transfer instruction describes the beneficiary of the payment inconsistently by name and account number, payment may be made on the basis of the account number even if it identifies a person different from the named beneficiary. If a funds transfer instruction describes a participating financial institution inconsistently by name and identification number, the identification number may be relied upon as the proper identification of the financial institution. Therefore, it is important that the Seller Representative takes such steps as it deems prudent to ensure that there are no such inconsistencies in the funds transfer instructions it sends to the Escrow Agent.

Part I

Name, Title, Telephone Number, Electronic Mail ("e-mail") Address, and Specimen Signature for person(s) designated to provide direction, including but not limited to funds transfer instructions, and to otherwise act on behalf of the Seller Representative

Name	Title	Telephone Number	E-mail Address	Specimen Signature

Part II

Name, Title, Telephone Number, and E-mail Address for person(s) designated to confirm funds transfer instructions

Name	Title	Telephone Number	E-mail Address

Part III

Means for delivery of instructions and/or confirmations

The security procedure to be used with respect to funds transfer instructions is checked below:

☐ *Option 1. Confirmation by telephone call-back.* The Escrow Agent shall confirm funds transfer instructions by telephone call-back to a person at the telephone number designated on Part II above. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-2.

☐ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by telephone call-back, the Escrow Agent may, at its discretion, confirm by e-mail, as described in Option 2.

☒ *Option 2. Confirmation by e-mail.* The Escrow Agent shall confirm funds transfer instructions by e-mail to a person at the e-mail address specified for such person in Part II of this Exhibit G-2. The person confirming the funds transfer instruction shall be a person other than the person from whom the funds transfer instruction was received, unless only one person is designated in both Parts I and II of this Exhibit G-2. The Seller Representative understands the risks associated with communicating sensitive matters, including time sensitive matters, by e-mail. The Seller Representative further acknowledges that instructions and data sent by e-mail may be less confidential or secure than instructions or data transmitted by other methods. The Escrow Agent shall not be liable for any loss of the confidentiality of instructions and data prior to receipt by the Escrow Agent.

☒ CHECK box, if applicable:
If the Escrow Agent is unable to obtain confirmation by e-mail, the Escrow Agent may, at its discretion, confirm by telephone call-back, as described in Option 1.

☐ **Option 3. Delivery of funds transfer instructions by password protected file transfer system only - no confirmation.* The Escrow Agent offers the option to deliver funds transfer instructions through a password protected file transfer system. If the Seller Representative wishes to use the password protected file transfer system, further instructions will be provided by the Escrow Agent. If the Seller Representative chooses this Option 3, it agrees that no further confirmation of funds transfer instructions will be performed by the Escrow Agent.

☐ **Option 4. Delivery of funds transfer instructions by password protected file transfer system with confirmation.* Same as Option 3 above, but the Escrow Agent shall confirm funds transfer instructions by ☐ telephone call-back or ☐ e-mail (must check at least one, may check both) to a person at the telephone number or e-mail address designated on Part II above. By checking a box in the prior sentence, the party shall be deemed to have agreed to the terms of such confirmation option as more fully described in Option 1 and Option 2 above.

**The password protected file system has a password that expires every 60 days. If you anticipate having infrequent activity on this account, please consult with your Escrow Agent before selecting this option.*

Dated this ____ day of _____, 2017.

SELLER REPRESENTATIVE:

REGIONALCARE HOSPITAL PARTNERS, INC.

By: _____

Name: Michael W. Browder

Title: Executive Vice President and Chief Financial Officer

SCHEDULE I

Wire Transfer Instructions

Buyer Representative

Seller Representative

Beneficiary Company:

Beneficiary Bank:

Beneficiary ABA #

Beneficiary Account #

Swift Code =

SCHEDULE I

Wire Transfer Instructions

Buyer Representative

Bank Name:

Bank Address:

Beneficiary:

Beneficiary ABA #

Beneficiary Account #

Seller Representative

BILL OF SALE

This Bill of Sale (this "**Bill of Sale**") is executed and delivered as of July 31, 2017 (to be effective as of 12:01 a.m. on August 1, 2017 (the "**Effective Time**")) by Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**") and Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**" and with Sharon, RHA and TSWS, each individually a "**Seller**" and collectively, the "**Sellers**"), pursuant to that certain Asset Purchase Agreement dated September 13, 2016 (the "**Asset Purchase Agreement**") by and among Sellers, Health Quest Systems, Inc., a New York non-profit corporation ("**Health Quest**") and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("**VHC**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**"), solely for the purposes of Sections 13.32 and 13.33 of the Asset Purchase Agreement.

1. Defined Terms. Capitalized terms used but not defined herein shall have the meanings set forth in the Asset Purchase Agreement.

2. Transfer of Assets. For the consideration set forth in the Asset Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Sellers do hereby grant, bargain, sell, transfer, assign, convey, and deliver to Buyer, Vassar Health Quest Medical Practice of Connecticut, Inc., a Connecticut non-profit corporation ("**MPC**") and their successors and assigns, forever, effective as of the Effective Time, all of Sellers' right, title, and interest in, to, and under the Assets.

3. Further Assurances; Successors and Assigns. From and after the Effective Time, Sellers will execute, acknowledge, and deliver such other instruments of conveyance and transfer and perform such other acts as may be reasonably required effectively to transfer to, and vest in, Buyer, MPC and their successors and assigns, all of Sellers' right, title, and interest in, to, and under the Assets. This instrument shall be binding on Sellers and their successors and assigns, and the covenants and agreements of the Sellers set forth herein shall inure to the benefit of Buyer, MPC and their successors and assigns.

4. Conflict with Asset Purchase Agreement. The terms of this Bill of Sale are subject to the terms, provisions, conditions, and limitations set forth in the Asset Purchase Agreement, and this Bill of Sale is not intended to alter the obligations of the parties to the Asset Purchase Agreement. In the event the terms of this Bill of Sale conflict with the terms of the Asset Purchase Agreement, the terms of the Asset Purchase Agreement shall govern.

5. Governing Law. This Bill of Sale and the transactions contemplated hereby shall be governed by and construed and enforced in accordance with the internal laws of the State of New York without regard to the conflict of law provisions thereof.

[Signature Page Follows]

IN WITNESS WHEREOF, Sellers have executed this Bill of Sale as of the date first written above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

SHARON HOSPITAL HOLDING COMPANY

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

REGIONAL HEALTHCARE ASSOCIATES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

TRI STATE WOMEN'S SERVICES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

ASSIGNMENT AND ASSUMPTION AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION AGREEMENT (this "**Agreement**") is made and entered into as of July 31, 2017, by and among Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**"), and Vassar Health Quest Medical Practice of Connecticut, Inc., a Connecticut non-profit corporation ("**MPC**"). This Agreement shall be effective as of 12:01 a.m. on August 1, 2017 (the "**Effective Time**").

WHEREAS, pursuant to that certain Asset Purchase Agreement dated September 13, 2016 (the "**Asset Purchase Agreement**") by and among Health Quest Systems, Inc., a New York non-profit corporation ("**Health Quest**"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("**VHC**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**"), SHHC, RHA, TSWS, Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**" and with SHHC, RHA and TSWS, each individually a "**Seller**" and collectively, the "**Sellers**") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**"), solely for the purposes of Sections 13.32 and 13.33 of the Asset Purchase Agreement, Buyer has agreed to purchase the Assets (as defined in the Asset Purchase Agreement); and

WHEREAS, pursuant to the Asset Purchase Agreement, Sellers have agreed to assign certain rights and agreements to Buyer or an Affiliate, and Buyer or an Affiliate has agreed to assume certain obligations of Sellers, as set forth herein, and this Agreement is contemplated by Sections 3.2(c) and 3.3(b) of the Asset Purchase Agreement.

NOW, THEREFORE, for the consideration set forth in the Asset Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Capitalized Terms. Capitalized terms used but not defined herein shall have the meanings set forth in the Asset Purchase Agreement.

2. Assignment. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, RHA, SHHC and TSWS, hereby assign to MPC all of their right, title, benefit, privileges, and interest in, to and under the Assumed Contracts, the Tenant Leases, and the Seller Leases (collectively, the "**Seller Agreements**").

3. Assumption. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, MPC hereby accepts the assignment set forth in Section 2 above and assumes and agrees to keep, perform, and fulfill all of the terms, covenants, conditions, and obligations required to be kept, performed, or fulfilled by RHA, SHHC or TSWS under the Seller Agreements. Additionally, subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, MPC hereby assumes and agrees to pay, perform, and discharge on a timely basis, in accordance with their terms, the Assumed Liabilities. Notwithstanding anything herein to the contrary, MPC does not hereby assume, and shall not be liable or otherwise responsible for, any Excluded Liabilities.

4. Appointment. RHA, SHHC and TSWS hereby appoint MPC as their true and lawful attorney, with full power of substitution by, on behalf of, and for the benefit of MPC and its successors and assigns, to enforce any right, title or interest hereby sold, conveyed, assigned, transferred, and delivered. The foregoing powers are coupled with an interest and shall be irrevocable by RHA, SHHC and TSWS for any reason whatsoever.

5. Terms of the Asset Purchase Agreement. The terms of the Asset Purchase Agreement are incorporated herein by this reference. Except as provided in Sections 2 and 3 above, the representations, warranties, covenants, and agreements contained in the Asset Purchase Agreement shall not be superseded hereby but shall remain in full force and effect to the full extent provided therein. In the event of any conflict between the terms of this Agreement and the Asset Purchase Agreement, but specifically excluding Section 2 and Section 3 of this Agreement, the terms of the Asset Purchase Agreement shall govern.

6. Further Actions. From and after the Effective Time, each party hereto (a "**Party**") will execute, acknowledge and deliver such other instruments of transfer, assignment and assumption and perform such other acts as may be reasonably required effectively to consummate the assignments and assumptions contemplated by this Agreement.

7. Governing Law. This Agreement and the transactions contemplated hereby shall be governed by and construed and enforced in accordance with the internal laws of the State of New York without regard to the conflict of law provisions thereof.

8. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

9. Counterparts. This Agreement may be executed in one or more counterparts, any one of which need not contain the signatures of more than one Party, but all such counterparts taken together will constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or other means of electronic transmission shall be as effective as delivery of a manually executed counterpart.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

REGIONAL HEALTHCARE ASSOCIATES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

TRI STATE WOMEN'S SERVICES, LLC

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

SHARON HOSPITAL HOLDING COMPANY

By:_____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH QUEST MEDICAL PRACTICE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

REGIONAL HEALTHCARE ASSOCIATES, LLC

By:_____

Name:_____

Title:_____

TRI STATE WOMEN'S SERVICES, LLC

By:_____

Name:_____

Title:_____

SHARON HOSPITAL HOLDING COMPANY

By:_____

Name:_____

Title:_____

VASSAR HEALTH QUEST MEDICAL PRACTICE OF CONNECTICUT, INC.

By:_____

Name: Glenn Loomis, MD

Title: President

ASSIGNMENT AND ASSUMPTION AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION AGREEMENT (this "**Agreement**") is made and entered into as of July 31, 2017, by and among Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("**Sharon**"), Health Quest Systems, Inc., a New York non-profit corporation ("**Health Quest**"), and Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("**VHC**" and with Health Quest, individually a "**Buyer**" and collectively, the "**Buyer**"). This Agreement shall be effective as of 12:01 a.m. on August 1, 2017 (the "**Effective Time**").

WHEREAS, pursuant to that certain Asset Purchase Agreement dated September 13, 2016 (the "**Asset Purchase Agreement**") by and among Buyer, Sharon, Sharon Hospital Holding Company, a Delaware corporation ("**SHHC**"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("**RHA**"), Tri State Women's Services, LLC, a Connecticut limited liability company ("**TSWS**" and with Sharon, SHHC and RHA, each individually a "**Seller**" and collectively, the "**Sellers**") and RegionalCare Hospital Partners, Inc., a Delaware corporation ("**RCHP**"), solely for the purposes of Sections 13.32 and 13.33 of the Asset Purchase Agreement, Buyer has agreed to purchase the Assets (as defined in the Asset Purchase Agreement); and

WHEREAS, pursuant to the Asset Purchase Agreement, Sellers have agreed to assign certain rights and agreements to Buyer, and Buyer has agreed to assume certain obligations of Sellers, as set forth herein, and this Agreement is contemplated by Sections 3.2(c) and 3.3(b) of the Asset Purchase Agreement.

NOW, THEREFORE, for the consideration set forth in the Asset Purchase Agreement and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. Capitalized Terms. Capitalized terms used but not defined herein shall have the meanings set forth in the Asset Purchase Agreement.

2. Assignment. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, Sharon hereby assigns to Buyer all of its right, title, benefit, privileges, and interest in, to and under the Assumed Contracts, the Tenant Leases, and the Seller Leases (collectively, the "**Seller Agreements**").

3. Assumption. Subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, Buyer hereby accepts the assignment set forth in Section 2 above and assumes and agrees to keep, perform, and fulfill all of the terms, covenants, conditions, and obligations required to be kept, performed, or fulfilled by Sharon under the Seller Agreements. Additionally, subject to the terms and conditions set forth in the Asset Purchase Agreement, as of the Effective Time, Buyer hereby assumes and agrees to pay, perform, and discharge on a timely basis, in accordance with their terms, the Assumed Liabilities. Notwithstanding anything herein to the contrary, Buyer does not hereby assume, and shall not be liable or otherwise responsible for, any Excluded Liabilities.

4. Appointment. Sharon hereby appoints Buyer as its true and lawful attorney, with full power of substitution by, on behalf of, and for the benefit of Buyer and its successors and assigns, to enforce any right, title or interest hereby sold, conveyed, assigned, transferred, and delivered. The foregoing powers are coupled with an interest and shall be irrevocable by Sharon for any reason whatsoever.

5. Terms of the Asset Purchase Agreement. The terms of the Asset Purchase Agreement are incorporated herein by this reference. Except as provided in Sections 2 and 3 above, the representations, warranties, covenants, and agreements contained in the Asset Purchase Agreement shall not be superseded hereby but shall remain in full force and effect to the full extent provided therein. In the event of any conflict between the terms of this Agreement and the Asset Purchase Agreement, but specifically excluding Section 2 and Section 3 of this Agreement, the terms of the Asset Purchase Agreement shall govern.

6. Further Actions. From and after the Effective Time, each party hereto (a "**Party**") will execute, acknowledge and deliver such other instruments of transfer, assignment and assumption and perform such other acts as may be reasonably required effectively to consummate the assignments and assumptions contemplated by this Agreement.

7. Governing Law. This Agreement and the transactions contemplated hereby shall be governed by and construed and enforced in accordance with the internal laws of the State of New York without regard to the conflict of law provisions thereof.

8. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

9. Counterparts. This Agreement may be executed in one or more counterparts, any one of which need not contain the signatures of more than one Party, but all such counterparts taken together will constitute one and the same instrument. Delivery of an executed counterpart of a signature page to this Agreement by facsimile or other means of electronic transmission shall be as effective as delivery of a manually executed counterpart.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____

Name: Michael W. Browder

Title: Executive Vice President, Chief Financial Officer

HEALTH QUEST SYSTEMS, INC.

By: _____

Name: _____

Title: _____

VASSAR HEALTH CONNECTICUT, INC.

By: _____

Name: _____

Title: _____

[Signature Page to Assignment and Assumption Agreement]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date first written above.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By:_____

Name:_____

Title:_____

HEALTH QUEST SYSTEMS, INC.

By:_____

Name: Robert Friedberg

Title: President

VASSAR HEALTH CONNECTICUT, INC.

By:_____

Name: Robert Friedberg

Title: Authorized Representative

RCCH
HealthCare Partners

CERTIFICATE

July 31, 2017
To be effective as of 12:01 a.m. on August 1, 2017 (the "Effective Time")

Pursuant to Sections 3.2(j) and 6.8 of that certain Asset Purchase Agreement (the "Agreement"), dated September 13, 2016, by and among Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation ("Sharon"), Sharon Hospital Holding Company, a Delaware corporation ("SHHC"), Regional Healthcare Associates, LLC, a Connecticut limited liability company ("RHA") and Tri State Women's Services, LLC, a Connecticut limited liability company ("TSWS" and with Sharon, SHHC and RHA, individually a "Seller" and collectively, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest") and Vassar Health Connecticut, Inc., a Connecticut non-profit corporation ("Newco" and with Health Quest, individually a "Buyer" and collectively, the "Buyers"), the undersigned, being the duly elected, qualified and acting Vice President of Risk Management of RCCH Healthcare Partners, hereby certifies as of the Effective Time that:

1. The Sellers certify that all known medical professional and general liability incidents have been reported. The Sellers will continue to self-insure all known and reserved professional or general liabilities until final settlement and /or resolution. Sellers certify that all incurred but not reported medical professional incidents and general liability incidents are self-insured for any medical professional incidents and general liability incidents incurred during the time period of the Sellers acquisition of the Facilities or the Assets and the time period ending on the Closing Date effective at 12:01 am local time.

2. Capitalized terms used but not defined herein shall have the meanings set forth in the Agreement.

IN WITNESS WHEREOF, the undersigned has executed this Certificate solely in his capacity as Vice President of Risk Management of RCCH Healthcare Partners.

By: _____
Name: Charley Thornburg
Title: Vice President of Risk Management

Limited Power of Attorney for Use of DEA and Other Registration Numbers, and Controlled Substances Order Forms

July 31, 2017
(To be effective as of 12:01 a.m. on August 1, 2017 (the "Effective Time"))

Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut stock corporation ("Registrant"), owns and operates a hospital ("Hospital") and hospital pharmacy located at 50 Hospital Hill Road, Sharon, Connecticut (DEA registration number BE7740562), is authorized to sign the current applications for registration and licensure as the registrant under the Controlled Substances Act (21 U.S.C. § 801 *et seq.*) or Controlled Substances Import and Export Act of the United States (21 U.S.C. § 951 *et seq.*), and is licensed to operate such pharmacy under the laws of the State of Connecticut.

Pursuant to that certain Asset Purchase Agreement dated as of September 13, 2016, (the "Purchase Agreement") by and among Registrant, Regional Healthcare Associates, LLC, a Connecticut limited liability company ("RHA"), Tri State Women's Services, LLC, a Connecticut limited liability company ("TSWS"), and Sharon Hospital Holding Company, a Delaware corporation ("SHHC" and together with Registrant, RHA, and TSWS, the "Sellers"), Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest"), Vassar Health Connecticut, Inc. a Connecticut non-profit corporation ("NewCo" and together with Health Quest, the "Buyer"), and RegionalCare Hospital Partners, Inc., a Delaware corporation ("RCHP"), solely for the purposes of Sections 13.32 and 13.33 of the Purchase Agreement, Registrant will transfer to NewCo substantially all of the assets, properties and rights relating to its provision of hospital services at the Hospital as of the Effective Time.

In recognition of the need to continue to make available controlled substances for treatment of the Hospital's patients and to continue to operate the Hospital's existing pharmacy during the period from the Effective Time until approval of NewCo's DEA application and Controlled Substances Ordering System ("CSOS") registration, Registrant has, effective as of the Effective Time, made, constituted and appointed, and by these presents does make, constitute, and appoint, NewCo as Registrant's agent and attorney-in-fact for the limited purpose of utilizing Registrant's DEA registration and any other registrations required under the laws of the State of Connecticut to continue pharmacy operations at the pharmacy facility located at the address set forth above (hereinafter "Pharmacy") and listed on **Exhibit A** attached hereto. NewCo may act in this capacity until such time as NewCo receives notice of the DEA's approval of NewCo's registration application (the "DEA Notice") and notice that NewCo is established in the DEA's CSOS, but in no event shall this limited power of attorney continue for more than one hundred twenty (120) days after the Effective Time (unless otherwise extended by mutual agreement of NewCo and Registrant).

Registrant further grants this limited power of attorney to NewCo to act, effective as of the Effective Time, as the true and lawful agent and attorney-in-fact of Registrant, and to act in the name, place, and stead of Registrant, to execute applications for books of

official order forms and to sign such order forms in requisition for Schedules II, III, IV and V controlled substances, whether these orders be on Form 222, other forms as may be required under the laws of the State of Connecticut, or electronic in accordance with Section 308 of the Controlled Substances Act (21 U.S.C. § 828) and part 1305 of Title 21 of the Code of Federal Regulations, as is necessary for the treatment of the Hospital's patients.

Registrant recognizes that it is legally responsible for the DEA and other registrations. Therefore, Registrant grants this limited power of attorney based upon the following covenants and warranties of NewCo: (a) that NewCo shall follow and abide by all federal, state and local laws governing the regulation of controlled substances and pharmacy practice at all times while this limited power of attorney is in effect; and (b) that NewCo shall diligently pursue and use its commercially reasonable efforts to obtain its own DEA and other registrations which are required for the distribution of pharmaceuticals, including, but not limited to, controlled substances at the Pharmacy, as soon as practicable after the Closing Date under the Purchase Agreement.

NewCo shall indemnify and hold harmless Registrant for all losses, liabilities, costs, expenses (including reasonable attorneys' fees) and penalties incurred, paid or required under penalty of law to be paid by Registrant related, in whole or in part, to NewCo's use of the pharmacy license, DEA, and other registrations of Registrant from and after the Closing Date. Indemnification claims shall be made and processed in accordance with the applicable provisions of Article 12 of the Purchase Agreement.

NewCo agrees to notify Registrant in writing within five (5) business days after receipt of the DEA Notice and within five (5) business days after receiving confirmation that NewCo is established in CSOS. Registrant agrees that it shall not take any action to deactivate any current DEA registration or CSOS registration until NewCo makes such notification to Registrant.

Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Purchase Agreement.

[*Signatures on following page.*]

IN WITNESS WHEREOF, Registrant and NewCo have executed this Limited Power of Attorney for Use of DEA and Other Registration Numbers and DEA Order Forms as of the date first set forth above.

NewCo:

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Its: _____

Witness:

_____

Registrant:

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name: Michael W. Browder
Its: Executive Vice President and Chief Financial Officer

Witness:
_____

IN WITNESS WHEREOF, Registrant and NewCo have executed this Limited Power of Attorney for Use of DEA and Other Registration Numbers and DEA Order Forms on this ____ day of _____, 2017.

NewCo:

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: Robert Friedberg
Its: Authorized Representative

Witness:

_____

Registrant:

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name:
Its:

Witness:

_____

EXHIBIT A
Licenses and Registrations
Covered by Limited Power of Attorney

Federal:

1. United States Department of Justice Drug Enforcement Administration, Controlled Substance Registration Certificate BE7740562; Registrant: Essent Healthcare of Connecticut, Inc.; Issue Date: August 12, 2013; Expiration Date: August 31, 2016.

State:

1. State of Connecticut, Department of Consumer Protection, Controlled Substances Registration for Hospitals, Registration Number CSP.0000875-HOSP; Registrant: Essent Healthcare of Connecticut, Inc.; Effective Date: March 1, 2015; Expiration Date: February 28, 2017.

Pharmacy Facility Address:

50 Hospital Hill Road
Sharon, CT 06069-2092

MANAGEMENT AGREEMENT

THIS HOSPITAL MANAGEMENT AGREEMENT (this "Agreement") is made and entered into as of the 13th day of September, 2016, by and between Vassar Health Connecticut, Inc., (the "Manager"), and Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital (the "Company"), which presently owns and operates Sharon Hospital, a 78-bed medical surgical hospital located in Sharon, Connecticut (the "Hospital"). Health Quest Systems, Inc., a New York non-profit corporation ("Health Quest") joins this Agreement solely for the purposes of Article XIV herein.

W I T N E S S E T H:

WHEREAS, the Company, Manager and certain of their affiliates have entered into that certain asset purchase agreement dated as of the date hereof (the "Purchase Agreement"), pursuant to which Manager shall acquire certain of the assets and assume certain of the liabilities of the Hospital upon the satisfaction of the terms and conditions set forth therein (the "Transaction").

WHEREAS, the Company, Manager and such affiliates will be filing a certificate of need application with the State of Connecticut Department of Public Health, Office of Healthcare Access Division ("OHCA") to seek the approval of OHCA for the Transaction.

WHEREAS, the Company desires to retain the Manager for the purpose of rendering management, administration, consulting and purchasing services and support, and all other support needed for the operation of the Hospital on the terms and conditions hereinafter set forth, subject to the policies established by the Company and the general direction and control of the Board of Directors of the Company (the "Board"); and

WHEREAS, the Manager desires to provide those management services that are set forth in more detail in this Agreement for the account of the Company.

NOW, THEREFORE, in consideration of the foregoing, of the mutual premises contained herein and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending legally to be bound, hereby agree as follows. Capitalized terms not defined herein shall have the meanings ascribed to them in the Purchase Agreement.

ARTICLE I. ENGAGEMENT OF MANAGEMENT SERVICES

1.1. The Company hereby engages the Manager, and the Manager agrees to provide the management services set forth in this Agreement (collectively, the "Management Services") upon the terms and conditions hereinafter set forth. Each of the Manager and the Company agree to work cooperatively to manage the Hospital as provided for herein and in accordance with the terms and provisions of the Purchase Agreement and neither party shall take, or fail to take, any action that will cause any breach of the representations and warranties and covenants of the other party in the Purchase Agreement. The Hospital and the businesses conducted at or in connection with the operation of the Hospital shall be collectively referred to herein as the "Business".

1.2. In carrying out its duties hereunder, Manager shall comply in all material respects with the charity care policy adopted by the Company.

ARTICLE II. RETENTION OF CONTROL

2.1. The Company shall retain all powers incident to ownership of the Hospital including, without limitation, the following: (a) approving the appointment of Key Personnel (as hereinafter defined), (b) appointing and dismissing members to the medical staff, (c) establishing policies regarding the admission of patients, (d) determining the general and fiscal policies of the Hospital, (e) making or filing any notification of non-compliance or self-disclosure, including self-disclosure made pursuant to the CMS Self-Referral Disclosure Protocol, with any governmental body or third-party payor, and (f) establishing the scope of services to be provided at the Hospital. During the Term (as defined herein), neither the Board nor the Advisory Board of Trustees (the "Advisory Board") of the Hospital shall change and the Company shall be and shall remain the owner and holder of all licenses, contracts, certificates and accreditations, shall maintain such control over the assets and operations of the Hospital that is required by applicable licensing, certification, accreditation and other applicable laws and shall be the "provider of services" within the meaning of any third party contracts for services. The Manager shall follow the policies and procedures of the Company in performing its obligations hereunder. The Company shall also have certain approval and notification rights as described herein. All matters requiring the professional medical judgment of a provider shall remain the responsibility of the Hospital's medical staff and other health professionals. The Manager shall have no responsibility whatsoever to exercise any professional medical judgment, whether reserved by applicable law to licensed physicians or other healthcare professionals on the Hospital's medical staff or otherwise. The parties acknowledge that by entering into this Agreement, the Company does not delegate to Manager any of the powers, duties and responsibilities vested in the Board by law or the Hospital's Bylaws.

2.2. The Manager shall ensure that any new relationships with providers that it authorizes or enters into during the term of this Agreement pursuant to Section 2.3 below, including the Hospital's medical staff and other healthcare professionals, are in full compliance with all applicable laws, regulations and orders of governmental bodies and agencies. The Manager covenants and agrees that prior to presenting a new member to the medical staff for admission, contracting with a health professional on behalf of the Company, or entering into a new agreement with a contractor on behalf of the Company, the Manager will conduct appropriate credentialing of those providers, including, but not limited to, taking reasonable steps to determine whether those providers have ever been included on the Office of Inspector General's "exclusion list" of providers sanctioned, suspended or excluded from participation in a federal or state health care program. Manager's actions in this regard shall be consistent with industry standards. Throughout the Term, to the extent its participation is necessary or appropriate, the Manager will follow the Medical Staff Bylaws and Peer Review procedures of the Company governing the Hospital as of the Effective Time.

2.3. Manager will carry out its duties and responsibilities under this Agreement subject to the ultimate authority of the Company and nothing in this Agreement is intended to alter, weaken, displace or modify the ultimate authority of the Company's Board. The Manager shall not terminate or reduce any inpatient or outpatient services offered by the Hospital as of the

Effective Date, except with the prior written consent of the Company and in compliance with all applicable laws, regulations and orders. Company shall consult with the Hospital's Advisory Board, prior to the termination or reduction of any inpatient or outpatient service.

2.3.1 Manager acknowledges and agrees that certain authority of the Manager and its authorization to act on behalf of the Company is expressly conditioned on the consent and approval of the Board as set forth in this Agreement and, if applicable, its prior consultation with the Advisory Board.

2.3.2 Notwithstanding anything to the contrary in this Agreement, the parties agree and acknowledge that the Manager is authorized on behalf of and without any further approval from the Board (except as otherwise noted in this Section 2.3.2) (a) to take any action that is contemplated in any then current operating or capital budgets for the Hospital or other budget approved by the Board, including without limitation the physician recruitment budget, if any; (b) to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, less than $10,000 per year; (c) after written notice to the Company (including a copy of such proposed contract) to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, between $10,000 and $24,999 per year; and (d) after written notice to the Company (including a copy of such proposed contract) and consent of the Company, to enter into, make, perform and carry out all types of contracts, leases and other agreements, and amend, extend or modify any contract, lease or agreement at any time entered into by the Company, provided that each such contract, lease or agreement obligates the Company to pay, or to provide goods or services valued at, over $25,000 per year. Manager shall be authorized to execute, amend or terminate any contract with affiliates of Manager without the prior approval of the Board provided such contract is on fair market value terms and at rates equal to, or less than, those amounts being paid by the Company to third party(ies) for the same services. Upon consummation of the Transaction, Manager shall be obligated to assume all agreements entered into on behalf of the Company during the Term. Notwithstanding the foregoing, Manager shall not have authority to enter into, make, amend, extend or modify any managed care contract.

2.3.3 Subject to and in accordance with the terms, conditions and limitations of this Agreement and applicable law, regulations and orders, and the general direction and control of the Board, it is the intention and understanding of the parties that the Manager is delegated the complete authority to manage the operations of the Hospital for the account of the Company.

2.3.4 Manager shall deliver to the Company monthly (and, if requested by the Company, more frequent) status reports as to the business and financial operations of the Hospital and the performance of Manager's duties and services under this Agreement. Furthermore, from the date hereof until the Closing Date, Manager shall in a timely manner provide the Company with such information that it obtains in its role as Manager regarding the operations of the Hospital necessary for the Company and its affiliates to comply with all

reporting and information requirements set forth in the Purchase Agreement, the Hospital's Bylaws or as required by law.

2.4. Manager shall manage the operations of the Hospital in accordance with all applicable laws, regulations and orders. Manager shall promptly notify the Company, and the Company shall promptly notify Manager, of any investigation or inquiry, instituted by any third party (including those relating to any federal health care program) in respect of the Hospital or the Business or of any event, circumstance or fact that the notifying party believes is a violation of law.

ARTICLE III. MANAGEMENT SERVICES

3.1. Subject to the provisions of this Agreement, the Manager or its Affiliates will be responsible for overseeing all services necessary for the Hospital to operate on a daily basis. Prior to the Effective Date, the Board shall present Manager with the 2016 operating and capital budgets for the Hospital. During the Term, Manager shall manage the operations of the Hospital within and in accordance with such budgets (including any amendments or revisions thereto), provided that (1) the capital budget for 2017 shall be pro-rated on a monthly basis in accordance with the 2016 capital budget for the Hospital and (2) the operating budget for 2017 shall be modified as follows:

(a) No later than October 31st of each year during the Term, Manager shall prepare an operating budget (the "Revised Budget") to be presented to the Board. Upon the Board's approval, the Manager shall provide the Management Services in a manner consistent with the Revised Budget, subject to the terms of this Agreement.

3.2. Notwithstanding the foregoing, in the event a circumstance exists at the Hospital that poses an imminent life safety risk to patients or employees, the Manager shall be empowered to take reasonable steps to remedy such situation at the expense of the Company. Manager shall inform the Company as soon as practicable of the situation and the Manager's remediation efforts.

ARTICLE IV. ACCOUNTING AND BOOKKEEPING SERVICES

4.1. The Company shall be responsible for providing the following accounting and bookkeeping systems with respect to the operation of the Hospital:

(a) record keeping, billing and accounts payable accounting systems;

(b) accounting systems and data processing systems at the Hospital that are utilized to perform the functions necessary to efficiently and effectively operate the Hospital, including, without limitation, such accounting systems as are necessary and appropriate to enable the Hospital to allocate its costs and revenues to designated cost centers, and in connection therewith, providing and maintaining all equipment necessary to provide the Management Services; and

(c) payroll systems.

4.2. The Manager shall be responsible for overseeing the accounting and bookkeeping functions under the systems provided by the Company and described in Section 4.1. In furtherance of the foregoing, the Manager will:

(a) not make any material changes in the accounting, financial or bookkeeping practices or systems of the Hospital without the consent of the Company;

(b) implement and administer policies and procedures for the management and control of purchases, accounts payable, cash disbursements and all business related transactions, including the maintenance of books of account and financial records;

(c) provide Management Services in accordance with the Company's policies and procedures for the management and control of patient billing, claims filing, accounts receivable, credit collection and receivables activities and all necessary patient account transactions;

(d) cooperate in periodic audits of the Hospital by state and/or federal agencies and the preparation and submission of all financial and other reports required to be submitted to OHCA, the Department of Public Health and the Office of the Attorney General;

(e) cooperate in the preparation of periodic financial statements, including those as required by the Company's organizational documents (if any);

(f) cooperate, when required, with the Company's internal audit and compliance requirements;

(g) deposit in the bank accounts for the Hospital all funds generated from the operation of the Hospital and supervise the disbursement of such funds for the operation of the Hospital subject to the budgets approved by the Company and the limitations agreed to by the parties; and

(h) prepare, or provide for the preparation of, information necessary for Company to process payroll.

ARTICLE V. OTHER MANAGEMENT SERVICES

Subject to the prior approval of the Company, the Manager and the Company may agree in writing to modify the Management Services to be provided pursuant to this Agreement.

ARTICLE VI. EMPLOYEES

During the term of this Agreement, the Manager will provide the Company with the services of a Chief Executive Officer, the Chief Financial Officer and the Chief Nursing Officer of the Hospital (the "Key Personnel"), each of whom shall be subject to the prior approval of the Board, provided, however, that if Manager offers employment to the Hospital's existing Chief Executive Officer, Chief Financial Officer or Chief Nursing Officer, such individuals shall be deemed to be approved by the Board. In addition to the Key Personnel,

certain other employees of the Manager and its affiliates may assist Manager in performing the Management Services (the "Other Employees").

All Key Personnel, and Other Employees when assisting Manager in performing Management Services, shall be responsible to the Board or the Chief Executive Officer as required by applicable law or regulations. All other employees of the Company providing services at the Hospital shall remain employees of the Company until the Closing of the Transaction. During the Term, the Manager shall have, in accordance with and subject to the Company's policies and procedures and any applicable state and federal employment laws, the right to control and direct the employees as to the performance of duties and as to the means by which such duties are performed. The Manager shall comply with the Company's human resources policies and procedures in sanctioning any employee of the Company, and shall not terminate any such employee without consulting with and obtaining the consent of the Company's Director of Human Resources. Any replacement or substitution of any Key Personnel during the term of this Agreement shall be subject to the prior approval of the Board. In the event that this Agreement terminates for any reason other than expiration at Closing, the Manager shall terminate the Key Personnel and Company shall be required to offer employment to the Key Personnel on the terms and conditions that it offered to such personnel prior to the Effective Date.

ARTICLE VII. LEGAL ACTIONS

The Manager shall advise and assist the Company in instituting or defending, as the case may be, in the name of the Company and/or the Manager, all actions arising out of the operation of the Hospital and any and all legal actions or proceedings relating to the Hospital and operations therefrom to which either the Company or the Manager is a named or threatened party. The Manager also shall assist the Company in taking such actions as are necessary to protest, arbitrate or litigate to a final decision in any appropriate court or forum any violation, penalty, sanction, order, rule or regulation affecting the Hospital. Upon request of the Company, Manager shall assist the Company with the filing of any notification of non-compliance or self-disclosure, including self-disclosure made pursuant to the CMS Self-Referral Disclosure Protocol, with any governmental body or third-party payor. Ultimately the Company shall determine when to engage outside legal counsel for a specific issue or matter and how to defend any such action.

ARTICLE VIII. TERM

The term of this Agreement shall commence on October 1, 2016 (the "Effective Date"), and shall remain in place and effective until the Closing, unless sooner terminated as provided herein.

ARTICLE IX. DEFAULT AND TERMINATION

9.1. It shall be an event of default ("Event of Default") hereunder:

9.1.1. If the Company shall fail to make or cause to be made any payment to the Manager required to be made hereunder and such failure shall continue for thirty (30) days after notice thereof shall have been given to the Company.

9.1.2. If either party fails in any material respect to comply with its obligations under this Agreement, including a failure by the Manager in any material respect to make available to the Company any material portion of the Management Services required by this Agreement, and such failure shall not be cured: (a) within thirty (30) days after notice thereof by the non-breaching party to the breaching party if such failure is capable of cure within such period; or (b) within a reasonable period of time for cure if such failure cannot reasonably be cured within such thirty (30) day period, provided the breaching party commences its curative actions within such thirty (30) day period and proceeds diligently to cure thereafter (in which event, the breaching party shall have a reasonable time beyond such thirty (30) day period to complete its cure of the alleged basis for the non-breaching party's election to terminate).

9.1.3 If either the Company or Manager is excluded from participation in any federal or state healthcare program, including Medicare and Medicaid, for any reason, or if either is convicted of violating a federal or state healthcare law that is material to the business or operations of such party in which case the excluded or convicted party, as applicable, shall promptly notify the other party in writing.

9.1.4. If either the Company or the Manager shall apply for or consent to the appointment of a receiver, trustee or liquidator of such party or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangements with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall be entered by any court of competent jurisdiction, on the application of a creditor, adjudicating such party bankrupt or insolvent, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days.

9.1.5. If any Event of Default by the Company shall occur and be continuing, or if any Event of Default by Manager shall occur and be continuing, the non-defaulting party may forthwith terminate this Agreement, and neither party shall have any further obligations pursuant to this Agreement, except those provided pursuant to the provisions of Articles IX, X, XII, and XIII hereof. If any Event of Default by the Company or Manager listed in Section 9.1.4 shall occur, the term of this Agreement shall terminate, at the option of the non-defaulting party, upon written notice to the bankrupt party.

9.1.6 If the Purchase Agreement expires or is terminated for any reason, this Agreement shall terminate.

9.2. Upon termination hereof, the Manager's obligations to perform services hereunder shall completely cease; provided, however, that the Company and the Manager shall perform such matters as are necessary to wind up their activities pursuant to this Agreement in an orderly manner. In the event of termination of this Agreement, the Manager also shall turn over to the Company as soon as possible any and all information related to the Company's

receivables, ledgers and other business records which are then in the Manager's possession. The Manager shall be entitled upon termination of this Agreement to receive payment of all amounts theretofore unpaid which have been earned and are due to the Manager through the date of termination.

ARTICLE X. MANAGEMENT FEES

10.1. In exchange for the Manager's provision of the Management Services, the Company shall pay the Manager a fair market value fee that, at a minimum, is equal to the Manager's direct costs in providing the Management Services (the "Management Fee"). Notwithstanding the above, any costs incurred by the Manager relating to the compensation of its employees, other than the Key Personnel, shall be excluded from the Management Fee.

10.2. The Management Fee will be Manager's sole compensation for the Management Services. The Manager acknowledges that the Management Fee is intended to be exempt from the Connecticut sales and use tax pursuant to Section 12-412 (5) of the Connecticut General Statutes through June 30, 2017 and that the Management Fee may be subject to the sales and use tax for periods arising after such date.

10.3. Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the Manager and any of its affiliates providing services with a value or cost of $10,000 or more over a twelve (12) month period shall make available to the Secretary the contract, books, documents and records that are necessary to verify the nature and extent of the cost of providing such services. Such inspection shall be available up to four years after the rendering of such services. The parties agree that any applicable attorney-client, account-client or other legal privilege shall not be deemed waived by virtue of this Agreement.

ARTICLE XI. NO PARTNERSHIP

The Manager and the Company affirmatively state that they do not have the intention to form a joint venture or partnership for tax or any other purposes, nor have they done so, by entering this Agreement. If, however, a joint venture or partnership is found to exist for federal income tax purposes (a) capital accounts will be maintained for the Manager and the Company on a tax accounting basis; (b) net income will be allocated to the Manager in the amount of the payments due the Manager pursuant to Article XI hereof; (c) all remaining net taxable income or loss will be allocated to the Company; and (d) upon termination, distributions will be in accordance with the Manager's and the Company's capital account balances.

ARTICLE XII. OWNERSHIP OF ASSETS; CONFIDENTIALITY

12.1. Systems Ownership. The Company retains all ownership and other rights in all the Assets, including but not limited to all systems, manuals, computer software, materials and other information, in whatever form (collectively referred to as the "Systems") and nothing contained in this Agreement shall be construed as a license or transfer of such Systems or any portion thereof, either during the Term or thereafter. Upon the termination or expiration of this

Agreement, the Company shall retain all of the Systems except as set forth in the Purchase Agreement.

12.2. Systems Confidentiality. The Manager acknowledges that the Company has invested a significant amount of its resources in developing and maintaining the Systems and that the value to the Company of the Systems may be diminished or destroyed if the Manager discloses the Systems or any portion thereof to a third party. Accordingly, the Manager shall maintain the confidentiality of the Systems. The Manager shall not duplicate or permit the duplication of any portion of the Systems and shall not permit access to the Systems by the Manager's personnel or any third party other than as reasonably necessary or appropriate to provide Management Services in the ordinary course of business. The Manager shall take at least those commercially reasonable steps to protect the Company's information that it would take to protect its own confidential information. The provisions of this Article XIV shall survive any termination or expiration of this Agreement, except as set forth in the Purchase Agreement.

12.3. Treatment of Confidential Information. Each party and its affiliates shall treat all non-public information regarding the other party or its affiliates that is obtained as part of this engagement as confidential and proprietary and shall not release or share such information with any third party, except as may be required by law or as authorized by the party to which the information pertains or as reasonably necessary in connection with the performance of its duties hereunder. Certain non-public information relating to Company, including but not limited to managed care contracts, managed care reimbursement rates, strategic and business plans, operating and capital budgets, physician recruitment plans, and employee compensation, may be considered competitively sensitive ("Competitively Sensitive Information") under federal and state antitrust laws. Company shall only disclose Competitively Sensitive Information to: (a) Key Employees; and (b) other employees of Manager as required to oversee and to maintain the operations of Company. Company shall not disclose, and Manager shall institute policies and procedures to prevent disclosure of, Competitively Sensitive Information to employees of Manager who also have direct responsibilities for the operations of Manager's other hospitals and employed physician groups. Summaries of Competitively Sensitive Information that are aggregated or blinded as to specific managed care organizations, vendors, or employees shall not be Competitively Sensitive Information hereunder. This restriction on sharing Competitively Sensitive Information shall only expire upon Closing of the Transaction and shall continue indefinitely in the event of a termination of this Agreement for any other reason.

12.4. Covenant Not to Solicit. During the Term, and for a period of one (1) year following the early termination or expiration of the Term for any reason other than the Closing, Manager shall not, through an affiliate or separate employee leasing or staffing company or otherwise, specifically solicit for employment, any employee or independent contractor of Company (collectively referred to herein as the "Employees" or individually as the "Employee"), unless Company gives its written consent thereto. As liquidated damages for any breach of this Section 12.4 by Manager, Manager agrees that, if it breaches this Section 12.4 of the Agreement, Manager will pay Company an amount equal to two times (2x) the then current salary of such Employee within 30 (thirty) days of the employment as reasonable compensation to Company for damages incurred by such actions on the part of Manager. The Parties acknowledge and agree that this amount (a) a constitutes a fair, reasonable and appropriate resolution of a violation of this Section and the resulting damages incurred by Company, and (b) does not constitute a

penalty. Manager's failure to pay this amount on or before the date due shall create an immediate right on the part of Company to pursue collection of this amount with interest. Manager agrees to reimburse Company for any and all reasonable attorney's fees, other costs, fees and expenses as may be incurred by Company in order to enforce its rights set forth in this Section 13.4. In the event that Manager fails to uphold its obligations hereunder, the Parties confirm that Company may seek any and all remedies in law or equity, including injunctive relief as applicable, relating to any violation of this Section or of any other provisions of this Agreement. By way of clarification, the Parties agree that Manager may generally advertise and post job openings and may hire an Employee who responds to such general solicitation.

ARTICLE XIII. INDEMNIFICATION

13.1. Indemnification by the Company. The Company agrees to indemnify and hold harmless the Manager, its affiliates and shareholders, and their respective shareholders, directors, officers, employees and agents (collectively, a "Manager Indemnified Party") from and against any and all losses, claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims) (a "Loss"), which may be asserted against any of the Manager Indemnified Parties arising in connection with performance of its duties or obligations hereunder, including without limitation matters relating to: (a) the breach of this Agreement by the Company; (b) any pending or threatened malpractice or other tort claims asserted against the Manager relating to the Hospital; (c) any action against the Manager brought by any current or former medical staff members or employees, and (d) any act or omission by any medical staff member, or employee, or other personnel who were under the supervision of a member of the medical staff as a result of providing medical services to such medical staff member's patient; provided that such Loss has not been caused by the breach of this Agreement by Manager or by the gross negligence or willful misconduct of or a knowing violation of law by, the Manager Indemnified Party seeking indemnification pursuant to this Agreement.

13.2. Indemnification by the Manager. The Manager agrees to indemnify and hold harmless the Company and its members, partners, or shareholders (as appropriate), its directors, and its officers, employees and agents (collectively, a "Company Indemnified Party") from and against any Loss, which is caused by: (a) the breach of this Agreement by the Manager; or (b) a violation of law by the Manager; provided that such Loss has not been caused by the gross negligence or willful misconduct of or a knowing violation of law by, the Company Indemnified Party seeking indemnification pursuant to this Agreement.

13.3. Sole Remedy. This Article XIII shall constitute the sole remedy of the parties hereto with respect to any Loss resulting from a third party claim.

ARTICLE XIV. GUARANTEE

14.1. HealthQuest Guarantee. HealthQuest hereby unconditionally and irrevocably guarantees, as a primary obligor and not only a surety (the "**HealthQuest Guarantee**"), the prompt and complete payment and performance (not just collection) of any and all of the Manager's obligations to the Company under this Agreement (the "**Obligations**"), if, as, when and to the extent that such Obligations are required to be performed pursuant to such

agreements. If Manager does not perform an Obligation, HealthQuest shall promptly perform the Obligation. The obligations of HealthQuest under the HealthQuest Guarantee are independent of the obligations of the Manager under the Agreement and a separate action or actions may be brought against HealthQuest, whether action is brought against the Manager or whether the Manager is joined in any such action or actions; provided, however, as a condition precedent to the commencement of any action against HealthQuest, (i) Manager shall have first failed to satisfy an Obligation in the time specified in the Agreement, taking into account any notice and cure periods, and (ii) Company shall have an ongoing duty to provide to Manager any notices required under this Agreement. Except as set forth in this Article XIV, HealthQuest hereby waives all rights and defenses of a surety under applicable law. Notwithstanding the foregoing, HealthQuest shall be entitled to assert as a defense to any claim under this Article XIV, (i) that the Obligations in respect of which a demand has been made are not yet due under the terms of this Agreement, (ii) that such Obligations have been previously performed in full, and (iii) any claims, defenses, counter claims, setoffs or circumstances excusing payment or performance which the Manager would be entitled to assert under this Agreement. Except as specifically set forth in this Article XIV, the HealthQuest Guarantee is an absolute, irrevocable, primary, continuing, unconditional, and unlimited guaranty of performance and payment subject to and within the limitations of this Agreement. The HealthQuest Guarantee shall remain in full force and effect (and shall remain in effect notwithstanding any amendment to this Agreement) for HealthQuest until all of the obligations of the Managers have been paid, observed, performed, or discharged in full.

ARTICLE XV. MISCELLANEOUS

15.1. Business Associate. Manager acknowledges that the services it provides hereunder may make it a business associate of the Hospital. Manager agrees to execute a HIPAA business associate agreement, in substantially the form attached hereto as Exhibit A, separately outlining its obligations as a business associate with respect to the privacy and security of individually identifiable health information it may acquire in the course of its duties hereunder.

15.2. Referral Disclaimer. The amounts to be paid hereunder represent the fair market value of the services to be provided as established by arm's length negotiations by the parties and have not been determined in any manner that takes into account the volume or value of any potential referrals between the parties. No amount paid hereunder is intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any party to any other party. In addition, the amounts charged hereunder do not include any discount, rebate, kickback or other reduction in charges, and the amount charged is not intended to be, nor shall it be construed to be, and inducement or payment for referral of patients by any party to any other party. Further, it is agreed that none of the parties shall refer or attempt to influence the referrals of any patients to any particular program.

15.3. Material Change in Law. In the event any material change in any federal or state law or regulation creates a significant likelihood of sanction or penalty based on the terms of this Agreement or would prohibit either party from billing for or receiving payment for any services provided by the parties, then upon request of either party, the parties hereto shall enter into good faith negotiations to renegotiate the affected provision or provisions of the

Agreement to remedy such term or condition. In the event the parties are unable to reach agreement on the affected provision or provisions, so as to bring such provision or provisions into compliance with the law or regulation within thirty (30) days of the initial request for renegotiation, this Agreement shall terminate upon ten (10) days' written notice or the effective date of such change (whichever is earlier). Each party hereto expressly recognizes that upon request for renegotiation, each party has a duty and obligation to the other only to renegotiate the affected term(s) in good faith.

15.4. Notices. All notices, demands and other communications to be given or delivered pursuant to or by reason of the provisions of this Agreement shall be in writing and shall be deemed to have been given (i) when personally delivered; (ii) on the business day sent (or the next business day if sent on a non-business day) if delivered by facsimile with receipt confirmation; (iii) one day after deposit with Fed Ex, UPS or similar reputable overnight courier service; or (iv) three days after being mailed by first class mail, return receipt requested. Notices, demands and communications to the Manager and the Company shall, unless another address is specified in writing, be sent to the addresses indicated below:

If to the Company:

Essent Healthcare of Connecticut, Inc.
103 Continental Place
Suite 200
Brentwood TN 37027
Attn: General Counsel

with a copy to:

RegionalCare Hospital Partners, Inc.
103 Continental Place
Suite 200
Brentwood TN 37027
Attn: General Counsel

Waller Lansden Dortch & Davis, LLP
Nashville City Center
511 Union Street, Suite 2700
Nashville, Tennessee 37219
Fax No. 615-244-6804
Attn: MaryEllen S. Pickrell

If to the Manager:

Health Quest Systems, Inc.
1351 Route 55, Suite 200
Lagrangeville, NY 12540
Attention: Michael Holzhueter, Senior Vice President and General Counsel

Email: mholzhue@health-quest.org

with a copy to:

McDermott Will & Emery
28 State Street
Boston, MA 02109-1775
Attn: Charles Buck Esq.

15.5. Section Captions. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

15.6. Assignment. Manager shall have the right to assign this Agreement without prior written consent of the Company if such assignment is to an affiliate of Manager. The Company shall not assign this Agreement without the prior written consent of Manager. Subject to the foregoing, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and permitted assigns. This Agreement is intended solely for the benefit of the parties hereto and is not intended to, and shall not, create any enforceable third party beneficiary rights.

15.7. Severability. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

15.8. Amendment. No changes in, additions or amendments to this Agreement shall be effective unless and until made in writing and signed by both parties hereto.

15.9. Counterpart Execution. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.

15.10. Integrated Agreement. This Agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations or warranties among the parties other than those set forth herein or herein provided for.

15.11. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Connecticut without regard to its principles of conflicts of laws.

15.12. Waiver. Failure by any party to enforce any of the provisions hereof for any length of time shall not be deemed a waiver of its rights set forth in this Agreement. Such a waiver may be made only by an instrument in writing signed by the party sought to be charged with the waiver. No waiver of any condition or covenant of this Agreement shall be deemed to imply or constitute a further waiver of the same or any other condition or covenant, and nothing contained in this Agreement shall be construed to be a waiver on the part of the parties of any right or remedy at law or in equity or otherwise.

15.13. Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT ANY ACTION, PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

15.14. Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine and neuter, and the number of all words herein shall include the singular and plural.

15.15. Force Majeure. Neither party shall be liable for any failure, inability or delay to perform hereunder, if such failure, inability or delay is due to any cause beyond the reasonable control of the party so failing, and due diligence is used in curing such cause and in resuming performance.

[Signature page follows]

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their duly authorized representatives effective as of the date and year first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name: Michael W. Browder
Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: _____

EXECUTED AND DELIVERED SOLELY FOR PURPOSES OF ARTICLE XIV OF THIS AGREEMENT:

HEALTH QUEST SYSTEMS, INC.

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their duly authorized representatives effective as of the date and year first above written.

ESSENT HEALTHCARE OF CONNECTICUT, INC.

By: _____
Name: _____
Title: _____

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: President

EXECUTED AND DELIVERED SOLELY FOR
PURPOSES OF ARTICLE XIV OF THIS AGREEMENT:

HEALTH QUEST SYSTEMS, INC.

By: _____
Name: _____
Title: _____

EXHIBIT A

HIPAA BUSINESS ASSOCIATE AGREEMENT

[SEE ATTACHED]

HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 13th day of September, 2016, by and between Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital, a Connecticut corporation (the "Company"), and Vassar Health Connecticut, Inc., (the "Manager"), a Connecticut non-profit corporation ("Business Associate").

1. Purpose. The Company and Business Associate hereby enter into this Agreement because Business Associate provides services for the Company which may involve the use and/or disclosure of individually identifiable health information relating to the Company's patients ("Protected Health Information" or "PHI"). In accordance with the federal privacy and security regulations set forth at 45 CFR Part 160 and Part 164 (the "HIPAA Regulations"), which require the Company to have a written contract with each of its business associates, the parties wish to incorporate satisfactory assurances that the Business Associate will appropriately safeguard the privacy and security of Protected Health Information.

2. Effective Date. The effective date of this Agreement shall be October 1, 2016 (the "Effective Date").

3. Permitted Uses and Disclosures. Business Associate shall not use or disclose any Protected Health Information other than as permitted by this Agreement or the Hospital Management Agreement by and between the Company and Business Associate dated September 9, 2016 (the "Underlying Agreement") in order to perform Business Associate's obligations hereunder or as required by law. Business Associate shall not use or disclose the PHI in any way that would be prohibited if used or disclosed in such a way by Company. Business Associate may also use or disclose PHI as required for Business Associate's proper management and administration, provided that if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring that party (i) to hold the PHI confidentially and not to use or further disclose the PHI except as required by law, and (ii) to notify Business Associate immediately of any instances of which it becomes aware in which the confidentiality of the PHI is breached.

4. Minimum Necessary Information. Business Associate shall only request from Company, and shall only use and disclose, and the Company shall only provide to Business Associate, the minimum amount of PHI necessary to carry out the Business Associate's responsibilities under this Agreement and the Underlying Agreement.

5. Reporting. If Business Associate becomes aware of any use or disclosure of PHI in violation of this Agreement, Business Associate shall immediately report such information to Company. Business Associate shall also require its employees, agents, and subcontractors to immediately report any use or disclosure of PHI in violation of this Agreement. Business Associate shall cooperate with, and take any action reasonably required by, the Company to mitigate any harm caused by such improper disclosure.

6. Agents and Subcontractors. Business Associate shall require its employees, agents, and subcontractors to agree not to use or disclose PHI in any manner except as specifically allowed herein, and shall take appropriate disciplinary action against any

employee or other agent who uses or discloses PHI in violation of this Agreement or the Underlying Agreement. Business Associate shall require any agent or subcontractor that carries out any duties for Business Associate involving the use, custody, disclosure, creation of, or access to PHI to enter into a written contract with Business Associate containing provisions no less restrictive than the restrictions and conditions set forth in this Agreement.

7. Company Policies, Privacy Practices, and Restrictions. The Company shall provide Business Associate with access to the Company's notices, policies, and procedures, including updates thereto provided from time to time by the Company, and Business Associate shall comply with all such notices, policies, and procedures. Business Associate shall assure that each of employees has received appropriate training regarding HIPAA confidentiality and patient privacy compliance issues.

8. Patient Rights. Business Associate acknowledges that the HIPAA Regulations require the Company to provide patients with a number of privacy rights, including (a) the right to inspect PHI within the possession or control of the Company, its business associates, and their subcontractors, (b) the right to amend such PHI, and (c) the right to obtain an accounting of certain disclosures of their PHI to third parties. Business Associate shall establish and maintain adequate internal controls and procedures allowing it to readily assist the Company in complying with patient requests to exercise any patient rights granted by the Privacy Regulations, and shall comply with all Company requests to amend, provide access to, or create an accounting of disclosures of the PHI in the possession of Business Associate or its agents and subcontractors. If Business Associate receives a request directly from a patient to exercise any patient rights granted by the Privacy Regulations, Business Associate shall immediately forward the request to the Company.

9. Safeguards. Business Associate shall use appropriate physical, technical, and administrative safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement and by the Company's privacy and security policies. Upon Company's reasonable request, Business Associate shall allow the Company to review such safeguards; provided, however, that any such review that requires access to Business Associate's facilities shall occur during normal business hours and shall be conducted in a manner that does not disrupt Business Associate's operations.

10. Security.

a. If Business Associate creates, receives, maintains, or transmits electronic PHI (as defined under HIPAA) on behalf of the Company, the Business Associate shall comply with the HIPAA Security Rule and shall:

i. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI;

ii. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate safeguards to protect the electronic PHI; and

iii. Report to the Company any security incident of which Business Associate becomes aware. The term "security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system (the parties acknowledge and agree that this section constitutes notice by Business Associate to Company of the ongoing existence and occurrence or attempts of unsuccessful security incidents for which no additional notice to Company shall be required).

b. For purposes of this section of this Agreement, "electronic PHI" shall mean PHI that is transmitted by electronic media or maintained in any electronic media. As used herein, "electronic media" shall mean:

i. Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

ii. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

11. Audits and Inspections. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Company for inspection upon request, and to the Secretary of Health and Human Services to the extent required for determining the Company's compliance with the Privacy Regulations. Notwithstanding the above, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by the Company or Business Associate by virtue of this provision.

12. Termination and Return of PHI. Notwithstanding anything to the contrary in the Underlying Agreement, the Company may terminate this Agreement immediately if, in the Company's reasonable opinion, Business Associate has breached any provision of this Agreement and has not cured such breach within thirty (30) days of Business Associate's receipt of written notice of such breach from the Company. Upon termination of this Agreement for any reason, Business Associate shall, if feasible, return or destroy all PHI received from the Company or created by Business Associate on behalf of the Company. If such return or destruction is not feasible, the parties agree that the requirements of this Agreement shall survive termination and that Business Associate shall limit all further uses and disclosures of PHI to those purposes that make the return or destruction of such information infeasible.

13. Interpretation; Change in Law. Any ambiguity in this Agreement shall be resolved to permit the Company to comply with the HIPAA Regulations. In the event of any inconsistencies between the terms of the Underlying Agreement and this Agreement, the terms of this Agreement shall prevail. The parties acknowledge that the American Recovery and

Reinvestment Act of 2009 ("ARRA") requires the Secretary of Health and Human Services to promulgate regulations and interpretative guidance that is not available at the time of executing this Agreement. In the event Company determines in good faith that any such regulation or guidance adopted or amended after the execution of this Agreement shall cause any paragraph or provision of this Agreement to be invalid, void or in any manner unlawful or subject either party to penalty, then the parties agree to renegotiate in good faith to amend this Agreement to comply with the change in law, regulation or interpretative guidance.

[Signature page follows]

IN WITNESS WHEREOF, the parties hereby indicate their acceptance of this Agreement.

ESSENT HEALTHCARE OF CONNECTICUT, INC. d/b/a Sharon Hospital, a Connecticut corporation

By: _____

Name: Michael W. Browder

Title: Executive Vice President and Chief Financial Officer

VASSAR HEALTH CONNECTICUT, INC.

By: _____

Name: _____

Title: _____

IN WITNESS WHEREOF, the parties hereby indicate their acceptance of this Agreement.

ESSENT HEALTHCARE OF CONNECTICUT, INC. d/b/a Sharon Hospital, a Connecticut corporation

By: _____
Name: _____
Title: _____

VASSAR HEALTH CONNECTICUT, INC.

By: _____
Name: _____
Title: President

EXHIBIT D

BYLAWS

OF

VASSAR HEALTH CONNECTICUT, INC.

(a Connecticut nonstock, nonprofit corporation)

ARTICLE I
Name and Organization

1.01 Name of the Corporation. The name of this corporation shall be Vassar Health Connecticut, Inc. (the "Corporation"). The Corporation shall do business under the assumed name "Sharon Hospital."

1.02 Principal Office. The principal office of the Corporation shall be located at 50 Hospital Hill Road, Sharon, Connecticut 06069.

ARTICLE II
Membership of the Corporation

2.01 Membership. The Corporation's sole member is Health Quest Systems, Inc. ("Health Quest" or the "Sole Member").

2.02 Operating Powers Delegated and Reserved to Health Quest. Health Quest, acting through its Board of Trustees, has accepted the delegation of and exercises the operating authority described in this Section 2.02 (collectively, "Reserved Powers"). The Corporation shall not take any action requiring the action of Health Quest until Health Quest has exercised the Reserved Powers. Action by the Corporation that is subject to the exercise of such Reserved Powers by Health Quest shall not be effective until the Corporation has received written notice of the appropriate action having been taken by Health Quest. The following Reserved Powers are reserved specifically and exclusively to Health Quest, and no attempted exercise of any such power by anyone other than Health Quest shall be valid or of any force or effect whatsoever:

(a) Corporate Documents. Adopt, approve, amend and repeal the Bylaws and Certificate of Incorporation of the Corporation.

(b) Appointment and Removal of Trustees and Board Chair. Fix the number of and elect, appoint, fill vacancies in and remove, with or without cause, the Trustees; and elect and remove, with or without cause, the Chair and Vice-Chair of the Board of Trustees of the Corporation, provided the Chair of the Corporation's Board of Trustees is consulted prior to the removal of the Vice-Chair.

(c) Strategic and Financial Plan. Approve the strategic and financial plan of the Corporation.

(d) Rationalization of Clinical Services. Subject to the requirements of law, open, close, locate or relocate any and all clinical services of the Corporation.

(e) Sale or Acquisition of Assets. Subject to the requirements of law and after notice to the Chair of the Corporation's Board of Trustees,

(i) Approve any sale, mortgage, lease, loan, gift or pledge of any of the Corporation's real property irrespective of amount, or of any other assets (other than real property, but including intellectual property) in excess of an amount to be fixed from time to time by Health Quest;
(ii) Approve any acquisition of real property for the Corporation, including the acquisition of any leasehold interests irrespective of amount;
(iii) Approve any acquisition by the Corporation of other assets (other than real property, but including intellectual property) whose value exceeds an amount to be fixed from time to time by Health Quest.

(f) Merger, Consolidation, Dissolution. Approve any merger, consolidation or dissolution of the Corporation and approve the disposition of the assets of the Corporation at the time of dissolution, after notice to the Chair of the Corporation's Board of Trustees.

(g) Reorganization and Formation of New Entities. Approve any corporate reorganization of the Corporation and the development or dissolution of any subsidiary organizations, including corporations, partnerships or other entities, after notice to the Chair of the Corporation's Board of Trustees.

(h) Approval of Budgets. Approve any capital or operating budgets of the Corporation.

(i) Approval of Debt. Approve the debt of the Corporation that is in excess of such limits as are established by Health Quest.

(j) Approval of CON Applications. Approve the submission of certificate of need applications by the Corporation.

(k) Election and Removal of Hospital President. Elect, appoint and remove, with or without cause, the President of the Corporation after consultation with the Chair of the Corporation's Board of Trustees, or if any such action is recommended by the Chief Executive Officer of Health Quest, approve such action as recommended.

(l) Evaluation of Hospital President. Approve the criteria for and the process of evaluating the performance of the President of the Corporation, or if any such action is recommended by the Chief Executive Officer of Health Quest, approve such action as recommended.

(m) Compensation of Hospital President. Determine the compensation of the Corporation's President.

(n) Appointment of Auditor. Appoint a certified public accountant to prepare certified audits of the Corporation's accounts for and on behalf of Health Quest, in addition to the annual financial audit prepared for and on behalf of the Board of Trustees.

(o) Settlement of Litigation. Approve settlement of any litigation to which the Corporation is

a party after consultation with the Chair of the Corporation's Board of Trustees.

(p) Subsidiary Corporations. Act for the Corporation, to the full extent of Health Quest's legal authority, whenever the Corporation acts as member or shareholder of another corporation.

(q) Philosophy and Mission Statement. Approve, interpret, and change the statement of mission and philosophy to be adopted by the Corporation and to require the Corporation to operate in conformance with its statement of mission and philosophy.

2.03 Annual Meeting. The annual meeting of the Sole Member shall be held annually with reasonable notice in the month of April, or such other month as approved by Health Quest.

2.04 Special Meetings. Special meetings of the Sole Member shall be held only at the discretion and call of the Chair, the Vice-Chair of the Board, if acting on behalf of the Chair, or the Sole Member.

2.05 Notices of Special Meetings. Notices of special meetings shall be given by facsimile, mail, email, or if necessary, orally, and shall state the purposes, time and place of the meeting. Notice of a special meeting shall be given not fewer than ten (10) days before that meeting except that, if the Chair determines, in his/her discretion, that it is not possible to give ten (10) days' notice due to exigent circumstances, notice may be given orally, in person or by telephone or email, one (1) day before the meeting. Only business stated in the notice may be transacted at the meeting. No prior notice shall be required for any special meeting called by the Sole Member.

2.06 Place of Meetings. Meetings of the Sole Member shall be held at the principal office of the Corporation or at such other place, within or without the State of Connecticut, as may be fixed by the Chair, the Vice Chair of the Board, if acting on behalf of the Chair, or the Sole Member.

2.07 Member Action In Lieu of a Meeting. Any action required or permitted to be taken by Health Quest under applicable law, the Certificate of Incorporation or these Bylaws may be taken without a meeting, without prior notice and without a vote, if Health Quest gives its written consent to such action in a manner consistent with law and Health Quest's corporate documents.

ARTICLE III
Board of Trustees

3.01 Composition. The Board of Trustees of the Corporation shall have no fewer than three (3) and no more than fifteen (15) Trustees, excluding *ex-officio* Trustees, which number may be changed by Health Quest. The Board of Trustees shall be comprised of the following members:

(a) Elected Trustees. Elected voting Trustees shall be elected solely by Health Quest

(b) *Ex-officio* Trustees. The following shall be voting *ex-officio* Trustees:

(i) The Hospital President
(ii) Immediate Past Chair; and
(iii) President of the Corporation Medical Staff.

For purposes of these Bylaws, the "entire Board of Trustees" shall mean the entire number of Trustees within the range specified in this Section 3.01 who were elected as of the most recently held election of Trustees, including any *ex-officio* Trustees.

3.02 Qualifications. All Trustees must be interested and willing to commit to the Corporation's mission and vision and to devote the time required. For the initial appointment of the Elected Trustees, at least eighty (80%) percent shall be individuals nominated by the Foundation for Community Health, Inc. ("FCH") (the "FCH Nominated Appointees). The initial FCH Nominated Appointees shall be divided such that an equal number of FCH Nominated Appointees serve in each of the initial staggered terms required by Section 3.03(a). Any vacancy or removal of a FCH Nominated Appointee, whether in the initial staggered term or immediately subsequent three (3) year term, shall be filled by an individual nominated by FCH.

3.03 Terms of Office and Term Limits.

(a) Elected Trustees. Elected Trustees shall be elected for an initial term of three (3) years. Such Trustees may be elected to successive terms. The term of office of an elected Trustee shall begin at the adjournment of the Annual Meeting at which he/she is elected. The Sole Member shall have the right to stagger the terms of elected Trustees by designating one-third of the elected Trustees as Group 1 Trustees, one-third of the elected Trustees as Group 2 Trustees, and one-third of the elected Trustees as Group 3 Trustees. If so designated by the Sole Member, the initial term of the Group 1 Trustees shall be one (1) year, the initial term of Group 2 Trustees shall be two (2) years and the initial term of the Group 3 Trustees shall be (3) years. Thereafter, the terms of each Group of Trustees shall be three (3) years.

(b) *Ex-Officio* Trustees. *Ex-officio* Trustees shall be members of the Board of Trustees for the period he/she holds such office.

3.04 Trustees *Emeriti*. Health Quest may elect present or former Trustees as Trustees *Emeriti* in recognition of such individuals' service to the Corporation. Trustees *Emeriti* shall have no vote or term limits and shall serve at the pleasure of Health Quest. They may be subject to call by the Chair or Hospital President for consultation or special assignments.

3.05 Vacancies. Vacancies occurring on the Board of Trustees in the period between Annual Meetings may be filled by Health Quest after consulting with the Chair of the Corporation's Board of Trustees. The term of office of a Trustee elected to fill a vacancy shall continue for the remainder of the term of the vacating Trustee.

3.06 Resignation. Any Trustee may resign his/her position as a Trustee by delivering a written resignation to the Chair of the Corporation's Board of Trustees.

3.07 Removal. Any Trustee may be removed with or without cause by Health Quest.

3.08 Attendance. Trustees shall attend at least seventy-five percent (75%) of the regular meetings of the Board, which shall be considered active participation by an elected Trustee. Attendance at fewer meetings, unless excused, shall constitute grounds for the Trustee's removal.

3.09 Conflicts of Interest. Trustees shall comply with Health Quest's Conflict of Interest Policy, including its requirements regarding annual disclosures and disclosure and recusal in the event of a conflict.

ARTICLE IV
Powers and Duties of the Board of Trustees

4.01 Powers of the Board of Trustees. The business and property of the Corporation shall be managed by the Corporation's Board of Trustees and Health Quest to the extent of the Reserved Powers. Although Health Quest may elect from time to time to delegate to and/or act jointly with the Corporation's Board of Trustees, Health Quest has the authority to exercise independently its established powers and rights in its capacity as the Sole Member. Any such delegated authority shall at all times remain subject to the oversight, modification or repeal of Health Quest as the Sole Member of the Corporation. Without limiting the foregoing powers, Health Quest shall consult with the Chair of the Corporation's Board of Trustees before modifying or repealing any joint operating authority delegated under Section 4.02.

4.02 Joint Operating Authority Delegated to the Corporation. Subject to Sections 2.02 and 4.01, the Board of Trustees of the Corporation shall have the following operating authority as delegated by Health Quest:

(a) Quality Assurance. Apply and execute the quality assurance standards and any quality assurance policies and plans adopted by Health Quest.

(b) Medical Staff Credentialing and Bylaws. Apply and execute the Medical Staff credentialing standards and any policies adopted by Health Quest, which includes being responsible for:

(i) Appointing the members of the Medical Staff;
(ii) Approving any Medical Staff appointments such as Medical Staff officers or department chairs requiring Board approval;
(iii) Pursuant to the procedures set forth in the Bylaws of the Medical Staff, dismissing any member of the Medical Staff, and approving, rejecting or modifying any corrective action taken or recommended by the Medical Staff for any member of the Medical Staff; and
(iv) Approving the Medical Staff Bylaws, Rules and Regulations.

(c) Strategic Planning. Provide input to the system-wide strategic planning process and the Corporation-specific strategic plan, as requested and approved by Health Quest, and monitor the implementation of such plan.

(d) Statements of Deficiency and Legal Compliance. Respond to any statements of deficiency issued by any regulatory or accrediting authority and take all appropriate and necessary action to monitor and restore compliance with deficiencies in the Corporation's compliance with statutory, regulatory or accreditation requirements, including but not limited to monitoring the submission and implementation of all plans of correction.

(e) Conflicts of Interest. Implement and comply with the written Conflict of Interest Policy as approved by Health Quest and as interpreted and directed by the Compliance and Audit Committee of Health Quest.

(f) Community Health Needs. Implement the statement of mission approved by Health Quest by developing a Community Service Plan tailored specifically to the work of the Corporation in the community it serves and monitoring performance thereof.

(g) Budgets and Financial Performance. Assist in developing and monitoring the budgets for

the Corporation, as requested by Health Quest and, as approved, monitor the financial performance of the Corporation.

(h) Physician Arrangements. Review and approve physician financial arrangements in accordance with and as permitted by a system-wide policy adopted by Health Quest.

(i) Evaluation of the Board of Trustees. Develop an annual action plan for the Corporation's Board of Trustees, perform an annual self-evaluation of the Board of Trustees, comparing performance to the goals set forth in the annual action plan, and execute a Board education plan developed and approved by Health Quest.

(j) Evaluation of Hospital President. Monitor and provide input to the Corporation and Health Quest concerning the performance of the President of the Corporation.

(k) Nominations for Trustee and Officer Positions. Recommend, subject to any rights of FCH, to the Health Quest Executive Committee, acting as the Governance and Nominating Committee, candidates for consideration for the Corporation Trustee and Officer positions.

(l) Minutes. Cause written minutes to be maintained of meetings of the Board of Trustees of the Corporation and its committees including a record of attendance, which minutes shall be signed by the Secretary/Treasurer of the Corporation and retained as a permanent record in the offices of the Corporation.

ARTICLE V
Meetings of the Board of Trustees

5.01 Annual Meetings. The Annual Meeting of the Board of Trustees shall be held annually with reasonable notice in the month of April, or such other month as approved by Health Quest.

5.02 Regular Meetings. Regular meetings of the Board of Trustees shall be held at least four (4) times per year without notice and at such other times and with such frequency as may be determined by resolution of the Board.

5.03 Special Meetings. Special meetings of the Board of Trustees shall be held only at the discretion and call of the Chair or the Vice-Chair of the Board, if acting on behalf of the Chair.

5.04 Notices of Special Meetings. Notices of special meetings shall be given by facsimile, mail, email, or if necessary, orally, and shall state the purposes, time and place of the meeting. Notice of a special meeting shall be given not fewer than ten (10) days before that meeting except that, if the Chair determines, in his/her discretion, that it is not possible to give ten (10) days' notice due to exigent circumstances, notice may be given orally, in person or by telephone or email, one (1) day before the meeting. Only business stated in the notice may be transacted at the meeting.

5.05 Waivers of Notice. Notice of a meeting need not be given to any Trustee who submits a signed waiver of notice in writing or electronically whether before or after the meeting, or who attends the meeting without protesting prior thereto or at its commencement, the lack of notice.

5.06 Place of Meetings. Meetings of the Board of Trustees shall be held at the principal office of the Corporation or at such other place, within or without the State of Connecticut, as may be fixed by the Board.

5.07 Quorum. A majority of the entire Board of Trustees shall constitute a quorum for the conduct of business. A majority of the Trustees with voting rights present at a meeting, whether or not a quorum is present, may adjourn the meeting to another time and place without notice to any Trustee.

5.08 Voting and Action by the Board. At each meeting of the Board of Trustees, each Trustee entitled to vote shall be entitled to cast one (1) vote on each matter presented to the Board for its approval. Except as otherwise provided by law or in these Bylaws, the act of the Board of Trustees means action at a meeting of the Board by vote of a majority of the Trustees present at the time of the vote, if a quorum is present at such time.

5.09 Action In Lieu of a Meeting. Any action required or permitted to be taken by the Board or any committee thereof may be taken without a meeting if all Trustees or members of the committee consent in writing or by email to the adoption of a resolution authorizing the action. The resolution and the written and email consents thereto by the Trustees or the members of the committee shall be filed with the minutes of the proceedings of the Board or committee.

5.10 Use of Telecommunications. Any one or more Trustees or members of any committee thereof may participate in a meeting of the Board or committee by means of telephone conference or similar telecommunications equipment (such as video or webcam) allowing all persons participating in the meeting to hear each other at the same time and to participate in all matters before the Board or committee, including, without limitation, the ability to propose, object to, and vote upon a specific action to be taken by the Board or committee. Participation by such means shall constitute presence in person at a meeting.

5.11 Parliamentary Procedure. Parliamentary procedure as described in Robert's Rules of Order shall be followed when not in conflict with any of these Bylaws.

5.12 Minutes. Separate written minutes shall be maintained of all Board and committee meetings of the Corporation and shall be retained as a permanent record in the offices of the Corporation. Such minutes shall reflect all business conducted, including findings, conclusions and recommendations, and a record of attendance.

ARTICLE VI
Officers

6.01 Officers. The Officers of the Corporation shall initially be a Chair and a Secretary/Treasurer, and shall, upon appointment by Health Quest, also include a Vice Chair and a Hospital President. From time to time, the Board of Trustees may appoint such other Officers with powers and duties not inconsistent with these Bylaws. Any two or more offices may be held by the same person, except the offices of Chair, Vice Chair, Hospital President and Secretary/Treasurer.

6.02 Election. The Chair of the Board, Vice-Chair, and the Hospital President shall be elected by Health Quest. The Secretary/Treasurer and other Officers shall be elected by a vote of the majority of the entire Board of Trustees at a meeting of the Board of Trustees; provided, that the initial Secretary/Treasurer shall be elected by Health Quest. All Officers shall serve for a term of two (2) years until successors are elected and qualified, such term commencing at the close of the meeting at which they are elected. Officers may be elected for no more than two (2), two year terms.

6.03 Vacancies. A vacancy occurring in any office during the year may be filled by a vote of a majority of the entire Board of Trustees for the remainder of the term thereof, at the next Annual Meeting

or any regular meeting of the Board or at a special meeting called for such purpose, provided that a vacancy in the office of Chair of the Board, Vice-Chair or Hospital President may be filled only by Health Quest.

6.04 Removal. Any Officer may be removed from office, with or without cause, by an affirmative vote of two-thirds (2/3) of the entire Board of Trustees at any meeting of the Board, except the Chair of the Board, Vice-Chair and the Hospital President may be removed only by Health Quest.

6.05 Duties and Responsibilities.

(a) Chair. The Chair shall preside at all meetings of the Board of Trustees. In accordance with Articles VII and VIII, the Chair also shall (i) appoint the Committee Chairs and members of all Committees of the Board (except the Executive Committee) and ad hoc committees, (ii) serve as an *ex-officio* member, with vote, on each Committee, and (iii) serve as the Chair of the Executive Committee. The Chair shall perform such other duties as may be provided for by law, these Bylaws, or resolution of the Board of Trustees. No employee of the Corporation shall serve as Chair nor hold any other title with similar responsibilities.

(b) Vice-Chair. In the absence of the Chair, the Vice-Chair shall preside at meetings of the Board of Trustees. When so acting as Chair, the Vice-Chair shall have all the powers and authority of the Chair. The First Vice-Chair shall perform such other duties as may be provided for by the Board of Trustees.

(c) Secretary/Treasurer.

(i) The Secretary/Treasurer shall be responsible for such books, documents, and papers as the Board may determine. The Secretary/Treasurer shall cause minutes to be kept for all meetings of the Board of Trustees, may sign any contracts or agreements with the Chair, the Hospital President or the Vice-Chair in the name of the Corporation if so authorized or ordered by the Board, and may affix the seal of the Corporation to written instruments when so authorized or ordered by the Board. The Secretary/Treasurer shall perform such other duties as shall be assigned by the Board of Trustees and as are incidental to the office of secretary of a not-for-profit corporation.

(ii) The Secretary/Treasurer shall either personally perform, or ensure that appropriate employees of the Corporation perform, the following functions: receive and care for all monies and properties belonging to the Corporation and dispose of the same under the direction of the Board of Trustees, receive and give receipts for all amounts due to the Corporation, endorse checks in its name and on its behalf, receive full discharge for the same in accordance with these Bylaws, and perform such other duties as assigned by the Board of Trustees and as are incidental to the office of treasurer of a not-for-profit corporation.

(d) Hospital President. The Hospital President shall serve as the chief executive officer of the Corporation and shall have the authority and responsibility to manage and operate the Corporation in all its activities, subject to these Bylaws, the Certificate of Incorporation, and such policies as may be adopted from time to time by the Board of Trustees or Health Quest. The Hospital President's responsibilities shall include, but are not limited to, the following:

(i) Acting under the direction of and being accountable to the Board of Trustees of the Corporation and Health Quest;
(ii) Providing effective liaison between the Board of Trustees and management;
(iii) Appointing (either personally or through delegation to responsible subordinates), and the Corporation shall employ, such personnel as may be required to conduct the affairs of the Corporation;
(iv) Ensuring that all activities are properly organized, directed and accounted for as established by the Board of Trustees;
(v) Providing reports to the Board of Trustees to keep the Board fully informed of the affairs of the Corporation;
(vi) Performing all duties required by law; and
(vii) Unless otherwise provided for herein, performing (either personally or through delegation to responsible subordinates) all acts and executing all documents necessary to carry out the duties of the position of Hospital President.

ARTICLE VII
Committees

7.01 Types of Committees. The Board of Trustees shall have the following committees: (a) Executive Committee, (b) Quality and Performance Improvement Committee, and (c) Community Health Needs Committee.

7.02 Size of Committees; Quorum. All Committees shall have at least three (3) members. Whenever these Bylaws establish the number of persons to be on a committee, any *ex-officio* members shall be counted in that number. For purposes of quorum, *ex-officio* members with vote shall be counted in that number. The presence of a majority of Committee members at a Committee meeting shall constitute a quorum.

7.03 Appointment. The Chair shall appoint the Committee Chair and members of all Committees of the Board (except the Executive Committee), subject to approval by the Board of Trustees. Only Trustees of the Corporation shall serve as Committee Chairs.

7.04 Membership. Only Trustees of the Corporation may serve as voting members on the Executive Committee. For all other Committees, a minimum of three (3) voting members must be Trustees of the Corporation. The Chair shall serve as an *ex-officio* member, with vote, of each Committee and shall be counted in the minimum number of Trustees on a Committee.

7.05 Ad Hoc Committees. Ad hoc committees shall be formed as authorized by the Board of Trustees. The members of ad hoc committees shall be appointed by the Chair of the Board of Trustees and shall be discharged upon completion of the committee's work.

ARTICLE VIII
Powers and Duties of Committees

8.01 Executive Committee. The Executive Committee shall consist of all Officers of the Board of Trustees and the Immediate Past Chair, with the Chair of the Board serving as the Committee Chair, and such other Trustees as are designated annually by resolution adopted by a majority vote of the entire Board of Trustees. It shall have the full power of the Board of Trustees between meetings of the Board of Trustees to the full extent permitted by the laws of the State of Connecticut, except as limited by resolution of the Board. Any such action shall be reported back to the Board at its next regular meeting.

8.02 Quality and Performance Improvement Committee.

(a) The Quality and Performance Improvement Committee shall implement initiatives relating to the Health Quest System's clinical and operational standards, receive monitoring reports from management regarding entity performance toward achieving those standards, and make recommendations thereon to the Board of Trustees. The Quality and Performance Improvement Committee shall also be responsible for applying and monitoring the Health Quest System's patient/customer satisfaction initiatives with respect to the Corporation and making recommendations thereon to the Board of Trustees.

(b) The Committee shall also function as the Quality Assurance Committee of the Corporation. It shall include at least one (1) Trustee who is not otherwise affiliated with the Corporation in an employment or contractual capacity, and such other members of the Board of Trustees, administrators, the Corporation and Medical Staff representatives. It shall implement and monitor the Quality Assurance Program of the Corporation to assure its compliance with legislative and accreditation requirements.

(c) The Committee shall also review and recommend to the Board of Trustees for approval the Medical Staff Bylaws, Rules and Regulations, the appointment of members of the Medical Staff, and the granting of clinical privileges, where applicable.

(d) The Committee shall make regular reports and recommendations to the Health Quest Quality and Performance Improvement Committee, as directed by such Committee. The Committee Chair shall be an *ex-officio* member of the Health Quest Quality and Performance Improvement Committee.

(e) The Committee shall consider and make recommendations to the Board of Trustees on such other matters as are of concern. It shall meet at least four (4) times a year, or at the call of the Committee Chair.

8.03 Community Health Needs Committee.

(a) The Community Health Needs Committee shall oversee the development and updating of the Corporation's Community Health Needs Assessment, implementation strategies and Community Service Plan, in accordance with applicable laws and regulations, the Corporation's mission as approved by Health Quest, and subject to final approval by the Corporation and Health Quest Boards of Trustees. The Committee shall recommend to the Corporation's Board of Trustees key hospital goals for service delivery and development based on such needs assessment, where such recommendations are subject to Health Quest's final approval.

(b) The Committee shall consider and make recommendations to the Board of Trustees on such other matters as are of concern. The Committee shall make regular reports to the Health Quest Board of Trustees, as directed by such Board. It shall meet at least four (4) times a year, or at the call of the Committee Chair.

ARTICLE IX
Medical Staff

9.01 Duties of the Board of Trustees. It shall be the duty of the Board of Trustees to supervise the activities of the Medical Staff for the purpose of ensuring that the highest standards of professional practice and patient care are maintained in the Corporation. This responsibility shall include, but not be limited to, review and approval of the Bylaws, Rules and Regulations of the Medical Staff, appointment of the members of the Medical Staff, and the granting of clinical privileges. The Board of Trustees has delegated to the Quality and Performance Improvement Committee the responsibility of reviewing and

recommending such actions to the Board of Trustees for final approval.

9.02 Medical Staff Responsible to the Board of Trustees. The Medical Staff shall be responsible to the Board of Trustees, for the fitness, adequacy and quality of medical care rendered to patients in the Corporation by: establishing and maintaining professional standards and practice; coordinating the clinical departments of the Corporation; promoting the scientific and educational advancement of all members of the Medical Staff through encouraging education and research; acting as a liaison whereby medical-administrative problems may be discussed and resolved among the members of the Medical Staff, the Corporation administration and the Board; and evaluating and making recommendations with respect to the professional competence of Medical Staff members, applicants for Medical Staff membership and the delineation of clinical privileges.

9.03 Medical Staff Bylaws. The Medical Staff shall submit Bylaws, Rules and Regulations for its organization and governance for the approval of the Board of Trustees. Such Bylaws, Rules and Regulations shall, among other things, direct and insure that only licensed practitioners with the appropriate clinical privileges are directly responsible for a patient's diagnosis and treatment; provide for the discharge of the Medical Staff's responsibilities to the Board as provided in Section 9.02; and establish a hearing procedure for dealing with grievances related to Medical Staff appointments and the granting of clinical privileges. The Bylaws of the Medical Staff have been reviewed and approved by the Board of Trustees and constitute the policy of the Corporation governing its relationships with its Medical Staff.

ARTICLE X
Auxiliaries

10.1 Policy Statement. The Board of Trustees, through the Hospital President, shall cause to be kept a list of societies, agencies, councils, communities and associations which have been approved by the Board of Trustees to cooperate and assist in obtaining funds, supplies and equipment for the Corporation or to further its objectives in any other way. Such organizations shall at all times be subject to the general supervision and control of the Board of Trustees in all of their activities on behalf of the Corporation. Their bylaws, if any, shall be subordinate to the Bylaws of the Corporation and shall be subject to the prior approval of the Board of Trustees. Such organizations shall at all times keep on file with the Hospital President a copy of their constitution, bylaws, rules and regulations and a list of their officers, committees and members. They shall keep accurate records of all moneys expended and report annually thereon to the Board of Trustees through the Hospital President.

ARTICLE XI
Indemnification

11.01 Indemnification. The Corporation shall defend and indemnify any person who is, or was, a Trustee or Officer of the Corporation in accordance with, to the full extent permitted by, and subject to the limitations contained in, the Revised Nonstock Corporation Act of the State of Connecticut, Chapter 602 of the Connecticut General Statutes or any successor provision of law. Trustees and Officers shall be entitled to such additional indemnification and/or advancement of expenses as may be authorized by a resolution of the Board or an agreement providing for indemnification, provided that no indemnification shall be made to or on behalf of any Trustee or Officer if a judgment or other final adjudication adverse to the Trustee or Officer establishes that his/her acts were committed in bad faith or were the result of active and deliberate dishonesty and were material to the cause of action so adjudicated, or that he/she personally gained, in fact, a financial profit or other advantage to which such Trustee or Officer was not legally entitled. Persons who are not Trustees or Officers of the Corporation may be similarly indemnified for service to the Corporation or to another such entity at the request of the Corporation, to

the extent the Board of Trustees by resolution designates any such persons as entitled to the benefits of this Section 11.01, subject to any restrictions herein.

11.02 Insurance. The Corporation shall purchase and maintain insurance to indemnify the Corporation for any obligation which it incurs as a result of the indemnification of any Trustee, Officer, employee, or other person, to the extent such insurance is reasonably available.

11.03 Other Protections. The foregoing policy of indemnification shall not abridge any protections to which such Trustee, Officer, employee or other person authorized to act on behalf of the Corporation may be entitled apart from this Article XII.

ARTICLE XII
Amendments

12.01 Amendments. The Certificate of Incorporation and these Bylaws may be adopted, approved, amended, or repealed by Health Quest at any Annual Meeting, regular meeting, or special meeting called for that purpose.

12.02 Amendments Proposed by the Board. The Board of Trustees of the Corporation may propose to Health Quest amendments to these Bylaws by a resolution adopted by the Board of Trustees at any Annual Meeting or regular meeting of the Board of Trustees or at any special meeting called for that purpose.

Adoption and Amendments:

User, OHCA

From: Roberts, Karen
Sent: Thursday, November 02, 2017 11:17 AM
To: User, OHCA
Cc: Cotto, Carmen; Clarke, Ormand; Martone, Kim
Subject: FW: Sharon Hospital -- Docket No. 16-32132-CON (Condition No. 6 Compliance)
Attachments: Sharon Mock Sch H_2016 (2).pdf; Mock 990 write-up.docx

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From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Thursday, November 2, 2017 11:16 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Bacher, Katherine <kbacher@Health-quest.org>; Cordeau, Peter <pcordeau@health-quest.org>; Deshay, Tammy (tdeshay@Health-quest.org) <tdeshay@Health-quest.org>
Subject: Sharon Hospital -- Docket No. 16-32132-CON (Condition No. 6 Compliance)

Karen,

In accordance with Condition No. 6 of the Agreed Settlement dated July 18, 2017, attached are a Mock IRS Form 990 for Sharon Hospital for 2016, and accompanying notes. The former owner, Essent Healthcare of Connecticut, Inc., did not track Other Benefits or Community Building Activities, so we were unable to estimate a baseline for these costs.

Please let me know if you have any questions.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
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Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization | **Employer identification number**

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	✓	
b	If "Yes," was it a written policy?	1b	✓	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	✓	
	☑ 100% ☐ 150% ☐ 200% ☐ Other _____%			
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	✓	
	☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	✓	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	✓	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		✓
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		✓
b	If "Yes," did the organization make it available to the public?	6b		
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			757,865	232,172	525,687	1.1%
b Medicaid (from Worksheet 3, column a)			11,238,861	7,233,732	4,005,129	8.4%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			11,996,726	7,465,904	4,530,816	9.5%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						9.5%

Part II Community Building Activities

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	**Total**						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		✓	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	2,684,721		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	22,212,537
6	Enter Medicare allowable costs of care relating to payments on line 5	6	1,436,139
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	20,776,398
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	✓	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 Sharon Hospital 50 Hospital Hill Road Sharon, CT	✓									
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group Sharon Hospital

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		✓
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	✓	
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	✓	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The significant health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20___			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	✓	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		✓
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	✓	
7	Did the hospital facility make its CHNA report widely available to the public?	7		✓
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☐ Hospital facility's website (list url):			
b	☐ Other website (list url):			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8		✓
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20___			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10		✓
a	If "Yes," (list url):			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		✓
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		✓
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		✓
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group Sharon Hospital

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	✓	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 100 % and FPG family income limit for eligibility for discounted care of 250 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☐ Medical indigency			
e	☑ Insurance status			
f	☐ Underinsurance status			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	✓	
15	Explained the method for applying for financial assistance?	15	✓	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☐ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	✓	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): www.sharonhospital.com			
b	☑ The FAP application form was widely available on a website (list url): www.sharonhospital.com			
c	☐ A plain language summary of the FAP was widely available on a website (list url):			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☐ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group Sharon Hospital

			Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	✓	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☑ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☐ None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	✓	
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☑ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☐ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs
- **b** ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- **c** ☑ Processed incomplete and complete FAP applications
- **d** ☐ Made presumptive eligibility determinations
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

			Yes	No
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	✓	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group Sharon Hospital

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	☐ The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	**23**		✓
	If "Yes," explain in Section C.			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		✓
	If "Yes," explain in Section C.			

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

3) Hospital Staff would communicate verbally about the availability of the financial assistance programs. Also, the information was publicly available through the website.

Part V #2 -
On August 1, 2017, Health Quest Systems, Inc. acquired Sharon Hospital in Sharon, Connecticut. Sharon Hospital is a small community hospital located just outside the health systems' primary service area.

Part V #5
The 2014 community needs assessment was a community-wide conducted by the Foundation for Community Health. Because the Foundation was very interested in learning what community residents and providers serving the community see as the key health needs in the region, a substantial component of the needs assessment focuses on gathering feedback from community residents, leaders, and service providers.

The report draws on quantitative and qualitative data from three sources. Secondary data come from the U.S. Census and state agencies (labor, education, and public health) as well as data collected by community-based agencies and researchers and community health needs assessments.

A web-based Community Stakeholder Survey, sent to approximately 450 stakeholders in or serving the 17 communities, was used to gather information about perceived health concerns and needed services in the region (43% response rate). Participants included health care providers, social service professionals, the faith community, government representatives, business people, and community residents. Respondents were initially identified through the Foundation's database of key contacts to which additional medical, mental, and oral health providers were added, including all medical providers at Sharon Hospital.

Ten focus groups with 82 community stakeholders were conducted to gather a more in-depth perspective on health status and needs in the communities served by the Foundation.

Part V #6B
The 2014 community needs assessment was a community-wide conducted by the Foundation for Community Health located in Sharon, CT.

Part V #11 At this time Sharon Hospital has not developed an implementation plan to address the needs identified in the most recent community survey. Sharon Hospital has plans to update the Community Needs Assessment in 2018 and will develop an implementation plan to address the needs identified.

User, OHCA

From: Roberts, Karen
Sent: Monday, December 18, 2017 2:12 PM
To: bbee@Health-quest.org
Cc: Cotto, Carmen; Clarke, Ormand; User, OHCA
Subject: FW: Sharon CON Conversion Reports

Hi Bonnie – please find below some clarification on filing timeframes for Agreed Upon Conditions #14 and #15 for Docket Number 16-32132-CON.

- Condition #14 – "The Sharon Hospital inpatient accrued charges divided by the case mix adjusted discharges (i/p prices per CMAD) is historically higher than the statewide average (using OHCA's HRS filings by the state hospitals). Vassar agrees to report its total inpatient accrued charges and case mix adjusted discharges on a semi-annual basis for a period of three (3) years as a calculation for inpatient charges per CMAD. If a reduction in average inpatient charges is reported, Vassar shall explain how the reduction was achieved."

  Please file the inpatient charges per CMAD by 11/30/2018 for the fiscal year 2018 (10/1/2017 to 9/30/2018 – the first full fiscal year post-closing). Then for FY 2019 by 11/30/2019 and for FY 2020 by 11/30/2020.

- Condition #15 – "Within six months following the Closing Date, Vassar shall file with OHCA the total price per "unit of service" using the below definitions for each of the top 25 most frequent MSDRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for the Hospital services. The first filing shall be for the period June 1, 2016 through June 30, 2017. Vassar shall provide the same information for three (3) fiscal years thereafter (FY 2017, FY 2018 and FY 2019), within sixty (60) days following the end of a fiscal year."

  Please file as the initial report "within six months following the Closing Date", so any time before 2/1/2018. This initial report is for the pre-closing period June 1, 2016 – June 30, 2017 as indicated in the condition.

  The condition is a little confusing in its reference to FY 2017 being due 60 days subsequent to the end of the FY. The Hospital can file the FY 2017 information (which then includes two months under HealthQuest) at the same time as the initial pre-closing period report. Then follow the 60 days following the end of the fiscal year instruction for FY2018 and FY 2019)

Thanks and let me or Carmen Cotto know if you have any questions on this matter. Please send any compliance related emails and documents to OHCA via the following: OHCA@ct.gov. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Martone, Kim
Sent: Monday, December 18, 2017 11:12 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: FW: Sharon CON Conversion Reports

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Bee, Bonnie [mailto:bbee@Health-quest.org]
Sent: Monday, December 18, 2017 10:56 AM
To: Martone, Kim
Cc: Schaeffer-Helmecki, Jessica; Johannes, Rebecca
Subject: Sharon CON Conversion Reports

Kimberly,
Hello. I am reaching out for a clarification of some dates requested for required reports related to Sharon's CON.

This is in regards to Conditions 14 and 15 of the Agreed Settlement (page 28). The dates for the first filing period are June 1, 2016 through June 30, 2017 and every year after for 3 years.

I believe these dates were based on the original sale date, but because our sale date was changed to August 1, 2017, we are wondering if the report dates should also be changed. Would OHCA want these reports based on July 1, 2016 through July 31, 2017 instead?

Thank you.

Bonnie Bee
Reimbursement Analyst
Sharon Hospital
o-860-364-4233

f-860-364-4407
bbee@Health-quest.org

Health Quest has a secure e-mail policy.
About Health Quest Systems, Inc.

Health Quest Systems, Inc., headquartered in LaGrangeville, New York, is a leading nonprofit healthcare system in the Mid-Hudson Valley and northwest Connecticut. The network includes four hospitals: Vassar Brothers Medical Center in Poughkeepsie, Northern Dutchess Hospital in Rhinebeck, Putnam Hospital Center in Carmel and Sharon Hospital in Sharon, Conn. It also includes Health Quest Medical Practice, Health Quest Urgent Care, and several affiliates, including Health Quest Home Care and The Heart Center. Health Quest comprises 691 licensed beds and more than 6,000 employees.

User, OHCA

From: Roberts, Karen
Sent: Monday, January 22, 2018 3:15 PM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Sharon Hospital (Docket No. 16-32132-CON) -- Compliance With Condition No. 6

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Monday, January 22, 2018 3:11 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Bacher, Katherine <kbacher@Health-quest.org>; Deshay, Tammy (tdeshay@Health-quest.org) <tdeshay@Health-quest.org>
Subject: Sharon Hospital (Docket No. 16-32132-CON) -- Compliance With Condition No. 6

Karen,

Please accept this email in follow-up to our recent conversation. In order to comply with Condition No. 6 of the Agreed Settlement regarding the sale of Sharon Hospital, the Hospital will prepare a "mock" Schedule H to the IRS Form 990 for the period of October 1, 2017 through September 30, 2018 (OHCA's FY 2018). Sharon Hospital proposes that it be allowed to submit this "mock" Form 990 to within two (2) months of the close of the aforementioned time period, or no later than November 30, 2018. This Form 990 will serve as the baseline for measuring compliance with Condition No. 6 going forward. Sharon Hospital will also provide a narrative description as to how it has met the balance of the requirements of Condition No. 6 during its first full year under Health Quest ownership.

Please let us know if the foregoing proposal is acceptable.

Thanks,
Jen

Jennifer Groves Fusco, Esq.
Principal
Updike, Kelly & Spellacy, P.C.
One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

User, OHCA

From: Cotto, Carmen
Sent: Monday, February 26, 2018 1:21 PM
To: Jennifer Groves Fusco
Cc: Roberts, Karen; User, OHCA
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1

Importance: High

Hi Jennifer,

Please provide OHCA with the names of Vassar's twelve community representatives selected to serve as voting members of the Hospital's board, set forth under Condition #1 of the order, which reads as follows:

"For three (3) years following the Closing Date, Vassar shall allow for twelve (12) community representatives to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting members under the Hospital's Board of Director Bylaws. Health Quest shall select, from those nominated by FCH in accordance with Section 2.7.1 of the Grant Agreement dated September 8, 2016, the community representatives in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."

It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, February 27, 2018 3:15 PM
To: User, OHCA
Cc: Roberts, Karen; Cotto, Carmen; Deshay, Tammy (tdeshay@Health-quest.org)
Subject: RE: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Attachments: VHC - Board Members - Class List.pdf; SH Board Member List with address.xls

Attached is a spreadsheet that lists all of the Sharon Hospital Board members, along with their towns and states of residence. As you can see, all Board members except Dr. Soucier (President of the Medical Staff) live in the greater Sharon area. I have also attached a document that shows Officers and Board members by class year.

Please let me know if you have any questions.

Thanks,
Jen

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, February 26, 2018 1:21 PM
To: Jennifer Groves Fusco
Cc: Roberts, Karen; User, OHCA
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Importance: High

Hi Jennifer,

Please provide OHCA with the names of Vassar's twelve community representatives selected to serve as voting members of the Hospital's board, set forth under Condition #1 of the order, which reads as follows:

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It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA

Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

HQ BOARD APPROVED 4-28-17

Vassar Health Connecticut, Inc.

Sharon HOSPITAL

Board of Trustees

2017 Board Officers

Chair	Joel Jones
First Vice Chair	Susan Iovino
Second Vice Chair	Vacant
Secretary-Treasurer	Vacant
President	Peter Cordeau
Assistant Treasurer	Katherine Bacher *(Non-Voting)*
Assistant Secretary	Michael Holzhueter *(Non-Voting)*
Assistant Secretary	Cheryl Booth *(Non-Voting)*

Classes of 2018, 2019 & 2020

All (14) Voting Members (unless indicated)

Class of 2018 *Term Ending in April 2018*	Class of 2019 *Term Ending in April 2019*	Class of 2020 *Term Ending in April 2020*
Bassin, Arthur	Cantele, Rick	Iovino, Susan
Hill, Hugh	Forood, Pari	Jones, Joel
Sioussat, Pierce	Kirber, William, MD	Quella, James
Tannen, Miriam, RN, NP-C	Palmer-House, Kathryn	Schechter, Kenneth

Ex Officio Board Members (w/Vote):

President	Peter Cordeau
President of Medical Staff	Donald Soucier, MD

First Name	Last Name	Board	Address
Peter	Cordeau	**SH**	Sharon, CT 06069
Joel W.	Jones	**SH**	Falls Village, CT 06031
Susan	Iovino, DNP, RN	**SH**	Kent, CT 06757
Arthur J.	Bassin	**SH**	Ancramdale, NY 12503
Richard	Cantele, Jr.	**SH**	Lakeville, CT 06039
Pari	Forood	**SH**	Lakeville, CT 06039
Hugh A.	Hill	**SH**	Kent, CT 06757-1431
William M.	Kirber, MD	**SH**	Lakeville, CT 06039
Kathryn (Katie)	Palmer-House	**SH**	Dover Plains, NY 12522
Kenneth	Schechter	**SH**	Salisbury, CT 06068
Pierce	Sioussat	**SH**	Millbrook, NY 12545
Miriam (Mimi)	Tannen	**SH**	Millbrook, NY 12545
James Andrew	Quella	**SH**	Sharon, CT 06069
Donald	Soucier, MD	**SH** *(Med Staff President)*	Avon, CT 06001

User, OHCA

From: Clarke, Ormand
Sent: Friday, April 06, 2018 3:28 PM
To: bbee@Health-quest.org
Cc: jfusco@uks.com; User, OHCA; Cotto, Carmen; Roberts, Karen
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Bonnie Bee
Reimbursement Analyst
Sharon Hospital
bbee@Health-quest.org

RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Dear Ms. Bee:

As a very courteous reminder, per Certificate of Need (CON), authorization under Docket Number 16-32132-CON, condition #15 stipulates the following:

"Within six months following the Closing Date, Vassar shall file with OHCA the total price per "unit of service" using the below definitions for each of the top 25 most frequent MSDRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for the Hospital services. The first filing shall be for the period June 1, 2016 through June 30, 2017. Vassar shall provide the same information for three (3) fiscal years thereafter (FY 2017, FY 2018 and FY 2019), within sixty (60) days following the end of a fiscal year."

A review of the record in this matter, to date, does not demonstrate compliance with this filing requirement, as yet. Please submit this material at the earliest convenience, but no later than April 16, 2018.

It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Sincerely,

Ormand Clarke
Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7047 / F: (860) 418-7053 / E: ormand.clarke@ct.gov


Keeping Connecticut Healthy
DPH
Connecticut Department
of Public Health
Accredited Health Department
PHAB
Advancing public health performance
Public Health Accreditation Board

User, OHCA

From: Bee, Bonnie <bbee@Health-quest.org>
Sent: Friday, April 06, 2018 4:18 PM
To: User, OHCA
Cc: Simon, Patrick; Johannes, Rebecca
Subject: Sharon Hospital (Docket No. 16-32132-CON) Condition 15 Report
Attachments: Condtion 15 Report 060116_063017.xlsx

Bonnie Bee
Reimbursement Analyst
Sharon Hospital
o-860-364-4233 T/Th/F
o-845-475-9584 M/W
f-860-364-4407

bbee@Health-quest.org

	DRG	DESCRIPTION	PATIENT COUNT	CHARGES	REIMBURSEMENT
1	795	NORMAL NEWBORN	126	403,433.95	267,021.18
2	775	VAGINAL DELIVER	108	1,251,622.15	615,932.20
3	57	DEGENERATIVE NER	98	4,040,935.35	1,510,306.07
4	795	NORMAL NEWBORN	68	224,480.25	108,279.82
5	190	CHRONIC OBSTRUC	58	950,536.95	615,553.22
6	885	PSYCHOSES	55	2,425,240.55	786,358.23
7	871	SEPTICEMIA OR S	55	1,636,144.23	973,193.29
8	71	NONSPECIFIC CERE	47	1,993,603.45	763,965.27
9	775	VAGINAL DELIVER	44	465,937.60	209,077.29
10	57	DEGENERATIVE NER	42	1,654,300.90	611,605.18
11	603	CELLULITIS W/O	41	562,816.68	334,108.44
12	794	NEONATE W OTHER	39	150,989.85	104,378.45
13	766	CESAREAN SECTIO	39	1,039,396.66	373,638.38
14	291	HEART FAILURE &	39	854,920.61	563,741.57
15	885	PSYCHOSES	39	1,468,494.62	469,123.76
16	884	ORGANIC DISTURB	33	1,306,258.15	462,384.42
17	690	KIDNEY & URINAR	31	522,660.79	251,722.28
18	470	MAJOR JOINT REP	30	1,817,220.09	629,950.93
19	392	ESOPHAGITIS, GA	30	519,880.70	243,606.82
20	766	CESAREAN SECTIO	28	738,566.39	205,306.91
21	603	CELLULITIS W/O	25	290,945.53	214,293.61
22	280	ACUTE MYOCARDIA	24	605,106.85	363,036.94
23	641	MISC DISORDERS	22	272,159.31	140,654.51
24	871	SEPTICEMIA OR S	21	590,648.28	335,820.99
25	774	VAGINAL DELIVER	19	268,287.90	104,499.54

PER UNIT OF SERVICE
3,201.86
11,589.09
41,234.03
3,301.18
16,388.57
44,095.28
29,748.08
42,417.09
10,589.49
39,388.12
13,727.24
3,871.53
26,651.20
21,921.04
37,653.71
39,583.58
16,860.03
60,574.00
17,329.36
26,377.37
11,637.82
25,212.79
12,370.88
28,126.11
14,120.42

	CPT	DESCRIPTION	NUMBER PTS	CHARGES	REIMBURSEMENT
1	12001	RPR S/N/AX/GEN/TRN	264	316,520.80	137,910.42
2	66984	CATARACT SURG W/IO	262	2,622,147.85	683,763.92
3	43239	EGD BIOPSY SINGLE/	252	1,671,327.95	550,251.17
4	29125	APPLY FOREARM SPLI	198	282,095.70	97,363.63
5	45385	COLONOSCOPY W/LESI	176	850,443.80	340,488.00
6	45380	COLONOSCOPY AND BI	165	877,042.55	357,376.44
7	45378	DIAGNOSTIC COLONOS	165	716,990.80	342,297.83
8	90471	IMMUNIZATION ADMIN	143	214,759.10	69,421.73
9	29515	APPLICATION LOWER	138	199,611.15	77,468.11
10	12002	RPR S/N/AX/GEN/TRN	130	216,769.65	92,675.96
11	12011	RPR F/E/E/N/L/M 2.	121	241,174.50	94,341.43
12	29130	APPLICATION OF FIN	89	89,602.40	50,650.47
13	43235	EGD DIAGNOSTIC BRU	83	495,390.35	166,467.44
14	G0105	COLORECTAL CANCER	79	332,193.60	112,218.15
15	G0121	COLORECTAL CANCER	68	282,821.50	85,569.46
16	58558	HYSTEROSCOPY BIOPS	68	684,865.05	233,937.14
17	50590	FRAGMENTING OF KID	64	478,005.37	250,658.86
18	10060	DRAINAGE OF SKIN A	62	104,915.65	33,504.64
19	64721	CARPAL TUNNEL SURG	52	407,733.36	107,638.05
20	36430	BLOOD TRANSFUSION	47	138,203.28	51,746.26
21	29881	KNEE ARTHROSCOPY/S	45	625,946.61	224,861.35
22	12013	RPR F/E/E/N/L/M 2.	38	141,199.80	43,281.52
23	66982	CATARACT SURGERY C	31	347,555.00	72,584.41
24	52648	LASER SURGERY OF P	26	459,023.34	119,883.21
25	99195	PHLEBOTOMY	25	7,790.20	3,729.97

PER UNIT OF SERVICE
1,198.94
10,008.20
6,632.25
1,424.73
4,832.07
5,315.41
4,345.40
1,501.81
1,446.46
1,667.46
1,993.18
1,006.77
5,968.56
4,204.98
4,159.14
10,071.54
7,468.83
1,692.19
7,841.03
2,940.50
13,909.92
3,715.78
11,211.45
17,654.74
311.61

User, OHCA

From: Cotto, Carmen
Sent: Tuesday, May 01, 2018 9:13 AM
To: User, OHCA
Subject: FW: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.
Attachments: Sharon Hospital Condition 15 Report 060116_063017.pdf

---

From: Bee, Bonnie [mailto:bbee@Health-quest.org]
Sent: Monday, April 30, 2018 7:00 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Johannes, Rebecca <RJohannes@Health-quest.org>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: Re: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Bonnie Bee
Reimbursement Analyst
Sharon Hospital
o-860-364-4233 T/Th/F
o-845-475-9584 M/W
f-860-364-4407

bbee@Health-quest.org

From: Cotto, Carmen <Carmen.Cotto@ct.gov>
Sent: Monday, April 30, 2018 4:51:00 PM
To: Bee, Bonnie
Cc: Roberts, Karen; Johannes, Rebecca; Clarke, Ormand
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Hi Bonnie,

I am missing the PDF attachment.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Bee, Bonnie [mailto:bbee@Health-quest.org]
Sent: Monday, April 30, 2018 4:16 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Johannes, Rebecca <RJohannes@Health-quest.org>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Carmen,
I apologize for the delayed response but my email system dumped your email into my junk email folder and I just saw it.

Please find the excel report, converted to a PDF as requested.

Thank you
Bonnie

Bonnie Bee
Reimbursement Analyst
Sharon Hospital-HealthQuest

O-845-475-9584

bbee@health-quest.org

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, April 25, 2018 4:30 PM
To: Bee, Bonnie <bbee@Health-quest.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Hi Bonnie,

The Excel document was received, however, it is missing a header and timeframes.

Could you please submit a PDF copy of the same document with a header that includes timeframes of the average prices on the reports?

Moving forward please continue to submit the document in Excel and PDF.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Bee, Bonnie [mailto:bbee@Health-quest.org]
Sent: Tuesday, April 24, 2018 9:30 AM
To: Clarke, Ormand <Ormand.Clarke@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Good Morning,
Can we please obtain confirmation that this was received by OHCA on 4/6/18?
Thank you
Bonnie Bee

From: Clarke, Ormand [mailto:Ormand.Clarke@ct.gov]
Sent: Friday, April 06, 2018 3:28 PM
To: Bee, Bonnie <bbee@Health-quest.org>
Cc: jfusco@uks.com; User, OHCA <OHCA@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Bonnie Bee
Reimbursement Analyst
Sharon Hospital
bbee@Health-quest.org

RE: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 15.

Dear Ms. Bee:

As a very courteous reminder, per Certificate of Need (CON), authorization under Docket Number 16-32132-CON, condition #15 stipulates the following:

"Within six months following the Closing Date, Vassar shall file with OHCA the total price per "unit of service" using the below definitions for each of the top 25 most frequent MSDRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for the Hospital services. The first filing shall be for the period June 1, 2016 through June 30, 2017. Vassar shall provide the same information for three (3) fiscal years thereafter (FY 2017, FY 2018 and FY 2019), within sixty (60) days following the end of a fiscal year."

A review of the record in this matter, to date, does not demonstrate compliance with this filing requirement, as yet. Please submit this material at the earliest convenience, but no later than April 16, 2018.

It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Sincerely,

Ormand Clarke
Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7047 / F: (860) 418-7053 / E: ormand.clarke@ct.gov

---

Health Quest has a secure e-mail policy.
About Health Quest Systems, Inc.

Health Quest Systems, Inc., headquartered in LaGrangeville, New York, is a leading nonprofit healthcare system in the Mid-Hudson Valley and northwest Connecticut. The network includes four hospitals: Vassar Brothers Medical Center in Poughkeepsie, Northern Dutchess Hospital in Rhinebeck, Putnam Hospital Center in Carmel and Sharon Hospital in Sharon, Conn. It also includes Health Quest Medical Practice, Health Quest Urgent Care, and several affiliates, including Health Quest Home Care and The Heart Center. Health Quest comprises 691 licensed beds and more than 6,000 employees.

If assistance is required, please send a message to the Help Desk at hqithelpdesk@health-quest.org or call (845) 483-6789. This email is intended for the use of the named recipient only. It may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please be notified that any use, dissemination, distribution or copying of this communication is prohibited. If you have received this communication in error, please utilize the reply option to advise the sender.

Health Quest has a secure e-mail policy.
About Health Quest Systems, Inc.

Health Quest Systems, Inc., headquartered in LaGrangeville, New York, is a leading nonprofit healthcare system in the Mid-Hudson Valley and northwest Connecticut. The network includes four hospitals: Vassar Brothers Medical Center in Poughkeepsie, Northern Dutchess Hospital in Rhinebeck, Putnam Hospital Center in Carmel and Sharon Hospital in Sharon, Conn. It also includes Health Quest Medical Practice, Health Quest Urgent Care, and several affiliates, including Health Quest Home Care and The Heart Center. Health Quest comprises 691 licensed beds and more than 6,000 employees.

If assistance is required, please send a message to the Help Desk at hqithelpdesk@health-quest.org or call (845) 483-6789. This email is intended for the use of the named recipient only. It may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please be notified that any use, dissemination, distribution or copying of this communication is prohibited. If you have received this communication in error, please utilize the reply option to advise the sender.

Revenue & Reimbursement
50 Hospital Hill Road
Sharon, CT 06069

860.364.4000
healthquest.org/Sharon

Sharon Hospital-Top 25 DRG's 06/01/2016-06/30/2017

	DRG	DESCRIPTION	PATIENT COUNT	CHARGES	REIMBURSEMENT	PER UNIT OF SERVICE
1	795	NORMAL NEWBORN	126	403,433.95	267,021.18	3,201.86
2	775	VAGINAL DELIVER	108	1,251,622.15	615,932.20	11,589.09
3	57	DEGENERATIVE NER	98	4,040,935.35	1,510,306.07	41,234.03
4	795	NORMAL NEWBORN	68	224,480.25	108,279.82	3,301.18
5	190	CHRONIC OBSTRUC	58	950,536.95	615,553.22	16,388.57
6	885	PSYCHOSES	55	2,425,240.55	786,358.23	44,095.28
7	871	SEPTICEMIA OR S	55	1,636,144.23	973,193.29	29,748.08
8	71	NONSPECIFIC CERE	47	1,993,603.45	763,965.27	42,417.09
9	775	VAGINAL DELIVER	44	465,937.60	209,077.29	10,589.49
10	57	DEGENERATIVE NER	42	1,654,300.90	611,605.18	39,388.12
11	603	CELLULITIS W/O	41	562,816.68	334,108.44	13,727.24
12	794	NEONATE W OTHER	39	150,989.85	104,378.45	3,871.53
13	766	CESAREAN SECTIO	39	1,039,396.66	373,638.38	26,651.20
14	291	HEART FAILURE &	39	854,920.61	563,741.57	21,921.04
15	885	PSYCHOSES	39	1,468,494.62	469,123.76	37,653.71
16	884	ORGANIC DISTURB	33	1,306,258.15	462,384.42	39,583.58
17	690	KIDNEY & URINAR	31	522,660.79	251,722.28	16,860.03
18	470	MAJOR JOINT REP	30	1,817,220.09	629,950.93	60,574.00
19	392	ESOPHAGITIS, GA	30	519,880.70	243,606.82	17,329.36
20	766	CESAREAN SECTIO	28	738,566.39	205,306.91	26,377.37
21	603	CELLULITIS W/O	25	290,945.53	214,293.61	11,637.82
22	280	ACUTE MYOCARDIA	24	605,106.85	363,036.94	25,212.79
23	641	MISC DISORDERS	22	272,159.31	140,654.51	12,370.88
24	871	SEPTICEMIA OR S	21	590,648.28	335,820.99	28,126.11
25	774	VAGINAL DELIVER	19	268,287.90	104,499.54	14,120.42

Sharon Hospital-Top 25 CPT's 06/01/2016-06/30/2017

	CPT	DESCRIPTION	NUMBER PTS	CHARGES	REIMBURSEMENT	PER UNIT OF SERVICE
1	12001	RPR S/N/AX/GEN/TRN	264	316,520.80	137,910.42	1,198.94
2	66984	CATARACT SURG W/IO	262	2,622,147.85	683,763.92	10,008.20
3	43239	EGD BIOPSY SINGLE/	252	1,671,327.95	550,251.17	6,632.25
4	29125	APPLY FOREARM SPLI	198	282,095.70	97,363.63	1,424.73
5	45385	COLONOSCOPY W/LESI	176	850,443.80	340,488.00	4,832.07
6	45380	COLONOSCOPY AND BI	165	877,042.55	357,376.44	5,315.41
7	45378	DIAGNOSTIC COLONOS	165	716,990.80	342,297.83	4,345.40
8	90471	IMMUNIZATION ADMIN	143	214,759.10	69,421.73	1,501.81
9	29515	APPLICATION LOWER	138	199,611.15	77,468.11	1,446.46
10	12002	RPR S/N/AX/GEN/TRN	130	216,769.65	92,675.96	1,667.46
11	12011	RPR F/E/E/N/L/M 2.	121	241,174.50	94,341.43	1,993.18
12	29130	APPLICATION OF FIN	89	89,602.40	50,650.47	1,006.77
13	43235	EGD DIAGNOSTIC BRU	83	495,390.35	166,467.44	5,968.56
14	G0105	COLORECTAL CANCER	79	332,193.60	112,218.15	4,204.98
15	G0121	COLORECTAL CANCER	68	282,821.50	85,569.46	4,159.14
16	58558	HYSTEROSCOPY BIOPS	68	684,865.05	233,937.14	10,071.54
17	50590	FRAGMENTING OF KID	64	478,005.37	250,658.86	7,468.83
18	10060	DRAINAGE OF SKIN A	62	104,915.65	33,504.64	1,692.19
19	64721	CARPAL TUNNEL SURG	52	407,733.36	107,638.05	7,841.03
20	36430	BLOOD TRANSFUSION	47	138,203.28	51,746.26	2,940.50
21	29881	KNEE ARTHROSCOPY/S	45	625,946.61	224,861.35	13,909.92
22	12013	RPR F/E/E/N/L/M 2.	38	141,199.80	43,281.52	3,715.78
23	66982	CATARACT SURGERY C	31	347,555.00	72,584.41	11,211.45
24	52648	LASER SURGERY OF P	26	459,023.34	119,883.21	17,654.74
25	99195	PHLEBOTOMY	25	7,790.20	3,729.97	311.61

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, May 08, 2018 11:30 AM
To: Roberts, Karen
Cc: User, OHCA; Cotto, Carmen; Clarke, Ormand; Greer, Leslie
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

Thanks, Karen. I will check to see who they'd like to use as a contact.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Tuesday, May 08, 2018 11:20 AM
To: Jennifer Groves Fusco
Cc: User, OHCA; Cotto, Carmen; Clarke, Ormand; Greer, Leslie
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

That's great Jen – thanks for the update.

It's likely that this CON record will be uploaded into the new CON portal in the next couple of weeks. After that all documents/communications will occur in or through the portal. We will let you and/or the main contact know when this occurs.

We have received emails/material related to this docket from both you and Bonnie Bee, Reimbursement Analyst for Sharon. Can you indicate if Bonnie or you will be the main contact for all compliance related material or will there be another person from the hospital or Healthquest through which communications will occur and documents will be filed going forward?

Please clarify as we get ready to upload the record to the portal. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, May 8, 2018 11:12 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>; Deshay, Tammy

(tdeshay@Health-quest.org) <tdeshay@Health-quest.org>
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

Good morning, Karen.

I wanted to let you know that the first Sharon Public Community Forum is scheduled for Wednesday, May 16, 2018, from 7:30 a.m. – 9:30 a.m. at the Sharon Town Hall. The Hospital has done outreach to ensure that members of the community know about the forum. This includes advertisement in the Lakeville Journal, a media alert inviting reporters from the local media, an event listing on social media, mailed invitations, and signage posted at the Hospital and Town Hall.

Per your email, we will follow-up afterwards with copies of sign-up sheets, etc.

Thanks,
Jen

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, March 01, 2018 12:53 PM
To: Jennifer Groves Fusco
Cc: Cotto, Carmen; Clarke, Ormand
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

Hi Jen – It appears that staggering the date of the October Joint Board Meeting and the date of the public meeting is acceptable. Your question appears to only be about the system-wide meeting in the fall, but remember that two public meetings need to occur annually per Condition #2. Also, as an FYI – for other similar filings we usually receive material after the public meetings, such as any powerpoint presentations done, public sign up sheets, agenda, and minutes if any are taken. Thanks. Karen

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From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, February 27, 2018 3:50 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Sharon Hospital -- Docket No. 16-32132-CON

Karen & Carmen,

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Please let me know.

Thanks,
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Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

User, OHCA

From: Jennifer Groves Fusco <jfusco@uks.com>
Sent: Tuesday, May 08, 2018 4:14 PM
To: Roberts, Karen
Cc: User, OHCA; Cotto, Carmen; Clarke, Ormand; Greer, Leslie; Deshay, Tammy (tdeshay@Health-quest.org)
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

Hi, Karen.

Trista Parker from Health Quest will be the primary contact for compliance going forward. She will register, and they may also register individuals as back-up on the portal in case Trista is unavailable to submit, etc.

Thanks,
Jen

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Tuesday, May 08, 2018 11:20 AM
To: Jennifer Groves Fusco
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From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, March 01, 2018 12:53 PM
To: Jennifer Groves Fusco
Cc: Cotto, Carmen; Clarke, Ormand
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

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Sent: Tuesday, February 27, 2018 3:50 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Sharon Hospital -- Docket No. 16-32132-CON

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One Century Tower
265 Church Street
New Haven, CT 06510
Office (203) 786.8316
Cell (203) 927.8122
Fax (203) 772.2037
www.uks.com

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, May 09, 2018 9:50 AM
To: Jennifer Groves Fusco; Roberts, Karen
Cc: User, OHCA; Clarke, Ormand; Greer, Leslie; Deshay, Tammy (tdeshay@Health-quest.org); Lazarus, Steven
Subject: RE: Sharon Hospital -- Docket No. 16-32132-CON

Hi Jen,

It is our understanding that only one person could register.

Please contact Steve Lazarus at Steven.Lazarus@ct.gov , (860) 418-7012 for questions regarding additional registrations.

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, May 8, 2018 4:14 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: User, OHCA <OHCA@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Deshay, Tammy (tdeshay@Health-quest.org) <tdeshay@Health-quest.org>
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New Haven, CT 06510
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Cell (203) 927.8122
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www.uks.com

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, May 09, 2018 4:18 PM
To: Jennifer Groves Fusco
Cc: Bee, Bonnie; tparker@health-quest.org; User, OHCA; Greer, Leslie; Roberts, Karen
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Attachments: VHC - Board Members - Class List.pdf; SH Board Member List with address.xls

Importance: High

Hi Jen,

In reference to the attached Excel document, please confirm that those listed are the twelve Community Representatives chosen to represent the community at the Hospital's Board and that their appointment was done "*…in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital.*" as stipulated under condition #1 of the order. Please provide a summary of the steps taken to select the twelve individuals and, in addition to their residency, provide further information to support their qualifications as "*unbiased individuals*" to represent the Hospital's community.

Please submit your response by Monday, May 14, 2018. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
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www.ct.gov/dph

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, February 27, 2018 3:15 PM
To: User, OHCA <OHCA@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Deshay, Tammy (tdeshay@Health-

quest.org) <tdeshay@Health-quest.org>
Subject: RE: Sharon's Docket Number 16-32132_Compliance Material _Condition #1

Attached is a spreadsheet that lists all of the Sharon Hospital Board members, along with their towns and states of residence. As you can see, all Board members except Dr. Soucier (President of the Medical Staff) live in the greater Sharon area. I have also attached a document that shows Officers and Board members by class year.

Please let me know if you have any questions.

Thanks,
Jen

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, February 26, 2018 1:21 PM
To: Jennifer Groves Fusco
Cc: Roberts, Karen; User, OHCA
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Importance: High

Hi Jennifer,

Please provide OHCA with the names of Vassar's twelve community representatives selected to serve as voting members of the Hospital's board, set forth under Condition #1 of the order, which reads as follows:

"For three (3) years following the Closing Date, Vassar shall allow for twelve (12) community representatives to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting members under the Hospital's Board of Director Bylaws. Health Quest shall select, from those nominated by FCH in accordance with Section 2.7.1 of the Grant Agreement dated September 8, 2016, the community representatives in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."

It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
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HQ BOARD APPROVED 4-28-17

Vassar Health Connecticut, Inc.

Sharon HOSPITAL

Board of Trustees

2017 Board Officers

Chair	Joel Jones
First Vice Chair	Susan Iovino
Second Vice Chair	Vacant
Secretary-Treasurer	Vacant
President	Peter Cordeau
Assistant Treasurer	Katherine Bacher *(Non-Voting)*
Assistant Secretary	Michael Holzhueter *(Non-Voting)*
Assistant Secretary	Cheryl Booth *(Non-Voting)*

Classes of 2018, 2019 & 2020

All (14) Voting Members (unless indicated)

Class of 2018 *Term Ending in April 2018*	Class of 2019 *Term Ending in April 2019*	Class of 2020 *Term Ending in April 2020*
Bassin, Arthur	Cantele, Rick	Iovino, Susan
Hill, Hugh	Forood, Pari	Jones, Joel
Sioussat, Pierce	Kirber, William, MD	Quella, James
Tannen, Miriam, RN, NP-C	Palmer-House, Kathryn	Schechter, Kenneth

Ex Officio Board Members (w/Vote):

President	Peter Cordeau
President of Medical Staff	Donald Soucier, MD

User, OHCA

From: Bee, Bonnie <bbee@Health-quest.org>
Sent: Friday, May 11, 2018 4:29 PM
To: User, OHCA
Cc: Deshay, Tammy; Theisen, Toni; Johannes, Rebecca
Subject: Sharon Hospital (Docket No. 16-32132-CON)-Compliance with Condition No. 14
Attachments: Sharon Hospital Condition 14 Report 080117_033118.pdf

Please confirm receipt of this report.
Thank you,
Bonnie

Bonnie Bee
Revenue Specialist
Health Quest
1351 Route 55
LaGrangeville, NY 12540

HEALTHQUEST

845-475-9584
bbee@health-quest.org

Revenue & Reimbursement
50 Hospital Hill Road
Sharon, CT 06069

860.364.4000
healthquest.org/Sharon

Sharon Hospital-Inpatient Charges per CMAD
08/01/2017-03/31/2018

	Inpatient Charges	Case Mix	Number of Accounts
Total	$35,345,336.09	1.1525	1551

CASE MIX ADJUSTED DISCHARGES	1787.4589
Inpatient Charges per CMAD	$19,774.07

User, OHCA

From: Cotto, Carmen
Sent: Monday, May 14, 2018 1:42 PM
To: Jennifer Groves Fusco
Cc: Bee, Bonnie; tparker@health-quest.org; User, OHCA; Greer, Leslie; Roberts, Karen
Subject: RE: Sharon's Docket Number 16-32132_Compliance Material _Condition #1

Importance: High

Hi Jen,

Please provide us with the status of our request below.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

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Sent: Wednesday, May 9, 2018 4:18 PM
To: 'Jennifer Groves Fusco' <jfusco@uks.com>
Cc: 'Bee, Bonnie' <bbee@Health-quest.org>; 'tparker@health-quest.org' <tparker@health-quest.org>; User, OHCA <OHCA@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
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Attachments: SH Board Member List with address.xls; SH Condition #1 response 5 11 18.docx

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If assistance is required, please send a message to the Help Desk at hqithelpdesk@health-quest.org or call (845) 483-6789. This email is intended for the use of the named recipient only. It may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please be notified that any use, dissemination, distribution or copying of this communication is prohibited. If you have received this communication in error, please utilize the reply option to advise the sender.

First Name	Last Name	Board	Address
Peter	Cordeau	**SH**	Sharon, CT 06069
Joel W.	Jones	**SH**	Falls Village, CT 06031
Susan	Iovino, DNP, RN	**SH**	Kent, CT 06757
Arthur J.	Bassin	**SH**	Ancramdale, NY 12503
Richard	Cantele, Jr.	**SH**	Lakeville, CT 06039
Pari	Forood	**SH**	Lakeville, CT 06039
Hugh A.	Hill	**SH**	Kent, CT 06757-1431
William M.	Kirber, MD	**SH**	Lakeville, CT 06039
Kathryn (Katie)	Palmer-House	**SH**	Dover Plains, NY 12522
Kenneth	Schechter	**SH**	Salisbury, CT 06068
Pierce	Sioussat	**SH**	Millbrook, NY 12545
Miriam (Mimi)	Tannen	**SH**	Millbrook, NY 12545
James Andrew	Quella	**SH**	Sharon, CT 06069
Donald	Soucier, MD	**SH** *(Med Staff President)*	Avon, CT 06001

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Cc: Bee, Bonnie; Parker, Trista; User, OHCA; Greer, Leslie; Roberts, Karen
Subject: RE: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Importance: High

Hi Jen,

Please provide us with the status of our request below.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Cotto, Carmen
Sent: Wednesday, May 9, 2018 4:18 PM
To: 'Jennifer Groves Fusco' <jfusco@uks.com>
Cc: 'Bee, Bonnie' <bbee@Health-quest.org>; 'tparker@health-quest.org' <tparker@health-quest.org>; User, OHCA <OHCA@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Importance: High

Hi Jen,

In reference to the attached Excel document, please confirm that those listed are the twelve Community Representatives chosen to represent the community at the Hospital's Board and that their appointment was done "*…in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital.*" as stipulated under condition #1 of the order. Please provide a summary of the steps taken to select the twelve individuals and, in addition to their residency, provide further information to support their qualifications as "*unbiased individuals*" to represent the Hospital's community.

Please submit your response by Monday, May 14, 2018. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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www.ct.gov/dph

From: Jennifer Groves Fusco [mailto:jfusco@uks.com]
Sent: Tuesday, February 27, 2018 3:15 PM
To: User, OHCA <OHCA@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Deshay, Tammy (tdeshay@Health-quest.org) <tdeshay@Health-quest.org>
Subject: RE: Sharon's Docket Number 16-32132_Compliance Material _Condition #1

Attached is a spreadsheet that lists all of the Sharon Hospital Board members, along with their towns and states of residence. As you can see, all Board members except Dr. Soucier (President of the Medical Staff) live in the greater Sharon area. I have also attached a document that shows Officers and Board members by class year.

Please let me know if you have any questions.

Thanks,
Jen

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, February 26, 2018 1:21 PM
To: Jennifer Groves Fusco
Cc: Roberts, Karen; User, OHCA
Subject: Sharon's Docket Number 16-32132_Compliance Material _Condition #1
Importance: High

Hi Jennifer,

Please provide OHCA with the names of Vassar's twelve community representatives selected to serve as voting members of the Hospital's board, set forth under Condition #1 of the order, which reads as follows:

"For three (3) years following the Closing Date, Vassar shall allow for twelve (12) community representatives to serve as voting members of the Hospital's Board of Directors with rights and obligations consistent with other voting members under the Hospital's Board of Director Bylaws. Health Quest shall select, from those nominated by FCH in accordance with Section 2.7.1 of the Grant Agreement dated September 8, 2016, the community representatives in a manner that ensures the appointment of unbiased individuals who will fairly represent the interests of the communities served by the Hospital. OHCA is imposing this Condition to ensure continued access to health care services for the patient population."

It is also requested that you submit your response via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me if you have any questions regarding this request.

Thank you,
Carmen

Carmen Cotto, MBA

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Connecticut Department of Public Health
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