FEB - 9 2012
OFFICE OF
HEALTH CARE ACCESS

Application Checklist

Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

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 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.**

For OHCA Use Only:

Docket No.: 12-31-747 **Check No.:** 1482635
OHCA Verified by: SD **Date:** 2/9/12

☒ **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) 428-7053, at the time of the publication)***

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

☒ **Attached are completed Financial Attachments I and II.**

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

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the singed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☒ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

YALE-NEW HAVEN HOSPITAL

RECEIVED
FEB - 9 2012
HOSPITAL ACCESS

February 1, 2012

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

Re: Yale-New Haven Hospital (YNHH)
Saint Raphael Healthcare System (SRHS) & Hospital of Saint Raphael (HSR)
Certificate of Need Application: YNHH's Acquisition of the Saint Raphael Healthcare System

Dear Ms. Martone:

Enclosed please find the original, four (4) hard copies and an electronic copy on CD of the Certificate of Need (CON) application for YNHH's Acquisition of the Saint Raphael Healthcare System.

This CON application is an extraordinary opportunity to improve healthcare quality, efficiency and access for residents of greater New Haven and the State of Connecticut. The proposal represents a unique opportunity for two hospitals in close proximity to integrate functions and services to achieve cost and operational efficiencies, enhance access and improve quality of care.

I look forward to working with you and Office of Health Care Access staff on this critically important proposal.

Thank you for your time and support of this project.

Sincerely,

Marna P. Borgstrom
President & Chief Executive Officer

Enclosures

20 York Street
New Haven, CT 06504

Saint Raphael Healthcare System

1450 Chapel Street • New Haven, Connecticut 06511 • 203.789.3000 • www.srhs.org

Christopher M. O'Connor, FACHE
President and Chief Executive Officer
Saint Raphael Healthcare System
and Hospital of Saint Raphael

203.789.3020
203.867.5235 Fax

February 2, 2012

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

Re: Yale-New Haven Hospital (YNHH)
Saint Raphael Healthcare System (SRHS) & Hospital of Saint Raphael (HSR)
Certificate of Need Application: YNHH's Acquisition of the Saint Raphael Healthcare System

Dear Ms. Martone:

Enclosed please find the original, four (4) hard copies and an electronic copy on CD of the Certificate of Need (CON) application for YNHH's Acquisition of the Saint Raphael Healthcare System.

This CON application is an extraordinary opportunity to improve healthcare quality, efficiency and access for residents of greater New Haven and the State of Connecticut. The proposal represents a unique opportunity for two hospitals in close proximity to integrate functions and services to achieve cost and operational efficiencies, enhance access and improve quality of care.

I look forward to working with you and Office of Health Care Access staff on this critically important proposal.

Thank you for your time and support of this project.

Sincerely,

Christopher O'Connor
President & Chief Executive Officer

Enclosures

Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Certificate of Need Application

February 8, 2012

YALE-NEW HAVEN HOSPITAL's
Acquisition of the Saint Raphael Healthcare System, Inc.

Certificate of Need Application

TABLE OF CONTENTS

	ITEM	PAGE(S)
	Public Notice	6 - 10
	Copy of Filing Fee Check	11 - 12
	Hospital Affidavits	13 - 15
	CON Application	16 - 52
ATTACHMENT		
I	Letters of Support	53 - 74
II	Corporate Organizational Charts for each Applicant prior to and after this Proposal	75 - 78
III	Asset Purchase Agreement	79 - 162
IV	Key Personnel CVs	163 - 221
V	Documentation of Non-Profit Status	222 - 224
VI	State of Connecticut, Department of Public Health License(s)	225 - 229
VII	OHCA Financial Attachments I for YNHH and HSR	230 - 234
VIII	Assumptions for OHCA Financial Attachment I	235 - 238
	MRI Appendix	239 - 250
A	MRI Scans by Patient Town of Origin	251 - 253
B	CVs	254 - 302
C	SRMRC's ACR Certificates	303 - 305
D	SRMRC's Internal Financial Statements	306 - 308
E	Financial Attachment I	309 - 310
F	Financial SRMRC's Charges	311 - 314

Public Notice

AFFIDAVIT OF PUBLICATION

New Haven Register

STATE OF CONNECTICUT

County of New Haven

I, S. Quinn ..... of New Haven

Connecticut, being duly sworn, do depose and say that I am Sales Classified .....

of the New Haven Register, and that on the following date Jan 9, 10, 11, to wit: 2012

there was published in the regular daily edition of the said newspaper an advertisement,

PUBLIC NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Yale-New Haven Hospital, Saint Raphael Healthcare System and Hospital of Saint Raphael will submit the following Certificate of Need application:

Applicant(s):	Yale-New Haven Hospital Saint Raphael Healthcare System, Inc. Hospital of Saint Raphael
Address:	20 York Street
Town:	New Haven
Proposal:	Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.
Estimated Total Project Cost/Expenditure:	$160,000,000

ned issues of said newspaper.

.....20 12 .....before me.

Notary Public

My Commission Expires 10/31/2012

AFFIDAVIT OF PUBLICATION

New Haven Register

STATE OF CONNECTICUT

County of New Haven

I, S. Quinn ..... of New Haven

Connecticut, being duly sworn, do depose and say that I am Sales Classified .....

of the New Haven Register, and that on the following date Jan 9, 10, 11, to wit: 2012

there was published in the regular daily edition of the said newspaper an advertisement,

PUBLIC NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Yale-New Haven Hospital, Saint Raphael Healthcare System and Hospital of Saint Raphael will submit the following Certificate of Need application:

Applicant(s): Yale-New Haven Hospital

and that the newspaper extracts hereto annexed were clipped from each of the above-named issues of said newspaper.

Subscribed and sworn to this 26th day of Jan .....20 12 .....before me.

Notary Public

My Commission Expires 10/31/2012

LEGALS

RETURN DATE: JANUARY 31, 2012 :SUPERIOR COURT

COMMODORE COMMONS CONDOMINIUM ASSOCIATION, INC. : JD OF ANSONIA/ MILFORD

VS. :AT MILFORD

THE WIDOW, HEIRS REPRESENTATIVES AND CREDITORS OF RICHARD SEPKO, ET AL :DECEMBER 5, 2011

NOTICE TO THE WIDOW, HEIRS, REPRESENTATIVES AND CREDITORS OF RICHARD SEPKO

The Plaintiff has named The Widow, Heirs, Representatives and Creditors of Richard Sepko, as party defendant(s) in the complaint which it is bringing to the above-named Court seeking a foreclosure of its statutory lien for common charges, assessments and late charges upon premises known as Unit No. 25 of COMMODORE COMMONS CONDOMINIUM, Derby, Connecticut.

The Plaintiff has represented to the said Court, by means of an affidavit annexed to the Complaint, that, despite all reasonable efforts to ascertain such information, it has been unable to determine the identity and/or whereabouts of The Widow, Heirs, Representatives and Creditors of Richard Sepko.

Now, Therefore, it is hereby ORDERED under C.G.S. §52-69 that notice of the institution of this action be given to each defendant by some proper officer causing a true and attested copy of this order be published in New Haven Register once a week for two conservative weeks, commencing on or before January 17th, 2012, and that return of service be made to the Court.

BY THE COURT
By J W Moran, JTR 12-13-11

A True Copy
Attest:
Gerald V. Cappiello
State Marshal
New Haven County

Call to place your ad today 203 777-3278

At Your Service

A GUIDE TO LOCAL BUSINESSES & SERVICES

ANTIQUES

BUYING FOR CASH
Jewelry, gold & silver, old toys, china & lamps. Musical Instruments, military, paintings, coins, hunting & fishing items
DEE'S ANTIQUES
203-235-8431

GUTTERS/SIDING

AB SEAMLESS GUTTERS
Installation, cleaning, repair Gutter guards, Fully Insured
Ct. Lic. #HIC0618885
BBB Accredited Business
Phone: (203) 530-7191

JUNK REMOVAL

1-800-MrJunker.com
COMMERCIAL - RESIDENTIAL
We Take It All Away!!!
Household • Furniture • Tenant Refuse Carpeting • Etc, Etc. Just Call.....
Local Call: 203-734-5865
Toll Free: 1-800-675-8652
Junk Removal Made Easy!!
SAVE $20 OFF YOUR FIRST JOB

PET CARE

CASTLE HILL DOGTRAINING.COM
"Since 1979"
• Puppy & Dog Obedience
• Resolve Behavior problems
Master Trainers
Dan and Sandra Cacace
(203) 934-2099

PLUMBING

DAVE MILLER PLUMBING
Licensed and Insured
Free Estimates
No job too big or too small
15 Years Experience
Lic. #PLM0285403-P1
Dave 203-410-9323 cell
203-468-5402 Office

ROOFING

Gutters/Roofing
Interior - Exterior
Ice and Leak Damage
Repairs Insurance Estimataes
V. Nanfito
BBB
(203) 639-1634
Lic #570192

ROOFING

SUPER DEAL HOME IMPROVEMENT
Roofing, siding, Kitchens, bathrooms, carpentry work painting, repairs & clean ups
100% Customer Satisfaction. Fully Insured
Lic. 0622958
Victor 203-314-9726 - 24/7
www.superdealroofing.com

The Deadline to Place Your AD in the At your Service Section is Wednesday 4:00 p.m. Every Week.

fyidriving.com

Private Parties: List your vehicle for 7 DAYS for only $20
203.777.3278 or 1.877.872.3278

Trucks/Vans/4x4s

MODEL	YEAR	PRICE	PHONE
Dodge Dakota ST Club Cab, V6, 4x4, trans war, 28K miles, silver, excellent condition	2006	$14,500	203-734-7136
FORD Tow Truck super duty Lariet, diesel, 200,000mi, 203-996-5624	1991	$6000	203-624-4119

BMW

MODEL	YEAR	PRICE	PHONE
550I 50,000mi. 6sp AT w/steptronic. 360hp. 27mpg hwy. Like new cond.	06	$24,999	(203)245-9479

Ford

MODEL	YEAR	PRICE	PHONE
EXPLORER Sport, 2dr, silver gray, excellent condition, new tires, 133k, loaded.	01	$4,900	860-663-5627

Fuel and Firewood

A-1 OIL SERVICE
$3.45 per gallon
203-932-0542

FORBES PREMIUM FUEL
Is now selling home heating oil. 203-468-2777 for pricing
GINNETTI ENERGY, LLC

HAMDEN

LEGAL NOTICE

TC#Audit--2011 287-7112 Pursuant to Section 7-394 of Connecticut General Statutes, a certified copy of Audit Reports for the Fiscal Year Ended June 30, 2011 (Audited Financial Reports and Audit Reports required under Federal and State of Connecticut Single Audit Acts) for the Town of Hamden are on file in the office of the Town Clerk, 2750 Dixwell Avenue,Hamden, CT and is available for the public review.

Dated at Hamden, Connecticut this 6th day of January, 2012.

Vera A. Morrison
Hamden Town Clerk

2472640

803 PETS & SUPPLIES

AKC Lab Puppies, Vet checked, shots. $800. 860-663-3886

ALL BREEDS PUPPIES
Statewidepets.com
203-795-9931 / ORANGE

BABY PARROTS. All kinds, tame & cuddly 203-824-1717

DOBERMAN Puppies, home raised fr $650. 203-654-5008

866 OFFICE/STORE RESTAURANT EQUIPMENT

RESTAURANT EQUIPMENT & furniture for sale, location: 685 Foxon Rd, East Haven.
Call 203-430-1300
or 203-645-2557

881 WANTED TO BUY

1 BUY RADIOS, HAM, CB, VINTAGE ELECTRONICS, TUBE AUDIO,GUITARS,AMPS, MUSICAL INSTRUMENTS
860-707-9350

ANTIQUES - MILITARY
Winchester, Books, tools, trains, toys. Knives, swords,

881 WANTED TO BUY

NICHOLS Salvage-will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

975 VEHICLES WANTED

JUNK CARS WANTED
And late model wrecks. Highest prices paid. 7 day & evening pickup. Atlas 203-865-JUNK (5865)

FIND IT IN CLASSIFIED
It's the key source for information you're seeking -- about job opportunities homes for sale, lost pets and more.
777-FAST
1-877-872-FAST

CALL EARLY, CALL LATE!

CLASSIFIED IS OPEN

8AM. - 5:30 PM
MON. - FRI.
Or email to:
CLASSIFIEDADS
@NHREGISTER.COM

LEGALS

MERCHANDISE Marketplace

Articles For Sale

4x8 UTILITY TRAILER, new spare wheel, $75. 203-457-9345.

MATTRESS
Queen pillow-top, new in plastic. Cost $799. SELL $279. Call - (203) 488-3615

MODEL TRAINS FOR SALE
Call 203-488-4974

SNOWBOARD (Burton) with odyssey binding. 138 CAM, 53.5" long. $100. 203-481-5080 203-843-8141

Household Goods

Affordable Washers, Dryers, Stoves, Refrigs. and Service.
Del. Avail. 203 - 284 - 8986

Furniture

Table - Blue Corian
44" sq. with four dark captain's chairs. $500. OR BEST OFFER. Call 203-589-5446

Bicycles & Mopeds

BIKE
Schwinn Sierra Model 700. New condition. Asking $300. Call 203-934-4824.

HOUSE HUNTING? SHOP CLASSIFIED FOR THE HOME OF YOUR DREAMS!

TAG SALES WORK BEST WHEN YOU REACH THE MOST PEOPLE!

Four ways to place your ad in the Marketplace:
• Call: 203.777.3278 or 1.877.872.3278
• Fax: 203.865.8360
• On the web: www.newhavenregister.com
• Email: classifiedads@nhregister.com

Please be sure to include your name, address and telephone number when submitting your ad.

NEED A CAR? SHOP THE CLASSIFIEDS!

TAG SALES WORK BEST WHEN YOU REACH THE MOST PEOPLE!

LEGALS

CALL 777-FAST or (TOLL FREE)1-877-872-FAST TO PLACE YOUR CLASSIFIED AD

LEGALS

PUBLIC NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Yale-New Haven Hospital, Saint Raphael Healthcare System and Hospital of Saint Raphael will submit the following Certificate of Need application:

Applicant(s):	Yale-New Haven Hospital Saint Raphael Healthcare System, Inc. Hospital of Saint Raphael
Address:	20 York Street
Town:	New Haven
Proposal:	Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.
Estimated Total Project Cost/Expenditure:	$160,000,000

GENERAL HELP WANTED

645 GENERAL HELP WANTED

645 GENERAL HELP WANTED

Drivers

MetroAccess
an affiliate of METRO TAXI

All You Need is 7 to Make Money in This Challenging Economy!
We're Expanding Our Fleet &
Going Greener With CNG Vehicles
Drivers Also Needed for
Our New Wheelchair-Accessible Service
If You're Looking for a Full Time Driving Career
or a Part Time Opportunity
We'll Train You and Get You Started
Each Vehicle is Equipped with the Latest Technology
Call Us Now to Hear More 203-777-7777 option 3
Send Resumes to: info@metrotaxict.com

650 HEALTH CARE OPPORTUNITIES

650 HEALTH CARE OPPORTUNITIES

HEALTH CARE JOBS!

No Resume? No Problem! Monster Match assigns a professional to hand-match each job seeker with each employer!

This is a FREE service!

Simply create your profile by phone or online and, for the next 90-days, our professionals will match your profile to employers who are hiring right now!

CREATE YOUR PROFILE NOW
BY PHONE OR WEB FREE!

1-800-344-8490

or

Jobs.nhregister.com

No Resume Needed!

Call the automated phone profiling system or use our convenient Online form today so our professionals can get started matching you with employers that are hiring - NOW!

Choose from one of the following main job codes to enter your information:

Dental - #55
Health Care Assistants - #57
Medical Records - #58
Medical Technicians - #56
Medical Therapists - #53
Nursing - #52
Pharmacy - #54

648 SALES & MARKETING

648 SALES & MARKETING

PLAN for the Future

SALES JOBS!

No Resume? No Problem! Monster Match assigns a professional to hand-match each job seeker with each employer!

			8	9			2	
						6		7

Directions: Fill the grid so that every row, column, and 3x3 box contains the digits 1 through 9

For solutions, check 'URC Publications' on the solutions page of www.sudoku.com.

su|do|ku
© Puzzles by Pappocom

YESTERDAY'S ANSWER

Easy-16

1	2	7	8	4	5	6	9	3
6	9	8	1	7	3	2	4	5
3	5	4	6	9	2	7	1	8
8	3	5	4	6	7	1	2	9
7	4	2	9	5	1	8	3	6
9	1	6	2	3	8	4	5	7
5	8	3	7	1	4	9	6	2
4	7	9	3	2	6	5	8	1
2	6	1	5	8	9	3	7	4

Health Care Opportunities

650 HEALTH CARE OPPORTUNITIES

CT TECHNOLOGIST
Experience necessary for Registered/Licensed Tech. Per diem position. Please call Patti 203-694-8260 for appointment.

Medical Secretary - Needed for medical office in New Haven w/3-5 yrs exp in billing & coding
Email resume to:
sabitarathi@gmail.com

RN, LPN, CNA - Choices and top pay are YOURS on our team. CT's Oldest staffing agency has Full & Part Time assignments NOW!!! 203-239-1036.

LEGALS

CITY OF NEW HAVEN, CONNECTICUT REQUEST FOR PROPOSALS

WEB HOSTING FOR
NHPS-2012-01-809
ERATE-FORM 470#
687110000992602
RFP due date: Tuesday, February 7, 2012 at 11:00 AM EST.

RFP can be downloaded at www.cityofnewhaven.com/purchasingbureau
Michael V. Fumiatti
Purchasing Agent

LEGAL NOTICE
Madison Inland Wetlands
The Madison Inland Wetlands Officer approved the following on January 5, 2012: 07-07 Ext: 1 Bishop Lane. Map 50, Lot 17. Owner/Applicant: Shoreline Warehousing LLC. Request for Extension of Regulated Activity Permit for construction of building, and parking and driveway area within 100 ft. of wetlands originally approved on July 2, 2007; now to expire July 2, 2017.
By: Shoreline Warehousing LLC

LEGAL NOTICE
Property contained in the following units will be sold to the highest bidder to satisfy the owner's lien for rent. Auction is With Reserve. Metro Self Storage reserves the right to set minimum bids and to refuse bids. CASH ONLY.
Sale Date: 1-24-12, time: 3:00pm, location of sale: METRO SELF STORAGE, 237 SAWMILL RD, WEST HAVEN, CT

LEGALS

NOTICE OF DISSOLUTION OF PERSONAS MORTGAGE, LLC

Pursuant to C.G.S. Sec. 34-213, notice is hereby given that Personas Mortgage, LLC, a Connecticut limited liability company ("Company") having its principal place of business of 2 Broad St., Milford, CT 06460, was dissolved on December 23, 2011 by a resolution adopted by its members. Articles of Dissolution were filed with the Secretary of the State of Connecticut. All creditors, if any, are warned to present their claims against the Company to Mark Pucci, 2 Broad St. Milford, CT 06460. All claims must state the name and address of the claimant, the amount claimed, the dates when the debt occurred, the facts and circumstances surrounding the claim, and all supporting documents. A claim will be barred unless a proceeding to enforce the claim is commenced within three years of the date of publication of this notice.
Dated January 9th, 2012, Personas Mortgage, LLC by Mark Pucci and Nelson Dasilva, Its Members

NOTICE TO CREDITORS

ESTATE OF:
MANUEL P. VALERIANO,
AKA MANUEL PHILIP VALERIANO

The Hon. John A. Keyes, Judge of the Court of Probate, New Haven Probate District, by decree dated December 29, 2011, 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.

Edward Cleary, Asst Clerk

The fiduciary is:

Carol R. Slade c/o Rosemary K. DeFilippo, 739 Carrington Road, Bethany, CT 06524

NOTICE TO CREDITORS

ESTATE OF:
RICHARD DONALESHEN,
AKA RICHARD N. DONALESHEN, AKA RICHARD NICHOLAS DONALESHEN

LEGALS

NOTICE TO CREDITORS

ESTATE OF:
MARY P. KRACHENFELS

The Hon. Salvatore L. Diglio, Judge of the Court of Probate, Hamden - Bethany Probate District, by decree dated December 21, 2011, 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.

Christine L. Panzo, Chief Clerk

The fiduciary is:

Christopher L. Donlin, Esq., 2508 Whitney Avenue, Suite E, Hamden, CT 06518

NOTICE TO CREDITORS

ESTATE OF:
CAROL A. POLLACK

The Hon. Beverly Streit-Kefalas, Judge of the Court of Probate, Milford - Orange Probate District, by decree dated December 8, 2011, 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.

Erin McGrath, Asst Clerk

The fiduciary is:

Dawn Quintiliano c/o John J. Coughlin Esq., Law Office of John J. Coughlin, LLC, 92 Cherry St., Milford, CT 06460

NOTICE TO CREDITORS

ESTATE OF:
NORMAN HARROWER,
AKA NORMAN HARROWER, JR.

The Hon. John A. Keyes, Judge of the Court of Probate, New Haven Probate District, by decree dated December 27, 2011, 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.

LEGALS

NOTICE TO CREDITORS

ESTATE OF:
RAYMONDE Z. FONTAINE

The Hon. Salvatore L. Diglio, Judge of the Court of Probate, Hamden - Bethany Probate District, by decree dated November 23, 2011, 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.

Valerie A. Dondi, Clerk

The fiduciary is:

Dominique Fontaine c/o Francis E. Lamboley, Esq. 1 Evergreen Ave, Suite 20, Hamden CT 06518

ANSONIA

CITY OF DERBY
PLANNING & ZONING COMMISSION
LEGAL NOTICE

The Planning & Zoning Commission of the City of Derby will conduct a public hearing on the following applications on Tuesday, January 17, 2012 at 7:00 p.m. in the Aldermanic Chambers, City Hall, 1 Elizabeth Street:

1. Application for Modification to Special Exception Use from White Hills Landscaping & Tree Service for 12 & 14 New Haven Avenue.

2. Application for Special Exception Use for Temporary Rock Crushing from City of Derby for property on between Main Street and Division Street.

3. Application for Special Exception Use and Site Plan Approval from Walgreen Eastern Co., inc. for retail/pharmacy at 60 Pershing Drive.

At said hearing interested persons may speak and written communications received.

Dated at Derby,Connecticut, this 3rd day of January, 2012.

PUBLIC NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Yale-New Haven Hospital, Saint Raphael Healthcare System and Hospital of Saint Raphael will submit the following Certificate of Need application:

Applicant(s):	Yale-New Haven Hospital Saint Raphael Healthcare System, Inc. Hospital of Saint Raphael
Address:	20 York Street
Town:	New Haven
Proposal:	Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.
Estimated Total Project Cost/Expenditure:	$160,000,000

Winchester, Books, tools, trains, toys. Knives, swords, muskets S. Papa 203-710-8146

NICHOLS Salvage-will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

CALL 777-FAST or
(TOLL FREE)1-877-872-FAST
TO PLACE
YOUR
CLASSIFIED AD

NEED A CAR?
SHOP THE CLASSIFIEDS!

Call to place your ad today 203 777-3278

At Your Service

A GUIDE TO LOCAL BUSINESSES & SERVICES

ANTIQUES

BUYING FOR CASH
Jewelry, gold & silver, old toys, china & lamps. Musical Instruments, military, paintings, coins, hunting & fishing items
DEE'S ANTIQUES
203-235-8431

GUTTERS/SIDING

AB SEAMLESS GUTTERS
Installation, cleaning, repair Gutter guards, Fully Insured
Ct. Lic. #HIC0618885
BBB Accredited Business
Phone: (203) 530-7191

JUNK REMOVAL

1-800-MrJunker.com
COMMERCIAL - RESIDENTIAL
We Take It All Away!!!
Household • Furniture • Tenant Refuse
Carpeting • Etc, Etc. Just Call....
Local Call: 203-734-5865
Toll Free: 1-800-675-8652
Junk Removal Made Easy!!
SAVE $20 OFF YOUR FIRST JOB

PET CARE

CASTLE HILL DOGTRAINING.COM
"Since 1979"
• Puppy & Dog Obedience
• Resolve Behavior problems
Master Trainers
Dan and Sandra Cacace
(203) 934-2099

PLUMBING

DAVE MILLER PLUMBING
Licensed and Insured
Free Estimates
No job too big or too small
15 Years Experience
Lic. #PLM0285403-P1
Dave 203-410-9323 cell
203-468-5402 Office

ROOFING

Gutters/Roofing
Interior - Exterior
Ice and Leak Damage
Repairs Insurance Estimataes
V. Nanfito
(203) 639-1634
Lic #570192

ROOFING

SUPER DEAL HOME IMPROVEMENT
Roofing, siding, Kitchens, bathrooms, carpentry work painting, repairs & clean ups
100% Customer Satisfaction. Fully Insured
Lic. 0622958
Victor 203-314-9726 - 24/7
www.superdealroofing.com

The Deadline to Place Your AD in the At your Service Section is Wednesday 4:00 p.m. Every Week.

BUSINESS and SERVICE DIRECTORY

ATTICS/CELLARS CLEANED
A1 ATTIC All/part H/H Cleanout Salv Cons Reas Rates Estbl 1988. Free est. 481-4845

ROOFING
Manoly Roofing- Fully Insured Comml/Res. BBB Lic#603258 - 203-640-9620

FIND IT IN CLASSIFIED
It's the key source for information you're seeking -- about job opportunities homes for sale, lost pets and more.
777-FAST
1-877-872-FAST

TAG SALES WORK BEST WHEN YOU REACH THE MOST PEOPLE!

LEGAL SERVICES

START FRESH!
One of Connecticut's oldest bankruptcy law firms since 1952
Groob, Ressler & Mulqueen P.C.
• STOP FORECLOSURES • STOP HARASSMENT
Simple Chapter 7 Bankruptcy
Free Initial Consultation
Chapters 11 & 13, Fees upon request
(203) 777-5741
123 York Street • New Haven
A Debt Relief Agency. We help people file for relief under the bankruptcy code.

LEGAL SERVICES

BANKRUPTCY/ FORECLOSURE MEDIATION
Eliminate your debt!
Stop Foreclosures. Save Your Home!
Ask about our flexible payment plans
Call for a FREE checkup
Stephen I. Small, LLC
(203) 937-8535
www.smallctlaw.com

TAG SALE
Tag Sales Work Best When You Reach The Most People!
Our special low rate is only available to "private party" advertisers, not commercial ones. 5 lines, 2 days, $11.50. 1 day ads will be billed at the open rate.
And, as an added bonus, each tag sale advertiser will receive a FREE Tag Sale Kit with every ad. The kit includes helpful hints on planning a successful sale; 2 signs to advertise your Tag Sale and a coupon for $3 off your next tag sale ad!
CALL NOW TO ADVERTISE YOUR TAG SALE! • 777-FAST or 1-877-872-FAST

MERCHANDISE marketplace

CALL EARLY, CALL LATE!
CLASSIFIED IS OPEN
8AM. - 5:30 PM
MON. - FRI.
Or email to:
CLASSIFIEDADS @NHREGISTER.COM

HOUSE HUNTING? SHOP CLASSIFIED FOR THE HOME OF YOUR DREAMS!

Call Early, Call Late
Classified lines are open Monday through Friday, 8AM-5PM
(203) 777-FAST
or
1-877-872-FAST

MILFORD

Legal Notice

City of Milford
Office of the Purchasing Agent
70 West River Street
Milford, CT 06460
Tel. 203-783-3225
Fax 203-876-1960

REQUEST FOR QUALIFICATION (RFQ)

The City of Milford seeks pre-qualifications from qualified firms for an

Investment Manager For the City of Milford Retiree Health Care Trust

Responses must be received by 2:00 p.m., Friday, February 17, 2012 at the Office of the Purchasing Agent

Proposal packages are available in the Purchasing Office Or may be downloaded at www.ci.milford.ct.us Click on "City Department" select "Purchasing" Then "Current Bids."

All submissions must be made in accordance with materials supplied therein.

L.M. Tomasco
Purchasing Agent

2473085

803 PETS & SUPPLIES

AKC Lab Puppies, Vet checked, shots. $800. 860-663-3886

ALL BREEDS PUPPIES
Statewidepets.com
203-795-9931 / ORANGE

BABY PARROTS. All kinds, tame & cuddly 203-824-1717

DOBERMAN Puppies, home raised fr $550. 203-654-5008

866 OFFICE/STORE RESTAURANT EQUIPMENT

RESTAURANT EQUIPMENT & furniture for sale, location: 685 Foxon Rd, East Haven.
Call 203-430-1300
or 203-645-2557

881 WANTED TO BUY

1 BUY RADIOS, HAM, CB, VINTAGE ELECTRONICS, TUBE AUDIO,GUITARS,AMPS, MUSICAL INSTRUMENTS
860-707-9350

ANTIQUES - MILITARY
Winchester, Books, tools, trains, toys. Knives, swords, muskets S. Papa 203-710-8146

NICHOLS Salvage-will buy your scrap steel, cars, trucks, alum., trailers, copper, batteries, heavy equip. 46 Meadow Rd. Clinton CT. 860-669-2808

975 VEHICLES WANTED

JUNK CARS WANTED
And late model wrecks. Highest prices paid. 7 day & evening pickup. Atlas 203-865-JUNK (5865)

TAG SALES WORK BEST WHEN YOU REACH THE MOST PEOPLE!

fyidriving.com
Private Parties: List your vehicle for 7 DAYS for only $20
203.777.3278 or 1.877.872.3278

Ford

MODEL	YEAR	PRICE	PHONE
EXPLORER	01	$4,800	860-663-5627

Sport, 2dr, silver gray, excellent condition, new tires, 133k, loaded,

LEGALS

Legal Notice
TOWN OF BRANFORD
REQUEST FOR BIDS
"Management of Bulky Waste"

The Town of Branford is requesting bid proposals for the "Management of Bulky Waste" to be transported and disposed from the Branford Transfer Station, located at 747 East Main Street, Branford, Ct. Specifications may be obtained from the Finance Department, Branford Town Hall, 1019 Main Street, Branford, CT or on the Town's website at www.branford-ct.gov.

Bids are to be submitted in a sealed envelope marked "Management of Bulky Waste" to the Finance Department, Attention, Purchasing Clerk, 1019 Main Street, Branford, Ct 06405 by 11:00 a.m., Thursday, January 26, 2012. Bids will be publicly opened and read at 11:30 a.m. on Thursday, January 26, 2012 in the Finance Department.

The Board of Selectmen or the majority reserves the right to select or reject any and/or all bids containing alternate proposals, to waive any informality in proposals and to reject any and/or all bids or accept such bid as shall, in their judgment, be in the best interest of the Town of Branford.

Anna DelRosso, Purchasing Clerk

2472941

LEGALS

PUBLIC NOTICE

Pursuant to section 19a-638 of Connecticut General Statutes, Yale-New Haven Hospital, Saint Raphael Healthcare System and Hospital of Saint Raphael will submit the following Certificate of Need application:

Applicant(s):	Yale-New Haven Hospital Saint Raphael Healthcare System, Inc. Hospital of Saint Raphael
Address:	20 York Street
Town:	New Haven
Proposal:	Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.
Estimated Total Project Cost/Expenditure:	$160,000,000

Copy of Filing Fee Check

Hospital Affidavits

AFFIDAVIT

Applicant: Yale-New Haven Hospital

Project Title: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc.

I, James M. Staten (Individual's Name) Chief Financial Officer (Position Title – CEO or CFO)

of Yale-New Haven Hospital being duly sworn, depose and state that
(Hospital or Facility Name)

Yale-New Haven Hospital's information submitted in this Certificate of Need
(Hospital or Facility Name)

Application is accurate and correct to the best of my knowledge.

James Staten
Signature

1/25/12
Date

Subscribed and sworn to before me on 1/25/12

Jacalyn D. Gonzalez

Notary Public/Commissioner of Superior Court

My commission expires: 3/31/16

My Commission Expires 03/31/2016

AFFIDAVIT

Applicant: Saint Raphael Healthcare System & Hospital of Saint Raphael

Project Title: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

I, Christopher M. O'Connor (Individual's Name) President and CEO (Position Title – CEO or CFO)

of Saint Raphael Healthcare System & Hospital of Saint Raphael (Hospital or Facility Name)

being duly sworn, depose and state that Saint Raphael Healthcare System & Hospital of Saint Raphael's information (Hospital or Facility Name)

submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature Date 2/3/12

Subscribed and sworn to before me on February 3, 2012

Lynne R Yarlock

Notary Public/Commissioner of Superior Court

My commission expires: July 31, 2012

CON Application

State of Connecticut

Office of Health Care Access

Certificate of Need Application

Instructions: Please complete all sections of the Certificate of Need ("CON") application. If any section or question is not relevant to your project, a response of "Not Applicable" may be deemed an acceptable answer. If there is more than one applicant, identify the name and all contact information for each applicant. OHCA will assign a Docket Number to the CON application once the application is received by OHCA.

Docket Number: TBD

Applicant: Yale-New Haven Hospital (YNHH)

Contact Person: Jean Ahn

Contact Person's Title: System Director, Planning & Business Development

Contact Person's Address: Yale-New Haven Hospital, Planning & Business Development
20 York Street (Howe 3)
New Haven, CT 06504

Contact Person's Phone Number: 203-688-2609

Contact Person's Fax Number:	203-688-5013
Contact Person's Email Address:	jean.ahn@ynhh.org
Applicant:	Saint Raphael Healthcare System and Hospital of Saint Raphael, Inc. (HSR)
Contact Person:	Terrie Estes
Contact Person's Title:	Director of Planning and Business Development
Contact Person's Address:	Saint Raphael Healthcare System & Hospital of Saint Raphael, Inc. (HSR) 1450 Chapel Street New Haven, CT 06511
Contact Person's Phone Number:	203-789- 4378
Contact Person's Fax Number:	203-867-5665
Contact Person's Email Address:	TBESTES@srhs.org
Project Town:	New Haven

Project Name: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Statute Reference: Section 19a-638, C.G.S.

Estimated Total Capital Expenditure: $160,000,000

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

a. Please provide a narrative detailing the proposal.

In the context of an increasingly challenging healthcare environment, this proposal presents an extraordinary opportunity to improve healthcare quality, efficiency and access for the residents of greater New Haven and the State of Connecticut.

Yale-New Haven Hospital (YNHH) proposes to acquire certain assets of the Saint Raphael Healthcare System, Inc. (SRHS) which include the following components:

- **The Hospital of Saint Raphael (HSR), a 511-bed acute care hospital;**
- **Saint Regis Health Center Inc. d/b/a Sister AnneVirginie Grimes Center (Grimes Center), a 120-bed short-term rehabilitation and long- term care facility; and**
- **SRHS's ownership interest in three joint ventures: Saint Raphael Magnetic Resonance Imaging, Connecticut CK Leasing, LLC and Saint Raphael's Dialysis Center Partnership;**
    - **See Appendix for MRI specific CON questions and responses.**

Some entities included in the acquisition do not require CON approval. Accordingly, this CON application is specifically requesting the Office of Health Care Access' (OHCA) approval for YNHH's acquisition of HSR as well as SRHS's ownership interest in the Saint Raphael Magnetic Resonance Imaging joint venture. However, the entire transaction has been described to provide OHCA with a comprehensive overview.

The result of this proposal will be a single acute care hospital in New Haven, CT, with two inpatient campuses and multiple ambulatory satellites that will deliver state-of-the-art health care. It is anticipated that inpatient and

ambulatory services will be delivered on both campuses. The proposal presents a unique opportunity for two hospitals in close proximity to integrate functions and services to achieve cost and operational efficiencies and more importantly, enhance access and improve the quality of care.

Since 1907, HSR has been providing health care services to the greater New Haven community. HSR was founded by the Sisters of Charity of Saint Elizabeth ("the Sisters"), who have continued to serve as the sponsors. For more than 100 years, HSR has continued its original mission, evolving into a sophisticated community teaching hospital, with a special concern for the underserved, poor, and elderly. It currently employs over 4,000 people and occupies an important place in the Connecticut's health care delivery system.

In addition to inpatient services, HS`R, under its acute care license, also provides clinic services in medicine, surgery, obstetrics & gynecology, pediatrics, psychiatry and geriatrics at its main campus. In addition, a number of community based programs are provided, some of which are outlined below:

- Father Michael J. McGivney Cancer Center in Hamden offering radiation therapy and other cancer support programs and services;
- Occupational health program which delivers healthcare services for employees of many local municipalities and businesses;
- Blood draw centers in West Haven and Hamden;
- Midwifery and pediatric services in Shelton;
- Geriatric Assessment Center in Branford and Hamden;
- Six Project Eldercare geriatric clinics located in senior centers and elderly housing complexes in New Haven and West Haven;
- Project MotherCare which provides primary care to women and children in community-based settings;
- Dental Van which provides mobile dental care in the community; and

- **School-based health clinics located at inner city Troup Magnet Academy of Sciences and Barnard Environmental Magnet School offering comprehensive primary care to students.**

Despite HSR's rich history and its numerous contributions to the local community, its future is uncertain. HSR has experienced significant financial losses for several years. These losses have required that HSR reduce operating expenses, including limiting employee benefits and delaying capital investments, and have challenged HSR's efforts to attract and retain physicians. Despite many efforts to mitigate financial losses, HSR recognized that without outside assistance and investment, it could not survive long term as a standalone entity. HSR evaluated its options and engaged in a thorough process to find a strategic partner in an effort to ensure continued access to its critically needed health care services for the greater New Haven community.

YNHH, a 1,008-bed teaching hospital, is affiliated with the Yale University School of Medicine and includes the Yale-New Haven Children's Hospital, the Yale-New Haven Psychiatric Hospital and the Smilow Cancer Hospital. A total of 874 general hospital beds and 92 bassinets are located in New Haven and effective January 11, 2012, 42 dedicated pediatric beds are located on the campus of Bridgeport Hospital. For the purposes of this Certificate of Need application, bed statistics included in this document will address only the New Haven campus.

Like HSR, YNHH has a long and rich history. YNHH opened in 1826 as a charitable institution for the care of the poor but soon expanded to caring for the entire community. YNHH now provides advanced treatment, employs over 8,500 people has now become a destination hospital offering tertiary and quaternary care which serves the local population as well as those throughout Connecticut and the Northeast. YNHH's comprehensive scope of

programs and services permits it to compete with referral centers located in New York and Boston.

In addition to the 1,008-bed acute care hospital and a vast array of ambulatory clinics located on the main New Haven campus, YNHH also provides a number of community-based services such as:

- Shoreline Medical Center: a free-standing emergency department, imaging center, ambulatory surgery, and radiation oncology program located in Guilford, CT;
- Imaging satellites at YNHH Temple Radiology in New Haven (Temple Street and Long Wharf), East Haven, West Haven, Hamden and North Haven;
- Ambulatory surgery center (Temple Street, New Haven);
- Walk-in/ Urgent Care Center in East Haven;
- Lab/Blood Drawing stations in numerous communities; and
- School-based health clinics at :
    - New Haven Schools: Hill Regional Career High School, James Hillhouse High School, and Mauro-Sheridan School
    - Branford Schools: Branford High School, Walsh Middle School, and Mary T. Murphy School.

Prior to the opening of the Smilow Cancer Hospital in 2009, YNHH experienced steady increases in demand for its services. Since the opening of Smilow Cancer Hospital, and particularly in FY 2011, the Hospital's rate of growth has been unprecedented. Demand for inpatient beds has increased significantly, especially in adult medicine and surgery, and the hospital is currently operating at high occupancy levels including continued use of the 1951 East Pavilion, which has significant physical plant limitations as documented in the Smilow Cancer Hospital Certificate of Need application. These high occupancy levels have become increasingly more challenging and have hampered YNHH's ability to efficiently care for inpatients.

The late 1980's YNHH's facilities master plan contemplated demolishing the East Pavilion (opened in the early 1950's) because of the inability to renovate it adequately for contemporary inpatient services and using the site for a new bed tower connected to all common services. Because of the significant growth in demand at YNHH, that plan is no longer feasible. Instead, absent the proposed acquisition of HSR, YNHH will have to construct a 5th bed tower to meet growing demand at a higher expense than the Smilow Cancer Hospital because it is not possible to connect it to common infrastructure and services. The 5th bed tower is estimated to cost approximately $400 million. In addition, it would take nearly five years to complete, thereby delaying access to critically needed capacity.

The proposed acquisition of HSR by YNHH presents opportunities for both organizations, employees, and the community. The proposed acquisition will remedy HSR's financial issues, as YNHH will make significant investments in the HSR campus to improve its facilities and technological capabilities. In addition, HSR's long term debt will be extinguished and resources will be provided to address the current Church plan pension shortfall. YNHH will also respect HSR's Catholic tradition by continuing to provide care at the HSR campus according to the Ethical and Religious Directives for Health Care Services.

The acquisition will enable YNHH to increase its bed capacity by acquiring HSR's 511 beds of which 421 are currently operational. The unused bed capacity at HSR will allow YNHH to defer plans for a 5th bed tower. Because of the close proximity of the two hospitals, this acquisition offers opportunities to combine appropriate service lines at one campus and to integrate other services across the two campuses. Although the planning process is not final, ultimately, integration of service lines will permit YNHH to meet projected increasing demand while delivering services in a more cost efficient way. The national consulting firm, Deloitte, was engaged by both

Applicants to identify cost savings which could be achieved through the acquisition. The plan identifies cost savings which are expected to exceed a half of a billion dollars over the next five years. These cost savings will ultimately reduce the costs of care while improving the quality of care.

This proposal has support from community and political leaders. Copies of letters of support have been provided in Attachment I.

b. Explain how each Applicant determined need for the proposal and discuss the benefits of this proposal for each Applicant (discuss each Applicant separately in separate paragraphs).

In this era of health reform, U.S. hospitals and health care providers face significant challenges in trying to simultaneously prepare for new payment models, while still succeeding in today's fee-for-service environment. Government and commercial reimbursement rates have not kept pace with operating expenses and hospitals are constantly making adjustments to remain financially viable. Both HSR and YNHH have focused on maintaining access and improving the quality of care despite the ever-present financial challenges of the industry. This proposal allows these two historic organizations to join together and continue their long-standing traditions but in a way that will allow them to more efficiently meet current and future demand.

Hospital of Saint Raphael:

Determination of Need by HSR:

As briefly discussed, HSR has been providing health care services to the community since 1907. It is one of only four Catholic hospitals in the State of Connecticut and has been an integral component of Connecticut's health care delivery system, especially in caring for the poor and the elderly. HSR has become increasingly dependent on government reimbursement with more than 70% of its revenue coming from Medicare and Medicaid. Unfortunately, government reimbursement rates have not kept pace with inflationary costs and HSR has seen its operating margin decline over the past several years.

HSR took many steps to address its financial situation including cost cutting initiatives, aggressive negotiations with managed care organizations, productivity enhancements, supply chain cost reductions, adjustments to fringe benefits and the postponement of essential renovations and equipment purchases. However, despite these efforts, it became clear that HSR's mission to serve to the poor, elderly and underserved and its heavy dependence on non-negotiable government reimbursement would prevent it from being able to achieve financial stability and prosper in the future.

Recognizing this vulnerability, the Saint Raphael Healthcare System Board of Trustees and the sponsoring Sisters of Charity of Saint Elizabeth concluded that integrating with a stronger hospital or system was necessary to meet its mission. In early 2010, a formal, thorough process—led by the SRHS Board's Ad Hoc Strategy Committee—began to explore and evaluate options to ensure continuation of the mission of Saint Raphael's and the Sisters into the future. In assessing options, goals included maintaining Saint Raphael's commitment to the community; preserving care delivery according to Catholic tradition; positioning the organization to successfully

address the challenges and expectations of healthcare reform (such as care coordination across providers); and financial stability.

With advice from an external advisor Navigant Consulting, the deliberative process examined Catholic and secular, not-for-profit and for-profit, and national, Connecticut and local systems. Of all the carefully considered options, the Sisters and Board determined that integrating with YNHH was in the best interest of Saint Raphael's, its staff, patients, physicians, and the community because:

- **This integration has the ability to transform and improve the way care is delivered—its quality, effectiveness and efficiency, as well as access to care.**
- **It will enable clinical service growth on the Saint Raphael campus.**
- **It will provide financial stability for Saint Raphael, in particular by eliminating long-term debt and significantly contributing to Church plan pension obligations, and by providing much needed capital.**
- **It will keep health care decisions local.**

Discussions with YNHH and HSR began in 2010 and were formalized with a Letter of Intent signed in March 2011.

<u>Benefits to HSR</u>

HSR identified YNHH as the optimal partner for a number of reasons as outlined below:

- **The organizations share a history of being part of the greater New Haven community.**
- **YNHH would address HSR's financial challenges by a capital contribution which would:**
    - **Eliminate long-term debt;**
    - **Significantly contribute to pension funding; and**
    - **Address capital needs.**

- **YNHH would employ the majority of HSR staff.**
- **YNHH would combine the medical staffs of both hospitals into one.**
- **YNHH would recognize the Teamsters as the bargaining unit for certain HSR employee groups.**
- **YNHH would provide representation for HSR physicians on the YNHH Medical Board and its committees.**
- **YNHH would enable HSR's campus to be the site of key centers of excellence as part of YNHH and in affiliation with the Yale University School of Medicine.**
- **YNHH would provide continuity and enhancement of patient care and stability through its investment in program development, infrastructure improvement and technology investments, in particular implementation of the Epic electronic medical record system; and**
- **YNHH agreed to respect HSR's Catholic tradition by:**
    - **Continuing to provide medical care on the HSR campus according to the Ethical and Religious Directives (ERDs) for Catholic Health Care Services;**
    - **Allowing the Sisters of Charity of Saint Elizabeth to have a role at YNHH through the selection of a senior leader to oversee matters pertaining to Catholic tradition, helping to select representatives for a committee to ensure clinical services are consistent with the ERDs; and serving on YNHH's Board of Trustees; and**
    - **Honoring HSR's Catholic heritage on the HSR campus through signage, the continued presence of the chapel, religious statuary and other symbols.**

This proposed purchase will provide the HSR campus and operations with significant capital investments in facilities, medical technology and information technology. In the first five years, YNHH plans to invest $129.5 million to:

- **Address deferred capital purchases and projects;**
- **Invest in clinical service infrastructure;**
- **Integrate existing information technology systems and implement the Epic electronic medical record system.**

This level of capital investment in the HSR campus is substantial and will allow the HSR campus to offer state-of-the art care and deliver it efficiently with the assistance of a fully integrated electronic medical record system.

A new integrated organization will preserve critical clinical services and ensure HSR's charitable assets for future generations. HSR's leadership determined that the opportunities for such extraordinary clinical integration, quality improvements, cost savings and investments do not exist with any other potential purchaser.

Yale-New Haven Hospital:

Determination of Need by YNHH:

Yale-New Haven Hospital has experienced significant growth and expansion in its services. Efforts during the past several years have been focused on securing YNHH's status as a destination hospital, on par with national referral centers in Boston and New York. Significant investments have been made in recruiting nationally and internationally known physicians and investing in technology and facilities. Yale-New Haven Children's Hospital and Smilow Cancer Hospital, are two examples of the level of commitment and investment in state-of-the art services and facilities which bring patients from near and far to New Haven, Connecticut for the best medical care.

YNHH offers a large number of programs and services as either the only provider or one of very few providers in Connecticut. Such services include:

- **Specialized Cardiac Services:**

- Heart valve program
- Implantable ventricular assist devices (VADs)
- Percutaneous aortic valve replacement (investigational)
- Less-invasive (mini-sternotomy) aortic valve replacement
- Percutaneous pulmonic valve replacement (investigational)
- Less-invasive (mini-thoracotomy) mitral valve replacement/repair
- Valve-sparing aortic root replacement

- Connecticut's only bi-plane hybrid MRI Operating Room
- Neuro-Interventional Center:
  - Neurological Intensive Care Unit staffed specifically with neurointensivists
  - Intracranial Aneurysms-GDC Therapy
  - Arteriovenous Malformations (AVMs)
  - Dural Arteriovenous Fistula (DAVFs)
  - Pre-Operative Tumor Embolization
  - Emergency Stroke Therapy
  - Carotid Artery Angioplasty & Stenting
  - Vertebroplasty
- Hemangioma Treatment
- Connecticut's only Liver Transplant Program (Adult and Pediatric)
- Level I Trauma Center
- Cancer Treatment:
  - Molecular profiling for cancer
  - Bone marrow & stem cell transplants
  - Rare and complex cancer treatment (recognized as a Center of Excellence for a dozen sites)

These programs have attracted patients from the State of Connecticut and beyond and have contributed to the significant growth in demand for inpatient services. Additionally, YNHH developed the Y Access Line, which opened in August, 2010 and facilitates the process wherein physicians,

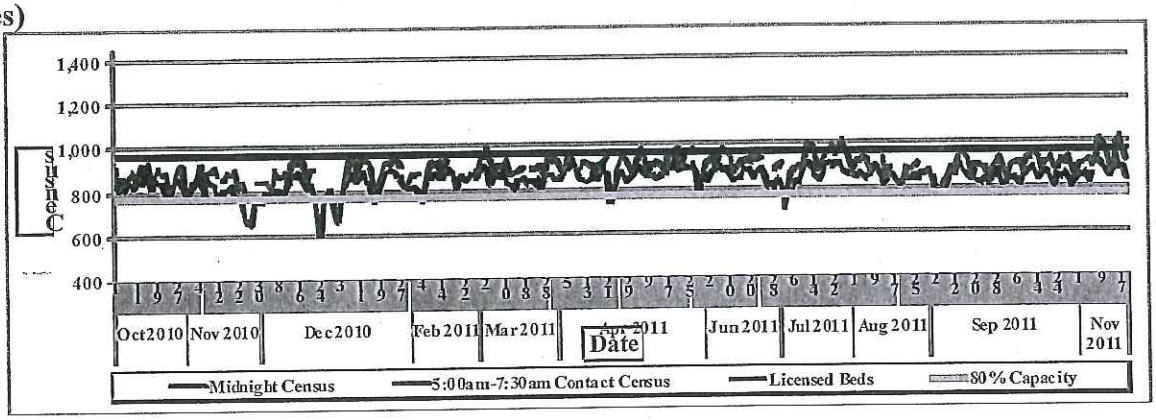
hospitals and other providers from across the State can transfer or directly admit patients for specialty care that cannot be provided or accessed elsewhere. YNHH is receiving a larger number of patients from all areas of Connecticut and bordering states, including referrals from 45 different Connecticut health care facilities outside the Yale-New Haven Delivery Network, 53 U.S. hospitals in 13 states outside of Connecticut and 7 hospitals outside the continental U.S. including Puerto Rico and 4 foreign countries. Inpatient cases transferred to YNHH totaled 2,996 the year before the Y Access Line was initiated and increased to 3,990 during the first year of its operation. This represents a 33% increase in volume and in the first two months of the second year of operation volumes have increased 46% as compared to the same time period in the previous year. It is important to note that patients who are transferred to YNHH via the Y Access Line have significantly longer lengths of stay and are more acutely ill, thus placing greater demands on bed resources and capacity.

As a result of the success of YNHH's clinical programs and corresponding growth in referrals, the hospital is currently facing considerable capacity constraints, most significantly in medical and surgical areas. These constraints have required that the Hospital utilize various approaches to safely and efficiently accommodate all patients that seek care at YNHH, including periodically placing patients on patient care units not typically intended for the patient's primary diagnosis. In addition, overflow areas have been developed to hold patients until they can be admitted to a bed; double rooms have been converted to triples; and Emergency Department (ED) patients requiring admission to an acute care or ICU bed may have to remain in the ED for an extended period of time until a bed is available. All of these factors can negatively impact patient and physician satisfaction.

Based on the midnight census, YNHH's overall occupancy routinely exceeds 80% and recently has approached 100%. YNHH also tracks the contact

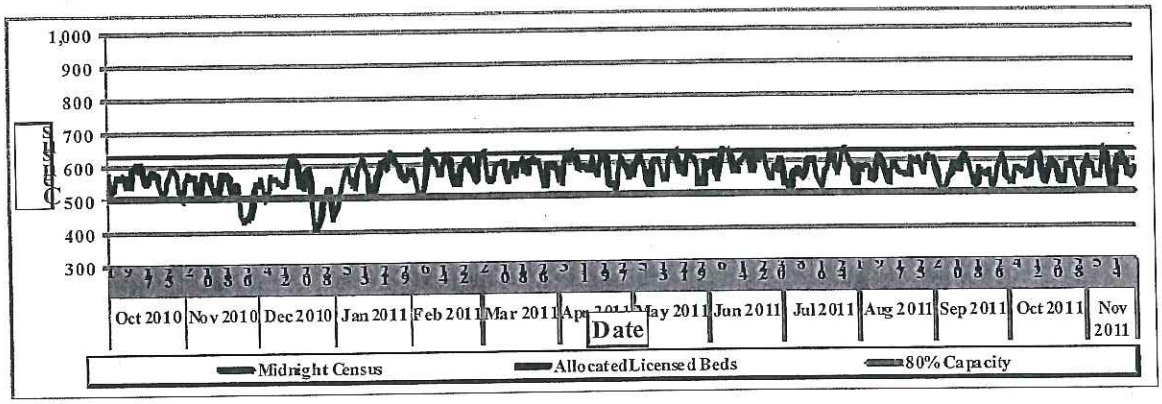
census which is a measure of the total number of patients that occupy a bed throughout a 24 hour period and provides an indication of the amount of inpatient activity that must be handled daily. The overall contact census frequently approaches the number of licensed beds. Both the midnight census and the contact census for YNHH (all services) are provided in Graph I below.

Graph I: YNHH FY 2011 -2012ytd Midnight Census and Contact Census (All Services)



Occupancy issues are even more pronounced for medical and surgical areas. There are 640 beds allocated to the medical and surgical areas and as shown in the graph below, occupancy levels are almost always above 80%. Average midnight census for medical/surgical services is depicted in Graph II below.

Graph II: YNHH Med/Surg Midnight Census: FY 2011 through 11/21/2011



Unfortunately, there are no opportunities to re-allocate beds from non-medical/surgical areas because referrals and fluctuations in census levels require the allotted number of beds in pediatrics, obstetrics and psychiatry.

YNHH recently submitted a Certificate of Need application to add 70 beds which will temporarily be located in the East Pavilion as a short term solution to its capacity issues. However, even with these additional beds and continued work to reduce length of stay, more beds will be required to accommodate projected demand. Based on YNHH's long range financial plan, even with 70 additional beds, by 2016, 74 more beds will be needed. Because HSR has approximately 90 licensed beds not currently operational, YNHH expects the acquisition of HSR will provide the necessary bed capacity to satisfy projected volume beyond 2016 while maintaining reasonable occupancy levels.

Inpatient volume projections were submitted to the Connecticut Attorney General and the Federal Trade Commission in connection with required federal review of the transaction and are summarized in the table below. The patient days, average daily census and bed requirement projections differ slightly from the projections included in the 70 bed CON because these projections were prepared at an earlier date and do not reflect the increase in patient days experienced at YNHH in FY 2011. In order to be consistent with materials submitted to the Connecticut Attorney General and the Federal Trade Commission, the financial schedules submitted with this CON coincide with the original projections.

YNHH has aggressively managed length of stay through numerous initiatives. Although length of stay reductions are projected, given the higher acuity patients being transferred via the Y Access Line and the aging of the population, continued length of stay reduction will be challenging. The projected length of stay, utilized in the financial model for the proposed

transaction, is 5.10 days in FY 2012 with steady reductions to 4.89 days by 2016. However, even if the length of stay can be reduced to this level, 74 additional beds will be required. Please note, based on the updated projections as submitted in YNHH's CON for 70 additional beds, the bed shortfall in FY 2014 based on updated patient day projections is calculated to be 43 beds, as opposed to 37 beds. This is due to higher projected patient days in the 70 bed CON as a result of actual volumes experienced in FY 2011.

Inpatient volume projections are summarized in the table below.

YNHH Inpatient Projections*	2012	2013	2014	2015	2016
Discharges	59,242	60,930	62,667	64,453	66,240
ALOS	5.10	5.05	5.00	4.95	4.89
Patient Days	302,134	307,781	313,389	318,959	324,106
Average Daily Census	828	843	859	874	888
Beds Required**	1,035	1,054	1,073	1,092	1,110
Beds Available***	994	1,036	1,036	1,036	1,036
Gap in Beds Required to Available	-41	-18	-37	-56	-74

* These projections were prepared at an earlier date but coincide with all the financial models prepared by Deloitte for the proposed transaction. 70 Bed CON patient days and bed requirements were updated based on FY 2011 actual volumes.

** Beds required based on 80% occupancy level

*** Beds available assume approval of 70 Bed CON with 28 available in 2012 and 42 more in 2013. Beds exclude pediatric beds located at Bridgeport Hospital

YNHH's long range facility planning efforts have identified that in order to meet projected inpatient demand, the hospital will have to construct a 5th bed tower at a cost approximately $400 million. The expected cost of the 5th bed tower will be particularly high because of the location. The only available site on the YNHH campus prohibits the new bed tower from being tied to YNHH's existing central medical complex and therefore would require

construction of duplicate facilities to service this one tower. In addition, this bed tower would not be available until late 2016; until this time, the Hospital will be severely challenged to accommodate its patient census. Both the cost and required time to construct this bed tower make this a less than ideal solution to YNHH's capacity needs. Accordingly, YNHH determined it was in its best interest to pursue discussions with HSR. As stated above, discussions began in 2010 and were formalized in March, 2011.

Benefits to YNHH

The potential HSR acquisition presents a much more cost-effective and timely option for increasing acute care bed capacity. Approval of this CON application as well as the recently submitted CON application for an increase of 70 beds will provide YNHH with critical inpatient capacity utilizing existing bed resources in the community as well as creating a wide range of other benefits. Expanded facilities for ambulatory services such as outpatient clinics, community based practices and programs, radiation therapy, and imaging services will also improve access to healthcare services for YNHH patients.

Given the nature of the evolving healthcare landscape and recognizing the distinctive attributes of both hospitals, a real opportunity exists today to bring together these organizations for the betterment of health care in the region. A single hospital provider with two campuses will create greater economies of scale and allow for the expansion of programs at both campuses, ultimately enhancing the provision of high quality care to patients and families. It will eliminate duplication of investments and maximize capacity while allowing each campus to remain true to its heritage. Efficiencies in the delivery of care will address HSR's financial issues and strengthen YNHH's performance. The opportunity to avoid duplicative investments and focus on key strategies, such as primary care development, will enhance access to services for patients in the region.

The proposed acquisition is also consistent with health reform efforts that focus on the principles of improved access to care and the provision of high quality, efficient and cost-controlled health care. The acquisition of HSR, along with the other SRHS entities, will position YNHH for success as the healthcare environment:

- **Evolves from a fragmented to an organized system of care;**
- **Holds providers accountable for the care delivered to the communities they serve;**
- **Shifts payments from volume based to payments for value;**
- **Focuses more on prevention and wellness; and**
- **Improves and strengthens the healthcare workforce.**

c. Provide a history and timeline of the proposal (e.g., When did discussions begin between the Applicants? What have the Applicants accomplished so far?).

As previously mentioned, HSR approached YNHH in early 2010 to discuss how the organizations could work together. These discussions culminated in the signing of a Letter of Intent in March 2011.

The parties began an extensive due diligence process which led to the Boards approving a definitive Asset Purchase Agreement in September 2011.

Subsequent discussions have been held with the State of Connecticut Attorney General and the Federal Trade Commission to initiate governmental approval of the transaction.

d. List any changes to the clinical services offered by the Applicants that result from this proposal, and provide an explanation.

The acquisition of HSR will permit YNHH to achieve substantial synergies by integrating specific medical and surgical services and consolidating them at the YNHH or the HSR campus. With the assistance of the consulting firm Deloitte, YNHH and HSR developed an integration plan for clinical and business operational services. Detailed operational planning to implement the integration plan must include medical staff leadership and management input and is still in process.

While the detailed implementation plan for the integration has not yet been finalized, the result will be a much more efficient, cost-effective health care system. YNHH and HSR have worked to identify a number of options to achieve cost savings and work flow efficiencies. It is anticipated that both campuses will continue to provide medical, surgical, psychiatric and obstetrical services, but certain subspecialties would be consolidated on one campus, while others will be offered at both. The Deloitte report describes how bariatric, urology, musculoskeletal, geriatric surgery, low-risk obstetrics and geriatric psychiatry could be centered at the HSR campus. The HSR campus has also been identified as an ideal location for many ambulatory services. Deloitte's report describes how the YNHH campus can serve as the hub for inpatient oncology, pediatrics, high risk obstetrics, and trauma. Deloitte has estimated cost savings from clinical and business operational integrations of at least $300 million over five years.

It is expected as more detailed operational planning is pursued that additional opportunities for integration and cost savings will be identified.

e. Describe the existing population served by the facility changing ownership or control, and how the proposal will impact these populations. Include demographic information as appropriate.

HSR's core service area comprises 22 cities and/or towns including: East Haven, New Haven, North Haven, West Haven, Hamden, Ansonia, Bethany, Branford, Cheshire, Clinton, Derby, Guilford, Madison, Meriden, Milford, North Branford, Orange, Oxford, Seymour, Shelton, Wallingford, and Woodbridge.

The total population in 2011 was 715,028 individuals. The population is projected to increase to 719,604 by 2016 and the percentage of elderly residents is projected to grow from 14% to 15% of the population.

The table below summarizes these demographic statistics.

HSR Service Area Population			
	2011 Population	2016 Population	% Change
Ansonia	18,410	18,129	-1.5%
Bethany	5,734	5,938	3.6%
Branford	29,175	29,019	-0.5%
Cheshire	29,258	29,367	0.4%
Clinton	13,966	14,133	1.2%
Derby	12,497	12,328	-1.4%
East Haven	29,319	29,275	-0.2%
Guilford	22,731	23,035	1.3%
Hamden	59,062	59,240	0.3%
Madison	19,150	19,446	1.5%
Meriden	60,908	61,184	0.5%
Milford	57,113	58,305	2.1%
New Haven	126,299	126,195	-0.1%
North Branford	14,511	14,583	0.5%
North Haven	24,635	24,856	0.9%
Orange	14,007	14,135	0.9%
Oxford	13,462	14,602	8.5%
Seymour	16,421	16,619	1.2%
Shelton	40,288	40,902	1.5%
Wallingford	45,596	46,092	1.1%
West Haven	53,132	52,804	-0.6%
Woodbridge	9,354	9,417	0.7%
TOTAL	**715,028**	**719,604**	**0.6%**

HSR Service Area Population		
65+ Population	Population	% of Total
2011	102,119	14%
2016	105,267	15%

The proposed purchase of HSR will allow this population to continue to receive high quality, cost effective health care services in their community. YNHH will offer services to this population at either its York Street location or the HSR campus. Because of this proposal, health care services historically offered by HSR will be preserved.

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

The Applicants are currently working on a transition plan and during the next six months YNHH and HSR will develop a detailed operating plan which will identify the timing and process to integrate clinical services, clinical support, non-clinical support and infrastructure services over a three year period following closing of the transaction. The plan will also detail how the medical staffs will be integrated. The plan will ensure a smooth transition from two hospitals to one hospital with two campuses with an integrated ambulatory network and make certain that all services will be of the highest quality and provided to the community in an efficient and effective manner. All services currently provided will remain and new services will be offered over time.

g. For each Applicant (and any new entities to be created as a result of the proposal), provide the following prior to and after this proposal:

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

Please see Attachment II for corporate organizational charts for each Applicant prior to and after this proposal.

h. Provide copies of all signed written agreements or memorandum of understanding, including all exhibits/attachments, between the Applicants related to the proposal. Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

A copy of the Asset Purchase Agreement has been included as Attachment III. Certain highly confidential content has been redacted.

2. Quality Measures

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

Please see Attachment IV for a list of key personnel and copies of their CVs.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

As stated above, the proposed acquisition of HSR by YNHH will combine two high-quality hospitals in a manner that improves patient care access, quality and service and achieves substantial cost savings.

YNHH is a high quality health care provider as evidenced by some of the many awards and designations it has received. In particular it has been recognized for its high quality of patient care services by several national organizations including, but not limited to:

- **U.S. News & World Report once again named YNHH as one of the top hospitals in the US with national recognition in 12 out of 16 specialties. YNHH has been selected by US News & World Report for 20 consecutive years.**

  - **YNHH's diabetes and endocrinology, geriatrics and psychiatry programs were ranked in the nation's top 10; and**
  - **Yale-New Haven Children's Hospital was nationally ranked in five specialties including diabetes and endocrinology, gastroenterology, urology, neonatology and pulmonary.**
- **YNHH received Magnet recognition in 2011 from the American Nurses Credentialing Center which signifies nursing excellence and collaboration between nurses and other health care team members. Only 6% of US hospitals have achieved this recognition.**
- **YNHH was named as one of the 100 Best Companies by Working Mother magazine. YNHH's support and recognition of its employees through its benefits and family friendly policies helped contribute to this designation.**
- **For the 12th year, YNHH was selected as one of the Most Wired Hospitals in the US by Hospitals and Health Networks. This recognition is based on technology advancements which improve patient safety, clinical quality and customer service.**
- **Connecticut Magazine named 191 YNHH physicians as "Top Doctors" as determined by their peers. These physicians span 25 areas of expertise and include adult and pediatric specialists and subspecialists.**
- **In 2010, YNHH was awarded the Connecticut Hospital Association's prestigious John D. Thompson Award for excellence in the delivery of healthcare through the use of data. This honor was awarded for YNHH's innovative tool to better manage blood glucose levels for the inpatient population.**

Similarly, Saint Raphael has been recognized by many national, independent organizations for the quality and safety of its care. Among its recent designations are:

- **Distinguished Hospital Award for Clinical Excellence based on clinical quality performance, ranking the Hospital among the nation's top 5%. Health Grades: 2011, 2010, 2009, 2008.**
- **Women's Health Excellence Award, placing Saint Raphael's in the top 5% of U.S. hospitals for women's services outcomes in maternity care and cardiac/stroke mortality. Health Grades: 2010-2011, 2009-2010.**
- **In the top 5% of U.S. hospitals for patient safety. HealthGrades: 2010, 2009, 2008, 2007, 2006, 2005.**
- **In the top 10% of U.S. hospitals for cardiac care. HealthGrades: 2011, 2010, 2009, 2008, 2007, 2006.**
- **Excellence Awards in cardiac care and surgery, coronary intervention, critical care, gastrointestinal care, general surgery, pulmonary care, and stroke care. HealthGrades: 2010-2012**
- **Bariatric Center of Excellence (Surgical Review Corporation; American Society for Metabolic and Bariatric Surgery).**
- **Designated Stroke Center, Joint Commission and Connecticut Department of Public Health. American Heart Association/American Stroke Association's Get with the Guidelines Stroke Silver Plus Quality Achievement Award, 2011.**
- **American College of Radiology Breast Imaging Center of Excellence, 2010, 2009.**
- **Nine clinical specialties designated as high performing in the region: nephrology, orthopedics, pulmonary, gastroenterology. geriatrics, gynecology, cardiology and cardiac surgery, diabetes, endocrinology, ear/nose/throat. U.S. News & World Report, 2011.**

The characteristics and programs highlighted in these quality awards will benefit future patients of both the YNHH and HSR campus. Additionally, the proposed acquisition will create one unified YNHH medical staff with the

same policies, procedures, order sets, etc., supporting the delivery of one standard of high quality, safe care in the community.

As previously noted, YNHH plans to spend a total of $129.5 million in capital expenditures, including $85 million for facility upgrades, $25 million for routine capital over the next five years as additional capital expenditures (in addition to the amounts budgeted by HSR), $5.1 million to integrate current YNHH and Saint Raphael's information technology systems and $14.4 million in capital expenditures to implement the Epic electronic medical records system at the Saint Raphael campus. These expenditures will ensure the quality and safety of services to be provided on the HSR campus.

The implementation of the Epic electronic medical record system at both campuses is expected to improve patient care by providing a seamless integration of the provision of medical care across physician offices, ambulatory centers, emergency services and inpatient environments. Epic will permit participating doctors to access patients' medical records in real time from any location. The installation of Epic at the Saint Raphael campus will provide substantial benefits to patients, physicians and payers for care provided at the HSR and will reduce the operating costs associated with the delivery of such care. The installation of Epic at YNHH is scheduled for February 2013.

3. **Organizational and Financial Information**

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

Both Applicants are 501c3 not for profit corporations.

b. Does the Applicant have non-profit status?

☒ Yes (Provide documentation) ☐ No

Please see Attachment V.

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

Please see Attachment VI.

d. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

Please see most recently completed fiscal year audited financial statements on file.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

Not applicable.

e. Submit a final version of all capital expenditures/costs as follows: Table 2:

Proposed Capital Expenditures/Costs

Medical Equipment Purchase	see all equipment
Imaging Equipment Purchase	see all equipment
Non-Medical Equipment Purchase	see all equipment
All Equipment	$29,030,000
Land/Building Purchase *	$70,722,000
Construction/Renovation **	
Other Non-Construction (Other Asset Purchases)	$60,248,000
Total Capital Expenditure (TCE)	
Medical Equipment Lease (Fair Market Value) ***	
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	
Total Project Cost (TCE + TCC)	**$160,000,000**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* 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.

Although incorporated in the total capital expenditure of $160,000,000, as OHCA requested, specific capital costs associated with the Hospital of Saint Raphael are noted below:

- **Hospital of Saint Raphael: $147,879,000.**

f. 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.

For the proposed acquisition, it is expected that YNHH will borrow $160 million by way of a public bond issue(s). Because YNHH anticipates that some of the assets purchased will not qualify for tax-exempt funding, YNHH will issue both tax-exempt and taxable bonds either in two bond issues sold at the same time or in a single issue with a tax-exempt series and a taxable series. Barclays Capital will be the lead underwriter on the transaction(s). YNHH has modeled the financing as 30-year, fixed rate bonds at 5% however; YNHH will evaluate the capital market at time of issuance for the structure that is best.

g. Demonstrate how this proposal will affect the financial strength of the state's health care system.

This proposal will positively affect the financial strength of the state's health care system. As previously described, the proposal preserves access to critically needed services in the greater New Haven community and permits expanded inpatient bed capacity at a substantially lower cost than if YNHH had to construct a new bed tower.

In addition, operational and clinical integration will reduce duplication, streamline services and overall produce significant operational cost savings.

Information technology enhancements, particularly the implementation of the Epic electronic medical record system, will improve productivity of clinical and administrative staff along with enhancing the quality of care delivered.

These improvements improve the financial health of two existing and significant health care providers which in turn improves the financial health of the State's health care system.

4. Patient Population Mix: Current and Projected

Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 3a: Patient Population Mix- YNHH – Inpatient (2013 – 2015 assumes HSR acquisition)

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	31%	38%	38%	38%
Medicaid*	29%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**60%**	**63%**	**63%**	**64%**
Commercial Insurers*	38%	35%	35%	34%
Uninsured (Self Pay)	2%	2%	2%	2%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**40%**	**37%**	**37%**	**36%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** New programs may leave the "current" column blank. Current includes only YNHH.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3b: Patient Population Mix- YNHH – Outpatient (2013 – 2015 assumes HSR acquisition)

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	21%	25%	25%	24%
Medicaid*	27%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**48%**	**50%**	**50%**	**50%**
Commercial Insurers*	45%	44%	44%	44%
Uninsured (Self Pay)	7%	6%	6%	6%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**52%**	**50%**	**50%**	**50%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.

** New programs may leave the "current" column blank. Current includes only YNHH.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3c: Patient Population Mix- HSR Inpatient

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	55%	N/A	N/A	N/A
Medicaid*	14%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**69%**	N/A	N/A	N/A
Commercial Insurers*	29%	N/A	N/A	N/A
Uninsured	2%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**31%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

Table 3d: Patient Population Mix- HSR Outpatient (Discharge Equivalent)

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	36%	N/A	N/A	N/A
Medicaid*	20%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**56%**	N/A	N/A	N/A
Commercial Insurers*	40%	N/A	N/A	N/A
Uninsured	4%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**44%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

a. Provide the basis for/assumptions used to project the patient population mix.

Projected payer mix for YNHH is based on the combination of YNHH volume and HSR volume by payer category. Projected volumes for FY 2013-2015 included holding HSR volume flat and YNHH volume increases 3% per year for inpatient admissions and 5% per year for outpatient encounters.

5. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

Included in Attachment VII are completed OHCA Financial Attachments I for YNHH and HSR.

b. Provide the assumptions utilized in developing **Financial Attachment I** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Assumptions utilized in developing Financial Attachments I has been included in Attachment VIII.

c. Identify the entity that will be billing for the proposed service(s).

Yale-New Haven Hospital will bill for the proposed services.

d. As a result of the proposal, will there be any change to existing reimbursement contracts between the Applicants and payers (e.g. Medicare, Medicaid, commercial)? Explain.

In recent payer negotiations at Yale-New Haven Hospital, payers have asked how contractual agreements will be handled if and when the proposed affiliation occurs. In these discussions, Yale-New Haven Hospital managed care representatives have agreed that new provider contracts would be negotiated based on the relative mix and volume of services in the combined institution. While the methodology for this analysis will be worked out with the payers, the intent of the negotiations will establish a melded, budget

neutral agreement, with new payment terms that will not result in an adverse financial impact to the managed care payers or the self-fund employers that they represent. A recent Letter of Agreement was established during the recent Aetna contract renewal negotiation that provided for such a budget neutral result if the transaction is approved. Such agreements will be reached with other payers as contractual agreements renew over the next few months. As neither YNHH nor HSR is aware of each other's managed care payment rates, details of the methodology and resultant negotiation with payers cannot be determined prior to regulatory approval.

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

Not applicable. The proposed acquisition includes multiple entities and a single volume statistic is not applicable.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

Incremental losses from operations are projected only in FY 2012 and are related to a one- time acquisition cost shown in the non operating revenue category. Incremental gains in FY 2013 alone more than offset the FY 2012 incremental losses. Incremental operating gains are also projected in FY 2014 and FY 2015.

g. Describe how this proposal is cost effective.

The acquisition of Saint Raphael by YNHH will defer significant capital investments in new facilities and technology at YNHH and will produce operating savings across both campuses. As noted previously, YNHH's need

for additional bed space will be met at substantially lower costs and the capital that is invested to expand capacity will support facility maintenance and improvement on the HSR campus.

The cost savings which can be achieved by the proposed acquisition include:

- **Savings from the integration of duplicative functions resulting in stronger economies of scale;**
  - **Clinical integration as previously outlined.**
  - **Non-clinical integration of infrastructure areas such as finance, information technology, human resources, support departments and other administrative functions would yield significant cost savings by not having to maintain separate complete departments at each site.**
- **Cost savings would result from the elimination of duplicative vendor contracts or more favorable volume-based vendor pricing; and**
- **Cost savings associated with capital expenditure avoidance both in terms of not having to construct a new bed tower for YNHH and capital equipment purchases that could be avoided in cases where HSR has such equipment.**

Implementation of the Epic electronic medical records system is expected to lower costs by reducing the variation in treatment and the costs of wasteful duplicative tests and procedures. Additionally, even if HSR were somehow able to find the financial means to install Epic independently (which is highly unlikely), this proposal permits the installation of Epic at the HSR campus at a substantially lower capital and operating cost (~$30 million less) than if HSR were to obtain and implement the system on its own.

Attachment I
Letters of Support

OFFICE OF THE MAYOR

165 CHURCH STREET • NEW HAVEN • CONNECTICUT 06510

*The vision of New Haven's children is our city's greatest resource**

JOHN DESTEFANO, JR.
Mayor

RECEIVED
DEC 5 – 2011
Marna P. Borgstrom
President & CEO

November 29, 2011

Ms. Marna Borgstrom
President & CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06511

Mr. Christopher O'Connor
President & CEO
Hospital of St. Raphaels
1450 Chapel Street
New Haven, CT 06511

Dear Marna & Chris:

On behalf of the City of New Haven, I am writing to formally endorse the proposal to integrate the Hospital of Saint Raphael and Yale-New Haven Hospital. Both hospitals have long served the people of New Haven with distinction and I firmly believe that their desire to formally become one hospital provides a meaningful opportunity to enhance quality care and access to care for the 135,000 residents of New Haven as well as the region.

Like many hospitals across the country, the Hospital of Saint Raphael has faced significant financial challenges in recent years. At the same time, Yale-New Haven Hospital continues to face significant capacity constraints. The proposal provides an opportunity to meet the financial needs of the Hospital of Saint Raphael while addressing the pressing capacity issues of Yale-New Haven in a manner that reduces costs.

In an era of healthcare reform and diminishing resources, this type of transaction makes sense. It protects pensions for employees who live and work in New Haven. It respects existing relationships between employees and organized labor. It provides opportunity long-term growth in a challenging economy. It is simply the right thing to do.

The proposed acquisition represents a New Haven solution to a New Haven issue and I am pleased to join many others in supporting this initiative.

Very truly yours,

John DeStefano, Jr.
Mayor

New Haven
All-America City
2009

phone 203.946.8200 *fax* 203.946.7683

**This creative impression is the work of Shayna Smith, a student at Wexler-Grant School.*

JOSEPH I. LIEBERMAN
CONNECTICUT

United States Senate

WASHINGTON, DC 20510

December 11, 2011

Chris O'Connor
President and CEO
The Hospital of St. Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Mr. O'Connor,

I am writing in support of the proposed merger between the Hospital of Saint Raphael and the Yale-New Haven Hospital.

I believe that this proposed merger is consistent with the goal of increased health care access and enhanced quality of care for the State of Connecticut. Both medical facilities have long traditions of serving some of Connecticut's most vulnerable populations. The Hospital of Saint Raphael serves the highest percentage of Medicare patients in the State of Connecticut and Yale-New Haven Hospital is our state's largest teaching hospital, caring for more than 500,000 patients annually.

It is my hope that this merger can improve the financial status of the Hospital of Saint Raphael while also addressing the capacity issues that at times hinder care at Yale New Haven. And your assurance that both hospitals will meet your employee's pension obligations, while maintaining the traditions and culture of each facility is encouraging. If I can be of any assistance with the merger moving forward, please don't hesitate to reach out to me or my staff in Washington D.C. or Connecticut

Once again, I support your efforts to merge these two hospitals so that we can protect patient access and enhance the quality of care provided to the citizens of Connecticut.

Sincerely,

Joseph I. Lieberman
UNITED STATES SENATOR

PRINTED ON RECYCLED STOCK

RICHARD BLUMENTHAL
CONNECTICUT

COMMITTEES
ARMED SERVICES
JUDICIARY
HEALTH, EDUCATION, LABOR, AND PENSIONS
AGING

United States Senate
WASHINGTON, DC 20510

702 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510
(202) 224-2823
FAX: (202) 224-9673

30 LEWIS STREET, SUITE 101
HARTFORD, CT 06103
(860) 258-6940
FAX: (860) 258-6958
http://blumenthal.senate.gov

December 13, 2011

Marna Borgstrom, President and CEO
Yale-New Haven Hospital and Yale New Haven Health System
20 York Street
New Haven, Connecticut 06504

Chris O'Connor, President and CEO
St. Raphael Health Care System and Hospital of St. Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Dear Presidents Borgstrom and O'Connor:

I am writing to express my support for the proposed merger of Yale-New Haven Hospital and Hospital of St. Raphael. The proposed would create a joint operating entity for both health care systems with the goal of providing greater efficiencies in the delivery of critical health care services in the New Haven area.

The proposed merger should benefit Greater New Haven residents if, as indicated, it reduces costs, enhances efficiencies and continues or even increases the delivery and accessibility of critical health care -- including important comprehensive women's health services. I am pleased to support the continued tradition and commitment of both institutions as they move forward as one entity.

I look forward to working with you on this and other issues of importance to the Greater New Haven community.

Very truly yours,

Richard Blumenthal
United States Senate

2413 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0703
(202) 225-3661

59 ELM STREET
SECOND FLOOR
NEW HAVEN, CT 06510
(203) 562-3718

DURHAM/MIDDLEFIELD/MIDDLETOWN
(860) 344-1159

WEBSITE: HTTP://DELAURO.HOUSE.GOV

UNITED STATES
HOUSE OF REPRESENTATIVES
ROSA L. DeLAURO
3RD DISTRICT, CONNECTICUT

CO-CHAIR, DEMOCRATIC STEERING AND POLICY COMMITTEE

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEES
CHAIRWOMAN
AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES
LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
FINANCIAL SERVICES AND GENERAL GOVERNMENT

COMMITTEE ON THE BUDGET

November 29, 2011

Ms. Marna Borgstrom
CEO
Yale New Haven Hospital
20 York Street
New Haven, Connecticut 06504

Mr. Christopher O'Connor
CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Dear Marna and Chris:

I am writing to support the proposal that would integrate the Hospital of Saint Raphael with Yale-New Haven Hospital.

I believe that this proposed merger is consistent with our goal to broaden access and enhance the quality of care provided while driving costs down. Both of your hospitals have proud traditions as safety net hospitals serving those in need. The Hospital of Saint Raphael serves the highest percentage of Medicare patients in the State of Connecticut and Yale-New Haven is the largest provider of services to Medicaid patients in the state.

Cultivating best practices at both hospital campuses and integrating programs has the potential to increase quality and patient safety while controlling costs. It will also address the pension responsibilities and debt liabilities of Saint Raphael while enabling Yale-New Haven to increase patient capacity. And your assurance that both campuses will continue their strong traditions as safety net hospitals is encouraging. It is imperative that we ensure that patients will continue have access to affordable, quality health care once the two hospitals are integrated.

I support your efforts to integrate the two hospitals while protecting patient access and improving hospital capacity in Connecticut.

Sincerely,

ROSA L. DeLAURO
Member of Congress

PRINTED ON RECYCLED PAPER

Agency on Aging
of South Central Connecticut

One Long Wharf Drive
New Haven, Connecticut 06511
(203) 785-8533
www.aoapartnerships.org

November 30, 2011

Marna Borgstrom,
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Christopher O'Connor,
President and CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Mrs. Borgstrom and Mr. O'Connor,

The mission of the Agency on Aging of South Central Connecticut is to empower adults to remain as independent and engaged as possible within their communities through advocacy, information, and services. I understand that the proposed integration of the Saint Raphael Healthcare System and Yale-New Haven Hospital would allow our seniors:

- additional access to hospital services with about 100 more staffed beds at the Saint Raphael campus,
- better coordination of care among the integrated hospital and its physicians, including a reduction of duplicative medical tests and an integrated medical record, and
- continued availability of inpatient and outpatient services at the Saint Raphael campus.

As our country and its seniors continue to face enormous economic difficulties, especially with increased healthcare costs and changes, we applaud your efforts to bring together the two hospitals to identify efficiencies and opportunities to reduce expenses while, at the same time, improving quality and patient safety.

We look forward to continuing our collaboration with Yale-New Haven Hospital at its main campus and at the Saint Raphael campus and commend you for bringing this proposal forward. The Agency on Aging of South Central Connecticut provides its support for the integration of the Saint Raphael Healthcare System and Yale-New Haven Hospital.

Sincerely,

Neysa Stallmann Guerino
Executive Director

United Technologies Corporation
United Technologies Building
Hartford, CT 06101
(860) 728-7670 Fax: (860) 728-7613

Louis R. Chênevert
Chairman & Chief Executive Officer

October 28, 2011

Ms. Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna:

I would like to express my strong support for the proposal to integrate Yale-New Haven Hospital and the Hospital of Saint Raphael. As a major employer in the State of Connecticut, our employees have come to count on the high quality and accessible care provided by Yale-New Haven. The integration of YNHH with the Hospital of Saint Raphael provides a unique opportunity to carry forward that quality and access in a new, more cost efficient manner.

United Technologies has a strong tradition of service in Connecticut. It is a trait that we share with both Yale-New Haven and the Hospital of Saint Raphael. We also recognize the importance of creating efficiency in operations for the benefit of our customers. In the same manner, this transaction makes sense because it provides the opportunity to strip out duplicative and costly capital and programmatic investments while enhancing service and quality.

We seek value in all that we do. We are encouraged that both hospitals are doing the same through creativity and innovation. As a result, we fully support Yale-New Haven Hospital's proposal to acquire the assets of the Hospital of Saint Raphael.

Sincerely,

Louis R. Chênevert

AMERICAN MEDICAL RESPONSE
Greater New Haven

Charles E. Babson, III
General Manager

Phone: 203-781-1322
Fax: 203-781-1364

January 18, 2012

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
and Yale New Haven Health System
20 York Street
New Haven, CT 06510

Christopher O'Connor, President and CEO
Saint Raphael Healthcare System
and Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Ms. Borgstrom and Mr. O'Connor,

As the leading provider of ambulance services in the greater New Haven community and an area employer, we are happy to support the proposed merger between the Saint Raphael Healthcare System and Yale-New Haven Hospital. We are fortunate to have many high-quality hospitals in the region, and we commend you for proposing to bring two of them together to better coordinate care, reduce capital expenditures, and identify efficiencies in the proposed combined organization. All of these goals have been discussed during the recent healthcare reform debate, and we are glad that your organizations had the energy and inspiration to bring this proposal to fruition.

While AMR is supportive of the proposal, we are well aware that hospital competition will remain with other area hospitals in close proximity to New Haven. Our company and its employees provide and receive services at multiple hospitals throughout Connecticut. We enjoy a collaborative working relationship with all of the hospitals for over 30 years and look forward to continuing our work with Yale-New Haven Hospital at its main campus and, hopefully, at its second campus at Saint Raphael's.

I am pleased to provide American Medical Response's support of the proposed integration of the Saint Raphael Healthcare System and Yale-New Haven Hospital.

Sincerely,

Charles E. Babson III

RAYMOND J. PEACH

Christopher O'Connor, President and CEO
Saint Raphael Healthcare System
and Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
and Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

November 30, 2011

Dear Chris and Marna,

I am pleased to support the proposed integration of the Saint Raphael Healthcare System and Yale-New Haven Hospital. As you know, in addition to my long banking career in this community, I have been closely involved with Saint Raphael's through a variety of roles ranging from being a board member to leading capital fundraising campaigns. Saint Raphael's provides exceptional, high-quality and compassionate medical care despite the financial challenges that have plagued the hospital for quite some time.

The proposed merger and acquisition by Yale-New Haven Hospital would allow Saint Raphael's mission to continue. Care would still be offered on its campus, consistent with Catholic tradition, including adherence to the Ethical & Religious Directives on the Chapel Street campus. Patients not interested in this focus can receive care on the main YNHH campus or from one of the many hospitals in the region and state, some of which are only 9-10 miles away.

It is clear that Saint Raphael's needs a strong hospital partner, like Yale-New Haven Hospital, that would, through the proposed transaction, be able to restore Saint Raphael's pension plan and pay its long-term debt. The acquisition of Saint Raphael's by Yale-New Haven Hospital would allow patients, employers, and the entire community continued access to high-quality care at either the Saint Raphael or Yale-New Haven Hospital campuses. As healthcare reform expands coverage to individuals, it is imperative that access to both campuses remains – this would be possible through approval of the Saint Raphael/Yale-New Haven Definitive Agreement.

I urge approval of the agreement by the various regulatory parties. Thank you for your attention.

Sincerely,

Raymond J. Peach

Raymond J. Peach
Retired Banker
Consultant, TD Bank

CITY OF NEW HAVEN
BOARD OF ALDERMEN

Gregory Dildine
Alderman, 25th Ward

Vice-Chair
City Services and Environmental Policy Committee

Member
Finance Committee
Legislation Committee
New Haven Free Public Library Board of Directors

227 McKinley Avenue
New Haven, CT 06515-2009

Telephone: (203) 228-4649
E-mail: Ward25@newhaven.net

November 20, 2011

Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Christopher O'Connor
President and CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Presidents Borgstrom and O'Connor,

I write to echo the support of my constituents regarding the proposed integration of the Hospital of Saint Raphael with Yale-New Haven Hospital. The greater New Haven community benefits - and will continue to benefit once combined - from both institutions' proud histories of delivering the highest quality of care.

Having become aware of the financial difficulties that the Hospital of Saint Raphael has faced over the past few years due to the increasing demands on healthcare providers, I understand and support community hospitals seeking alternative solutions and partnerships. A merger of the two hospitals and new investments in the Hospital of Saint Raphael's campus will ensure the Saint Raphael campus' continued availability to provide needed services. Merging will also improve efficiencies in providing healthcare for the citizens of New Haven and the region. Also, knowing that regional healthcare system demand continues to increase, the integration between Yale-New Haven Hospital and the Hospital of Saint Raphael will allow increasing beds to licensed capacity.

As the representative of Ward 25 and a member of New Haven's Board of Aldermen representing residents of the entire city, I perceive strong support for the integration of the Hospital of Saint Raphael and Yale-New Haven Hospital. I too support the proposed integration.

Sincerely,

Greg Dildine

CITY OF NEW HAVEN
BOARD OF ALDERMEN
165 CHURCH STREET, NEW HAVEN, CT 06510
(203) 946-6483 (V); (203) 946-7476 (Fax)

December 2, 2011

Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Christopher O'Connor
President and CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Marna and Chris:

The undersigned members of the New Haven Board of Aldermen are pleased to support the proposed integration between the Hospital of Saint Raphael and Yale-New Haven Hospital. Both institutions have a long standing history of delivering the highest quality of care to the greater New Haven community. We believe that as one integrated institution, this practice will continue, and New Haven residents, as well as people in the broader region, will have greater access to an advanced, well-coordinated healthcare network.

We are aware of the financial difficulties that the Hospital of Saint Raphael has faced over the last few years. Due to the increasing demands on healthcare providers, many community hospitals find it necessary to seek alternative solutions to sustain themselves. We are pleased that a Connecticut solution will address this matter, and that Yale-New Haven Hospital will be able to make investments in the Hospital of Saint Raphael campus and to continue to have that campus available to provide needed services.

Additionally, the integration between Yale-New Haven Hospital and the Hospital of Saint Raphael is timely, in that Yale-New Haven Hospital's patient base continues to increase, therefore leading to capacity concerns. The Hospital of Saint Raphael is currently licensed as a 511 bed hospital, but currently operates only 400 of those beds. The integration of the two facilities will help to address the capacity limitations at Yale-New Haven Hospital.

The integration between Yale-New Haven Hospital and the Hospital of Saint Raphael makes sense. The agreement between the two facilities protects the Ethical and Religious Directives for Catholic Health Care Services at the Saint Raphael campus, preserves needed healthcare services, and respects the existing relationships between organized labor and employees.

On behalf of the New Haven community, we strongly support the integration of the Hospital of Saint Raphael with Yale-New Haven Hospital.

Sincerely,

Honorable Michael Jones
Ward 1, Alderman

Honorable Gregory Smith, Sr.
Ward 2, Alderman

Honorable Jacqueline M. James
Ward 3, Alderwoman

Honorable Andrea Jackson-Brooks
Ward 4, Alderwoman

Honorable Jorge L. Pérez
Ward 5, Alderman

Honorable Frances Clark
Ward 7, Alderwoman

Honorable Michael B. Smart
Ward 8, Alderman

Honorable Matt Smith
Ward 9, Alderman

Honorable Gerald M. Antunes
Ward 12, Alderman

Honorable Stephanie Bauer
Ward 14, Alderwoman

Honorable Ernie Santiago
Ward 15. Alderman

Hon. Migdalia Castro
Ward 16, Alderwoman

Honorable Alphonse Paolillo, Jr.
Ward 17, Alderman

Honorable Arlene DePino
Ward 18, Alderwoman

Honorable Alfreda Edwards
Ward 19, Alderwoman

Honorable Charles A. Blango
Ward 20, Alderman

Honorable Katrina Jones
Ward 21, Alderman

Honorable Gregory Morehead
Ward 22, Alderman

Honorable Al Hajj Yusuf Ibn Shah
Ward 23, Alderman

Honorable Marcus Paca
Ward 24, Alderman

Honorable Sergio Rodriguez
Ward 25, Alderman

Honorable Thomas Lehtonen
Ward 27, Alderman

Honorable Claudette-Robinson Thorpe
Ward 28, Alderwoman

Honorable Carl Goldfield
Ward 29, Alderman

Honorable Darnell Goldson
Ward 30, Alderman

Hill South Management Team

410 Howard Avenue
New Haven, Connecticut 06519

December 30, 2011

RECEIVED
JAN 4 - 2012
Marna P. Borgstrom
President & CEO

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
And Yale New Haven Health System
20 York Street
New Haven, CT 06504

Christopher O'Connor, President and CEO
Saint Raphael Healthcare System
And Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Ms. Borgstrom and Mr. O'Connor,

The Hill South Community Management Team is pleased to support the proposed integration of Yale-New Haven Hospital and the Hospital of St. Raphael. We understand the agreement reached between the two organizations would alleviate the financial strain that St. Raphael's has faced over the last several years and would provide the necessary capital to stabilize the hospital well into the future. At the same time, the Hospital of St. Raphael would be able to open up and staff about 100 additional licensed beds, which have not been utilized in several years, to address the overcrowding situation at Yale-New Haven Hospital. This is a win-win opportunity for both organizations and for the greater New Haven community.

The Hill South Community Management Team membership has worked closely with Yale-New Haven for many years on projects that improve and strengthen our neighborhood, including those that focus on health, neighborhood prosperity, and economic development. The proposed integration will ensure that decisions affecting healthcare access will be made locally and continue to provide opportunities that benefit our community.

We look forward to continuing our relationship with Yale-New Haven Hospital, and we fully support the integration with the Hospital of Saint Raphael.

Sincerely yours,

Johnny Dye
Chairman
Hill South Community Management Team

Hill North Management Team

December 31, 2011

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
And Yale New Haven Health System
20 York Street
New Haven, CT 06504

Christopher O'Connor, President and CEO
Saint Raphael Healthcare System
And Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Ms. Borgstrom and Mr. O'Connor,

The Hill North Community Management Team is pleased to support the proposed integration of Yale-New Haven Hospital and the Hospital of St. Raphael. We understand the agreement reached between the two organizations would alleviate the financial strain that St. Raphael's has faced over the last several years and would provide the necessary capital to stabilize the hospital well into the future. At the same time, the Hospital of St. Raphael would be able to open up and staff about 100 additional licensed beds, which have not been utilized in several years, to address the overcrowding situation at Yale-New Haven Hospital. This is a win-win opportunity for both organizations and for the greater New Haven community.

The Hill North Community Management Team membership has worked closely with Yale-New Haven for many years on projects that improves and strengthens our neighborhood, including those that focus on health, neighborhood prosperity, and economic development. The proposed integration will ensure that decisions affecting healthcare access will be made locally and continue to provide opportunities that benefit our community.

We look forward to continuing our relationship with Yale-New Haven Hospital, and we fully support the integration with the Hospital of Saint Raphael.

Sincerely yours,

L. Largie

Lena Largie
Chairperson
Hill North Community Management Team

Lodging

Learning

Shopping

Dining

Healing

C H A P E L W E S T

Special Services District
Linking the Neighborhood
chapeldistrict@aol.com

1205 Chapel Street
New Haven, CT 06511-4601
Phone: 203 787-3000
Fax: 203 787 6103

December 2011

Christopher O'Connor,
President and CEO
Saint Raphael Healthcare System

Marna Borgstrom,
President and CEO
Yale-New Haven Hospital

Dear Chris and Mrs. Borgstrom,

The Chapel West Special Services District supports Yale-New Haven Hospital's proposal to acquire the Saint Raphael Healthcare System.

Chapel West has worked with Saint Raphael's for close to 30 years on issues impacting our community, such as crime, economic development, and beautification/streetscape projects. Over recent years, we have been concerned about Saint Raphael's financial future -- we applaud your leadership for developing a win-win proposal that would not only address Saint Raphael's debt and help to offset its pension liability but would also address Yale-New Haven Hospital's overcrowding/capacity challenges. In this difficult economy, we are also grateful that Connecticut residents would continue to be hired at both campuses and that the Hospital of Saint Raphael campus would be able to open and staff all licensed beds to meet demand.

We look forward to our collaboration with Yale-New Haven Hospital at both its main campus and at the Saint Raphael campus and respectfully request approval of your proposed integration by those who would consider it.

Sincerely,

Vincent A. Romei, President

December 2011

Christopher O'Connor, President and CEO
Saint Raphael Healthcare System
and Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
and Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

Dear Mr. O'Connor and Mrs. Borgstrom,

The West River Neighborhood Services Corporation (WRNSC) is pleased to support the proposed integration of Saint Raphael's and Yale-New Haven Hospital. We understand the agreement reached between the two organizations would alleviate the financial strain that Saint Raphael's has faced over the last several years and would provide the necessary capital to stabilize the hospital well into the future. At the same time, the Hospital of Saint Raphael would be able to open up and staff about 100 additional licensed beds, which have not been utilized in several years, to address the overcrowding situation at Yale-New Haven Hospital. This is a win-win opportunity for both organizations and for the greater New Haven community.

The WRNSC and its members have worked collaboratively with Saint Raphael's on projects to enhance our surrounding neighborhood, improve the health of its residents, and provide economic development opportunities, mostly through the employment of many New Haven residents. The proposed integration would provide the necessary capital that Saint Raphael's needs to offset its existing pension liability and to continue providing care to patients from greater New Haven and beyond, regardless of ability to pay.

We look forward to continuing our work with Yale-New Haven Hospital at its main campus and at the Saint Raphael campus and urge approval of the Definitive Agreement. Thank you.

Sincerely,

Stacy Spell, President
West River Neighborhood Services Corporation

DCMT DWIGHT CENTRAL MANAGEMENT TEAM

P.O Box 143, New Haven, CT 06501

December 7, 2011

Officers:

Florita Gillespie,
Chairperson

Curlena McDonald
Vice Chairperson

Bianca Bowles
Secretary

Geraldine Cullinan
Treasurer

Members-At-Large:
Sheila Shanklin
Michael Shanklin
Pedro Nelson Reyes

Empower New Haven
Representative
Board Member
Curlena McDonald

DCMT Representatives To The GDDC Board Of Directors
Betty Cardoza

DCMT Neighborhood Representatives To The GDDC Board Of Directors
Curlena McDonald

Christopher O'Connor,
President and CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Marna Borgstrom,
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Mr. O'Connor and Mrs. Borgstrom,

The Dwight Central Management Team (DCMT) supports the proposed integration of the Saint Raphael Healthcare System and Yale-New Haven Hospital (YNHH). The members of the DCMT have worked with Saint Raphael's for close to 20 years on a variety of community projects that have helped to enhance and stabilize our neighborhood. We have also worked with YNHH over the last several years in the same manner.

We are pleased that the two hospitals have proposed coming together -- Saint Raphael's can address its financial challenges while hundreds of employees of both hospitals who live and work in our community will continue to have stable employment. In addition, by becoming one hospital, YNHH would avoid building

***DCMT Meetings** are held the first Tuesday of every month except if there is a holiday, major election and during July & August. Requests to be placed on the agenda must be done two weeks in advance. Please contact Florita Gillespie at 776-0169 or Curlena McDonald at 624-3923, (cmcdonald04@snet.net) for further information. Thank you.*

another large patient tower on its campus to address its capacity challenges. Patients would still receive the high-quality care they need and expect, regardless of ability to pay, and patient care would be better coordinated with one workforce, one medical staff, and one integrated medical record system.

The Dwight Central Management Team is pleased to provide our support of the integration of Saint Raphael's and Yale-New Haven Hospital.

Sincerely,

Florita Gillespie

Florita Gillespie
Chairperson,
Dwight Central Management Team

Christian Community Action, Inc.

Administrative Offices

168 Davenport Avenue
New Haven, CT 06519
Phone: (203) 777-7848
Fax: (203) 777-7923
Email: cca@ccahelping.org
www.ccahelping.org

Hillside Family Shelter

Davenport Site
166-168 Davenport Avenue
New Haven, CT 06519
Phone: (203) 777-7848
Fax: (203) 777-7923
Sylvan Site
124 Sylvan Avenue
New Haven, CT 06519
Phone: (203) 777-7172
Fax: (203) 777-7174

Stepping Stone Transitional Housing Program

660 Winchester Avenue
New Haven, CT 06511
Phone: (203) 777-7167
Fax: (203) 777-7171

Advocacy and Education Project
Mothers For Justice
LifeWorks Center

660 Winchester Avenue
New Haven, CT 06511
Phone: (203) 777-6072
Fax: (203) 777-6039

PIVOT
LifeWorks Center

660 Winchester Avenue
New Haven, CT 06511
Phone: (203) 777-6072
Fax: (203) 777-6039

United Way

Offering Help, Housing and Hope

January 23, 2012

Marna Borgstrom, President and Chief Executive Officer
Yale-New Haven Hospital and
Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

Christopher O'Connor, President and Chief Executive Officer
Hospital of Saint Raphael and
Saint Raphael Healthcare System
1450 Chapel Street
New Haven, CT 06511

Dear Chris and Marna,

Christian Community Action (CCA) is pleased to provide its support for the proposal to integrate the Saint Raphael Healthcare System and Yale-New Haven Hospital.

CCA's mission is to offer help, housing and hope to those who are poor in New Haven. Our services focus on emergency and transitional programs and advocacy in the areas of housing, workforce development and health care.

Because of our work with families in need, my staff members and I are aware of the issues that both hospitals face. We hear about the difficulties people have with attempting to gain access to and receive needed health care services. The times in which we live are challenging and the environment in which such services are to be delivered is rapidly changing.

The Saint Raphael Healthcare System has been stalwart in advancing its mission– to care for and improve the health of patients, with special concern for those who are underserved, poor, and elderly – while maintaining strong fiscal performance. The same can be said for Yale-New Haven Hospital – serving the community as a public health advocate – in its strong efforts to provide support and services which respond to the area's health care needs through health education, health promotion and access to care.

The overall commitment to excellence and affording quality care within both institutions is consistent and deeply felt -- that is just one reason why I believe this action is best thing to take under the circumstances. Saint Raphael's campus would become financially stable, jobs would be saved, access would be improved, and capacity issues at Yale-New Haven Hospital would be addressed. It's a win-win proposal for all.

Without a doubt, people in the community and who need services would benefit. This is a priority and a reason to support the joining together of two valuable and valued partners. It bodes well, too, for fuller participation in the discussions about health care reform that are taking place in CT and throughout the country.

I look forward to our continued work together and hearing more about how the Saint Raphael Healthcare System/Yale-New Haven Hospital integration proceeds.

Sincerely,

Rev. Bonita Grubbs
Executive Director

UIL Holdings Corporation
157 Church Street
PO Box 1564
New Haven CT 06506-0901
Phone 203.499.2430
Fax 203.499.3664

James P. Torgerson
President and Chief Executive Officer

UIL

November 16, 2011

Marna Borgstrom, President and Chief Executive Officer
Yale-New Haven Hospital and
Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

Christopher O'Connor, President and Chief Executive Officer
Hospital of Saint Raphael and
Saint Raphael Healthcare System
1450 Chapel Street
New Haven, CT 06511

Dear Marna and Chris,

I would like to express my support for the Definitive Agreement between the Saint Raphael Healthcare System and Yale-New Haven Hospital. As the President and CEO of UIL Holdings Corporation, including the United Illuminating Company, Connecticut Natural Gas Company and Southern Connecticut Natural Gas Company, I have had the privilege of working with both of you on community initiatives, as a Saint Raphael board member, and, most importantly, as one of the area's major employers. The employees of my company receive high-quality care at both hospitals.

I believe the acquisition of the Saint Raphael Healthcare System by Yale-New Haven Hospital would result in healthcare efficiencies, better coordination of patient care, and would also stabilize Saint Raphael's financial future. With recent passage of healthcare reform and the ongoing pressure across our country to contain healthcare costs, it is prudent for the two hospitals to come together to save precious healthcare dollars. The business community and the general public are demanding these types of changes – changes that would help to contain healthcare premiums, decrease duplication of medical equipment and services, and allow for better coordination of care and access.

As an area business leader, I commend both of you for your vision – putting aside the differences of each organization and focusing on what is best for patients, business, and Connecticut's residents. At the same time, I am pleased that choice of hospitals would remain for our

operating companies' employees and customers as our service area extends into the Bridgeport and Valley communities where other hospitals are located.

Again, I support the Definitive Agreement between the Saint Raphael Healthcare System and Yale-New Haven Hospital and hope you will receive the necessary regulatory approvals to move forward. Thank you.

Sincerely,

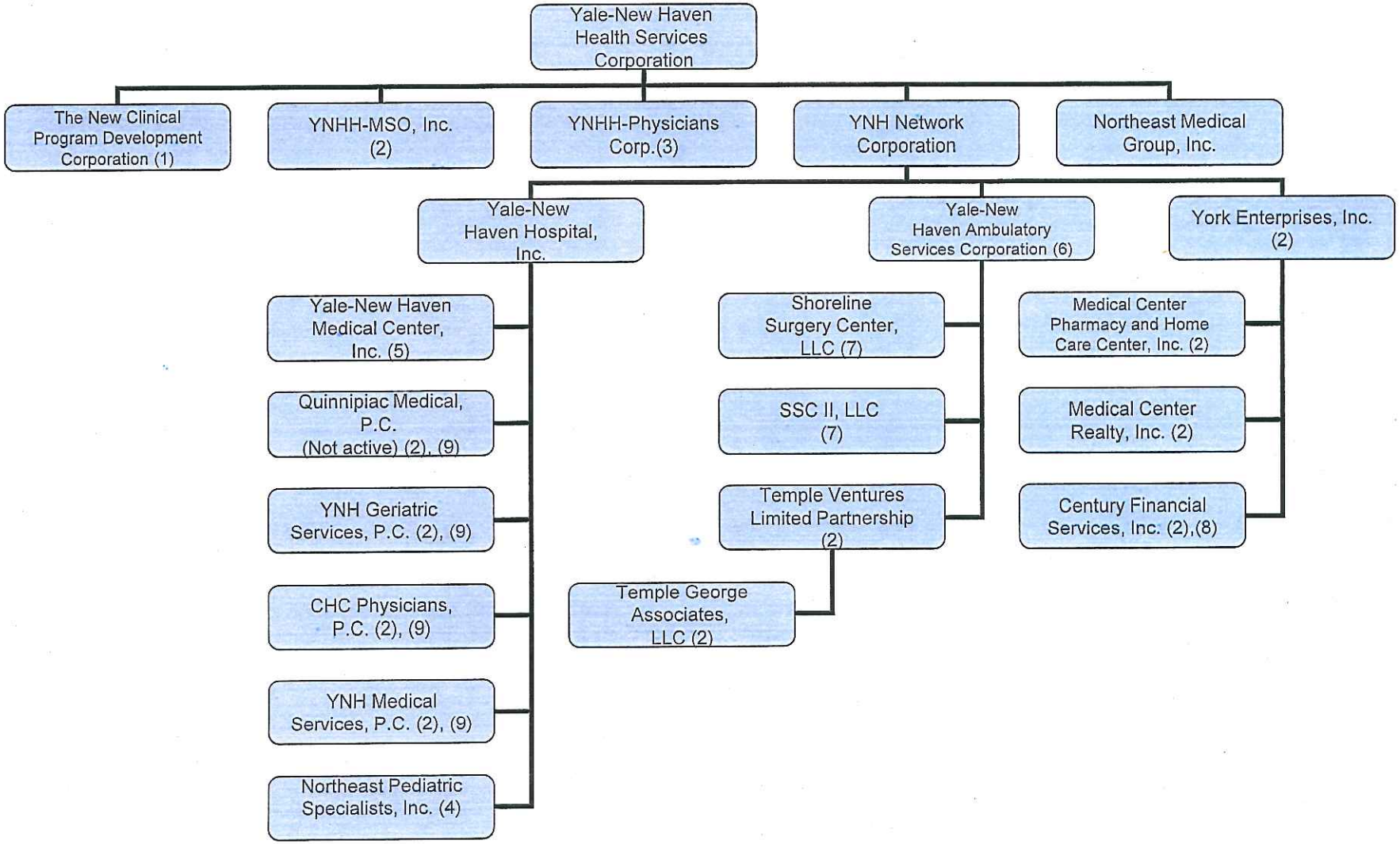
J. P. Torgerson

James P. Torgerson
President & CEO
UIL Holdings Corporation

Attachment II

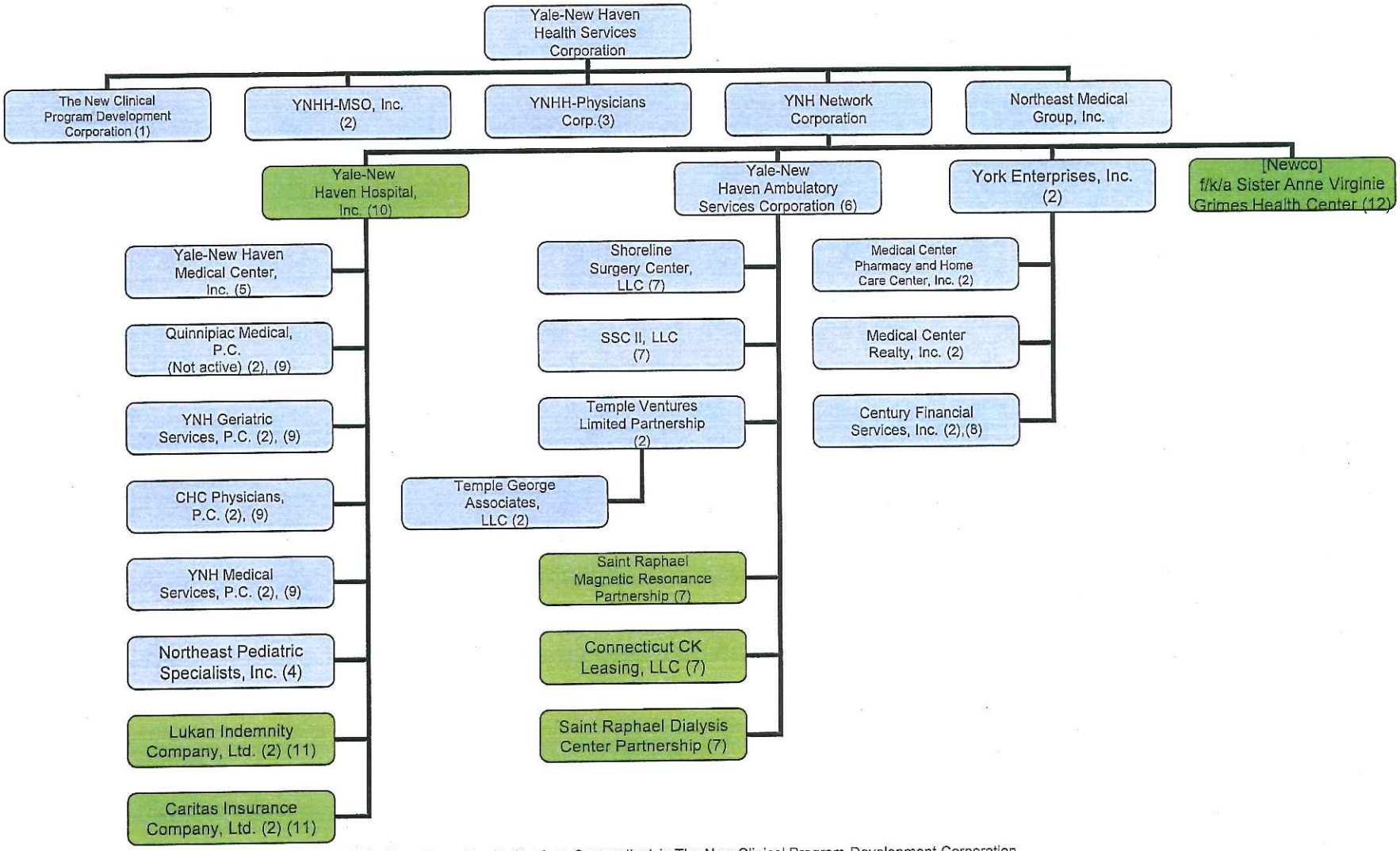
Corporate Organizational Charts for each Applicant prior to and after this Proposal

Yale New Haven Health System/
Yale-New Haven Hospital Delivery Network
(Pre-Acquisition of Hospital of Saint Raphael and Certain Affiliates)



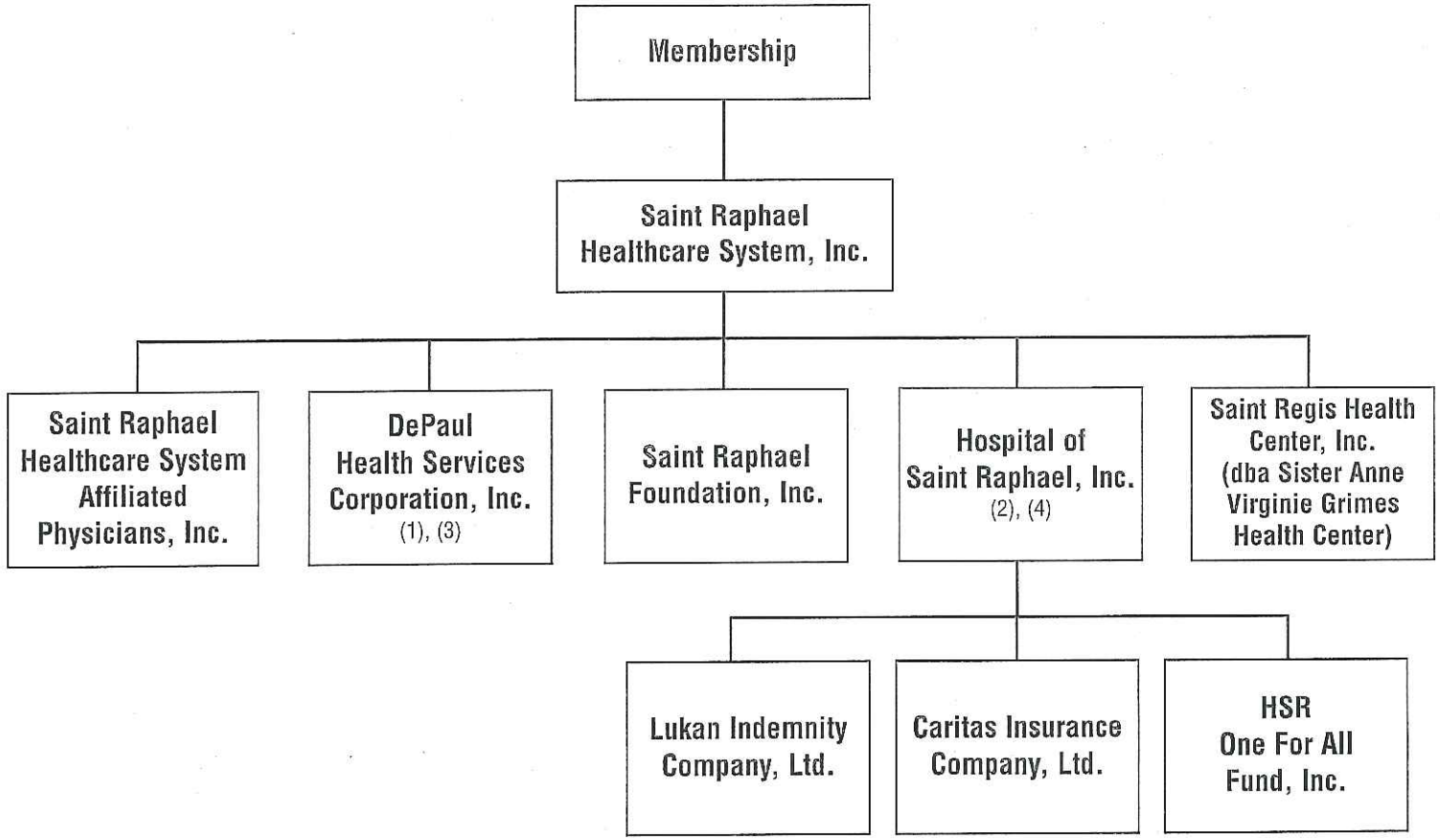
(1) Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
(2) For profit entity.
(3) Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp. YNHH-Physicans Corp. is nonprofit, but is not tax-exempt.
(4) Connecticut Children's Medical Center is an equal member (with Yale-New Haven Hospital) in Northeast Pediatric Specialists, Inc.
(5) Yale University is a 50% member of Yale-New Haven Medical Center, Inc.
(6) Yale-New Haven Ambulatory Services Corporation is nonprofit, but is not tax-exempt.
(7) Shoreline Surgery Center, LLC and SSC II, LLC are joint ventures with forprofit entities (including physicians)
(8) Approximately 47% of the stock of Century Financial Services, Inc. is owned in part by York Enterprises, Inc. The remaining stock is held by other hospitals or affiliates thereof.
(9) "Friendly PCs" controlled by Yale-New Haven Hospital (through shares owned by Chief of Staff)

Yale New Haven Health System/Yale-New Haven Hospital Delivery Network
(Post-Acquisition of Hospital of Saint Raphael and Certain Affiliates – Changes/Additions Highlighted in Green)



(1) Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
(2) For profit entity.
(3) Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp. YNHH-Physicans Corp. is nonprofit, but is not tax-exempt.
(4) Connecticut Children's Medical Center is an equal member (with Yale-New Haven Hospital) in Northeast Pediatric Specialists, Inc.
(5) Yale University is a 50% member of Yale-New Haven Medical Center, Inc.
(6) Yale-New Haven Ambulatory Services Corporation is nonprofit, but is not tax-exempt.
(7) Joint ventures with forprofit entities (including physicians); acquisition still under review by YNHH and subject to negotiation with joint venture partners.
(8) Approximately 47% of the stock of Century Financial Services, Inc. is owned in part by York Enterprises, Inc. The remaining stock is held by other hospitals or affiliates thereof.
(9) "Friendly PCs" controlled by Yale-New Haven Hospital (through shares owned by Chief of Staff).
(10) Includes all assets of Hospital of Saint Raphael; single licensed hospital operated on separate campuses.
(11) Captive insurers that will be acquired by Yale-New Haven Hospital or its affiliated insurer, MCIC Vermont, Inc.
(12) Disposition of assets of Grimes nursing home under review and subject to negotiation.

Saint Raphael Healthcare System



KEY:
1. MRI Partnership
2. CT Hospital Laboratory Network, LLC
3. Dialysis Ventures
4. CT CK Leasing, LLC

Attachment III

Asset Purchase Agreement

REDACTED COPY

ASSET PURCHASE AGREEMENT

BY AND AMONG

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

HOSPITAL OF SAINT RAPHAEL

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC.

DEPAUL HEALTH SERVICES CORPORATION, INC.

SAINT RAPHAEL FOUNDATION, INC.

SAINT REGIS HEALTH CENTER, INC.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

YALE-NEW HAVEN HOSPITAL, INC.

Dated as of September 26, 2011

TABLE OF CONTENTS

		Page
ARTICLE 1.	DEFINITIONS	2
ARTICLE 2.	PURCHASE AND SALE OF ASSETS	13
2.1	Purchase and Sale of Assets	13
2.2	Assumption of Liabilities	15
2.3	Purchase Price	15
2.4	Title Company Escrow	15
ARTICLE 3.	REPRESENTATIONS AND WARRANTIES OF SELLERS	16
3.1	Organization; Authority	16
3.2	Powers; Consents; Absence of Conflicts	16
3.3	Absence of Certain Changes	16
3.4	Compliance with Laws	17
3.5	Licenses	18
3.6	Accreditation; Government Reimbursement Programs	18
3.7	Medical Staff Matters	19
3.8	Contracts and Leases	19
3.9	Real Property; Condition of Facilities	20
3.10	Personal Property	22
3.11	Labor and Employee Matters	22
3.12	Litigation or Proceedings	24
3.13	Special Funds	24
3.14	Tax Matters	25
3.15	Environmental Matters	25
3.16	Insurance	26
3.17	Brokers	27
3.18	[REDACTED]	
3.19	Financial Statements	27
3.20	Assets; Sufficiency of Assets	27
3.21	Equipment	28
3.22	Intellectual Property	28
3.23	Software	28

TABLE OF CONTENTS
(continued)

		Page
3.24	Absence of Default	28
3.25	Charitable Funds	28
3.26	Bank Accounts	29
3.27	No Undisclosed Liability	29
3.28	No Untrue or Inaccurate Representations or Warranties	29
ARTICLE 4.	REPRESENTATIONS AND WARRANTIES OF BUYER	29
4.1	Organization; Authority	29
4.2	Powers; Consents; Absence of Conflicts	29
4.3	Brokers	30
ARTICLE 5.	CERTAIN COVENANTS OF SELLERS	30
5.1	Information	30
5.2	Operations	31
5.3	Negative Covenants	32
5.4	Governmental Approvals	33
5.5	Charitable Funds	34
5.6	Church Approvals	34
5.7	Closing Conditions	34
5.8	Payment of Obligations	34
5.9	No-Shop Clause	35
5.10	Transfer of Assets	35
5.11	Real Property	35
5.12	Insurance Coverage	35
5.13	[REDACTED]	
5.14	Pharmacy License	36
5.15	Disclosure Supplements	36
5.16	Continuation of Group Health Plan Coverage and COBRA Continuation Coverage	37
5.17	Notice of Breach	37
ARTICLE 6.	CERTAIN COVENANTS OF BUYER	37
6.1	Governmental Approvals	37

TABLE OF CONTENTS
(continued)

Page

6.2 Church Approvals 38
6.3 Closing Conditions 38
6.4 Notice of Breach 38
6.5 Real Property Reports 38
ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER 38
7.1 Representations/Warranties 38
7.2 Covenants 39
7.3 Officers' Certificate 39
7.4 Litigation or Proceedings 39
7.5 Governmental Approvals 39
7.6 Church Approvals 39
7.7 Closing Deliveries 39
7.8 Third Party Consents 39
7.9 Satisfaction of Retained Liabilities 39
7.10 Charitable Funds 40
7.11 Grimes Center Medical Rate 40
7.12 [REDACTED]
ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS 41
8.1 Representations/Warranties 41
8.2 Covenants 41
8.3 Officers' Certificate 41
8.4 Litigation or Proceedings 41
8.5 Governmental Approvals 41
8.6 Closing Deliveries 41
8.7 Church Approvals 41
ARTICLE 9. CLOSING 42
9.1 Closing 42
9.2 Actions of Sellers at Closing 42
9.3 Actions of Buyer at Closing 44
9.4 Close of Title Company Escrow 44

TABLE OF CONTENTS
(continued)

Page

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS 47
10.1 [REDACTED]
10.2 Preservation of Catholic Heritage 50
10.3 Preservation and Access to Records After Closing 52
10.4 [REDACTED]
10.5 Tax Matters 54
10.6 Sellers' Cost Reports 55
10.7 [REDACTED]
10.8 Patient Receivables 55
10.9 Return of Payments 56
10.10 Title and Survey Contingency 56
10.11 Due Diligence Contingency 57
10.12 Confidentiality 58
10.13 Tail Insurance 59
10.14 Press Releases 59
10.15 Compliance with the Transfer Act 59
10.16 Post Effective Time Operations 60
10.17 Post Effective Time Negative Covenants 60
10.18 Restrictive Covenants 61
ARTICLE 11. TERMINATION 62
11.1 [REDACTED]
11.2 [REDACTED]
11.3 [REDACTED]
11.4 [REDACTED]
11.5 [REDACTED]
ARTICLE 12. INDEMNIFICATION 64
12.1 Indemnification by Sellers 64
12.2 Indemnification by Buyer 65
12.3 Time and Amount Limitations 65

TABLE OF CONTENTS
(continued)

Page

12.4 Notice and Control of Litigation 66
ARTICLE 13. GENERAL 67
13.1 Choice of Law 67
13.2 Assignment 67
13.3 Cost of Transaction 67
13.4 Notice 68
13.5 Severability 69
13.6 Gender, Number and Inferences 69
13.7 Divisions and Headings 69
13.8 No Third-Party Beneficiaries 69
13.9 Entire Agreement 69
13.10 Counterparts 70
13.11 Amendment 70
13.12 Waiver of Breach 70
13.13 Other Interpretative Matters 70
13.14 Reproduction of Documents 70
13.15 Waiver of Jury Trial 70
13.16 Time of the Essence 71

ASSET PURCHASE AGREEMENT

THIS ASSET PURCHASE AGREEMENT (this "**Agreement**") is made and entered into as of September 26, 2011 (the "**Effective Date**"), by and among: (a) Saint Raphael Healthcare System, Inc., a Connecticut nonstock corporation ("**SRHS**"), (b) Hospital of Saint Raphael, a Connecticut nonstock corporation ("**HSR**"), (c) Saint Raphael Healthcare System Affiliated Physicians, Inc. d/b/a Affiliated Physicians of Saint Raphael, a Connecticut nonstock corporation ("**SRHSAP**"), (d) DePaul Health Services Corporation, Inc., a Connecticut nonstock corporation ("**DHSC**"), (e) Saint Raphael Foundation, Inc., a Connecticut nonstock corporation (the "**Foundation**"), (f) Saint Regis Health Center, Inc. d/b/a Sister Anne Virginie Grimes Health Center, a Connecticut nonstock corporation ("**Grimes Center**" and each of SRHS, HSR, SRHSAP, DHSC, Foundation and Grimes Center, a "**Seller**" and, collectively, the "**Sellers**"), Yale-New Haven Health Services Corporation d/b/a Yale New Haven Health System, a Connecticut nonstock corporation ("**YNHHS**") and Yale-New Haven Hospital, Inc., a Connecticut nonstock corporation or its designee in accordance with Section 13.2 ("**Buyer**").

RECITALS

A. SRHS is the tax-exempt parent company of the Sellers;

B. Sellers, through the operation of the Hospital (as defined below) and the other health care facilities and businesses identified on Exhibit A hereto and all of their health care related businesses operating in the State of Connecticut (together with the Hospital, the "**Facilities**"), are in the business of, and are dedicated to, assuring the promotion of health and the provision of the continuum of health care services, ranging from wellness programs to acute care and long-term care (the "**Business**");

C. HSR, under the control of SRHS, owns and is engaged in the business of operating, a 511-bed general acute care community and teaching hospital facility in New Haven, Connecticut (the "**Hospital**");

D. YNHHS, through its several delivery networks, including Buyer, provides comprehensive, cost-effective, advanced patient care, educates health professionals and advances clinical care in affiliation with the Yale University School of Medicine;

E. Buyer owns and is in the business of operating a 966-bed tertiary medical center in New Haven, Connecticut that provides comprehensive, multidisciplinary, family-focused care and is the primary teaching hospital for the Yale University School of Medicine;

F. HSR desires to sell to Buyer, and Buyer desires to purchase from HSR, certain of the assets used by HSR in the operation of the Hospital on the terms and subject to the conditions set forth in this Agreement.

G. Sellers desire to sell to Buyer, and Buyer desires to purchase from Sellers, certain of the assets used by Sellers in the operation of the Business on the terms and subject to the conditions set forth in this Agreement; and

H. Sellers desire to assign to Buyer, and Buyer desires to assume from Sellers, certain liabilities of Sellers incurred in the operation of the Business on the terms and subject to the conditions set forth in this Agreement.

AGREEMENT

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1. DEFINITIONS

The following terms used in this Agreement shall have the respective meanings ascribed to them in this Article 1:

[REDACTED]

[REDACTED]

"**Affiliate**" means, as to the entity in question, any Person that directly or indirectly controls, is controlled by, or is under common control with, the entity in question; and the term "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, membership interests, by contract, the power to appoint directors or trustees or otherwise.

"**Agreement**" has the meaning set forth in the introductory paragraph.

"**Alternative Transaction**" means any of the following transactions with a Person other than Buyer, or an Affiliate thereof, involving any of the Sellers or any Affiliates of the Sellers: (a) sale, transfer or other disposition of the ownership or direct or indirect control of any of the Sellers or any of their Affiliates; (b) merger, reorganization, consolidation, affiliation or other business combination or similar transaction involving any of the Sellers or their Affiliates; (c) sale, lease, exchange, transfer or other disposition of a substantial portion of the assets or the Purchased Assets of any of the Sellers or their Affiliates; or (d) agreement with any Person or organization (other than Buyer and its Affiliates) with respect to any ownership or control interest in any Seller or the management or operation of the Purchased Assets or any material portion thereof (other than any employment contract entered into with any management employee in the ordinary course of business). For the avoidance of doubt, an Alternative Transaction shall include any transactions arising under a sale authorized pursuant to title 11 of the United States Code, a plan of reorganization, plan of liquidation or other plan of arrangement under applicable law, in each case, that provides for the sale or restructuring of all, substantially all or any substantial portion of the assets of the Business.

"**Applicable Law**" means any constitution, law, ordinance, principle of common law, code, statute, act, treaty or order of general applicability of any Governmental Authority, including the rules and regulations promulgated thereunder.

"**Assignment and Assumption of Leases**" means an assignment and assumption of leases agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit B.

"**Assumed Contracts**" means the Contracts listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Leases**" means the Leases listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Liabilities**" has the meaning set forth in Section 2.2(a).

"**Balance Sheet Date**" means March 31, 2011.

[REDACTED]

[REDACTED]

"**Basket Amount**" has the meaning set forth in Section 12.3(c).

"**Benefit Liabilities**" means the liabilities with respect to the frozen accrued pension benefits under the Church Plan and the liabilities incurred by HSR under its post-retirement medical benefits plan.

"**Benefit Plans**" has the meaning set forth in Section 3.11(a).

[REDACTED]

[REDACTED]

"**Bill of Sale, Assignment and Assumption Agreement**" means a bill of sale, assignment and assumption agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit C.

[REDACTED]

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

"**Buyer**" has the meaning set forth in the introductory paragraph.

"**Buyer Effect**" means a material adverse effect on the ability of Buyer to perform its obligations under this Agreement or to consummate the transactions contemplated hereby.

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.1.

"**Caritas**" has the meaning set forth in Section 5.12.

"**Caritas SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit D.

"**Charitable Funds**" has the meaning set forth in Section 5.5.

"**Church**" has the meaning set forth in Section 5.6.

"**Church Approvals**" has the meaning set forth in Section 5.6.

"**Church Plan**" means The Retirement Plan for Employees of The Hospital of Saint Raphael, a frozen defined benefit pension plan that qualifies as a church plan described in Section 414(e) of the Code.

"**Claims**" has the meaning set forth in Section 10.11(d).

"**Claims Notice**" has the meaning set forth in Section 12.4(a).

"**Close of Escrow**" has the meaning set forth in Section 9.4(a).

"**Closing**" has the meaning set forth in Section 9.1.

"**Closing Date**" has the meaning set forth in Section 9.1.

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

[REDACTED]

[REDACTED]

"**Commitment Period**" means the period of time beginning at the Effective Time and continuing until the five-year anniversary of the Effective Time.

"**CON Filing**" means the filings, application and process by and pursuant to which Certificate of Need authorization is requested from the State of Connecticut Office of Health Care Access and any other Governmental Authority with respect to this Agreement and the transactions contemplated hereunder.

"**Confidential Information**" has the meaning set forth in Section 10.12.

[REDACTED

[REDACTED]

"**Contracts**" means all rights, benefits and interests of any Seller in, to and under all contracts relating to the conduct of the Business, including, without limitation, physician agreements, agreements with third party payors, joint venture or partnership agreements, supply purchase agreements, employment agreements, tenant leases, equipment leases, equipment maintenance agreements, agreements with municipalities and labor organizations, settlement

agreements, loan agreements, bonds, mortgages, liens or other security agreements, but excluding the Leases.

"**Cost Reports**" means all cost and other reports related to the Sellers filed pursuant to the requirements of the Government Reimbursement Programs for cost-based payments or reimbursement due to or claimed by the Sellers from the Government Reimbursement Programs or their fiscal intermediaries or payor agents, including all Cost Report receivables or payables and all related appeals and appeal rights and other forms or claims filed or submitted by the Sellers to the Government Reimbursement Programs or their fiscal intermediaries or payor agents for payment or reimbursement due to or claimed by the Sellers on a fee-for-service, prospective payment, fee schedule or other similar basis.

"**Deeds**" means the special warranty deeds for each parcel of the Owned Real Property, dated as of the Closing Date, executed by each Seller, as applicable, substantially in the form of Exhibit E.

"**DHSC**" has the meaning set forth in the introductory paragraph.

"**De Minimis Threshold**" has the meaning set forth in Section 12.3(c).

"**Directives**" means Catholic ethical tradition as referenced in the Ethical and Religious Directives for Catholic Health Care Services (Fifth Edition).

"**Disclosure Schedule**" means the disclosure schedule, dated as of the date hereof, that is attached hereto and incorporated in and made a part of this Agreement.

"**Effective Date**" has the meaning set forth in the introductory paragraph.

"**Effective Time**" has the meaning set forth in Section 9.1.

"**Environmental Laws**" means all statutes, laws, rules, regulations, codes, ordinances, standards, guidelines, authorizations and orders of any federal, state or local public agency or authority having jurisdiction over the Purchased Assets that deal with Solid Waste, toxic or hazardous waste, wastewater discharges, water quality, drinking water, air emissions, air quality, Hazardous Substances (including Medical Hazards), lead-based paint or employee health, safety or community right-to-know.

"**Environmental Permits**" has the meaning set forth in Section 3.15(a).

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

[REDACTED]

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

[REDACTED]

[REDACTED]

"**Financial Certificate**" has the meaning set forth in Section 9.2(j).

"**Financial Statements**" has the meaning set forth in Section 3.19.

"**Foundation**" has the meaning set forth in the introductory paragraph.

"**GAAP**" means generally accepted accounting principles in the United States.

"**Good Standing**" with respect to individuals employed by Sellers shall mean that such individual is legally eligible to work in the State of Connecticut and, within the 12 months immediately preceding the Effective Time, the individual has (a) not received a written warning or higher-level of discipline pursuant to Sellers' progressive disciplinary process, (b) not been placed on a performance improvement plan or similar process, and (c) received at least a satisfactory performance evaluation on the last such evaluation. In offering employment to Sellers' employees, Buyer shall reasonably determine their good standing based on their official personnel file where the foregoing information is retained by Sellers.

"**Government Reimbursement Programs**" means the Medicare program, the Connecticut Medicaid program, the federal TRICARE program, and any other, similar or successor federal, state or local health care payment programs with or sponsored by Governmental Authorities, including without limitation, current federal and Connecticut disproportionate share "DSH" reimbursement or adjustments applicable to Sellers, and federal reimbursement or adjustments for or related to the Sellers' graduate medical education programs.

"**Governmental Authority**" means any federal, state, local or any foreign governmental unit, agency, commission or authority.

"**Guarantee**" by any Person means any obligation, contingent or otherwise, of such Person directly or indirectly guaranteeing or otherwise supporting in whole or in part the payment of any Indebtedness or other obligation of any other Person and, without limiting the generality of the foregoing, any obligation, direct or indirect, contingent or otherwise, of such Person (a) to purchase or pay (or advance or supply funds for the purchase or payment of) such Indebtedness or other obligation of such other Person (whether arising by virtue of partnership arrangements, by agreements to keep well, to purchase assets, goods, securities or services, to take or pay, or to maintain financial statement conditions or otherwise) or (b) entered into for the purpose of assuring in any other manner the obligee of such Indebtedness or other obligations of the payment of such Indebtedness or to protect such obligee against loss in respect of such Indebtedness (in whole or in part). The term "Guarantee" used as a verb has a correlative meaning.

"**Hart-Scott-Rodino Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations promulgated thereunder.

"**Hazardous Substances**" means asbestos, radioactive substances, radon, PCBs, petroleum, Medical Hazards and any chemical, substance or material that is listed or regulated under Environmental Laws as a hazardous or toxic substance, material, chemical substance, pollutant, waste, pesticide or fungicide or that under applicable Environmental Laws requires special handling or notification of any federal, state or local governmental agency or authority in its collection, storage, treatment, recycling or disposal.

"**Healthcare Laws**" means, collectively, any and all federal, state or local statutes, rules, regulations and administrative manuals, orders, guidelines and requirements of law of any Governmental Authority governing the licensure of or regulating healthcare providers, professionals, facilities or payors or otherwise governing or regulating the provision of, or payment for, healthcare services, the sale of controlled substances or other pharmaceuticals, medical devices or supplies and the like. Without limiting the generality of the foregoing, Healthcare Laws include, without limitation, state corporate practice of medicine laws, statutes and regulations, Section 1128B(b) of the Social Security Act, as amended, 42 U.S.C. Section 1320a 7(b) (Criminal Penalties Involving Medicare or State Health Care Programs), commonly referred to as the "Federal Anti-Kickback Statute," Section 1877 of the Social Security Act, as amended, 42 U.S.C. Section 1395nn and related regulations (Prohibition Against Certain Referrals), commonly referred to as "Stark Law", the federal False Claims Act, 31 U.S.C. Section 3729 et seq., corresponding state laws and other state and federal fraud and abuse laws.

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

"**HSR**" has the meaning set forth in the introductory paragraph.

"**HSR Financing Agreements**" means the agreements associated with the CHEFA Hospital of Saint Raphael Series H, L and M bond financing and the Master Financing Agreement, dated January 1, 2006, by and among Chase Equipment Leasing Inc., State of Connecticut Health and Education Facilities Authority and HSR.

"**Improvements**" means means all buildings, structures, parking areas, sidewalks, landscaping and other improvements located on the Owned Real Property.

"**Indebtedness**" of any Person means either (a) any liability of such Person (i) for borrowed money (including the current portion thereof), (ii) under any reimbursement obligation relating to a letter of credit, bankers' acceptance or note purchase facility, (iii) evidenced by a bond, note, debenture or similar instrument (including a purchase money obligation), (iv) for the payment of money relating to any lease that is required to be classified as a capitalized lease obligation in accordance with GAAP, (v) for all or any part of the deferred purchase price of property or services (other than trade or accounts payables), including any "earnout" or similar payments or any noncompete payments, (vi) under interest rate swap, hedging or similar agreements or (vii) for any credit card payables with respect to charges having a transaction date of 30 days or more prior to the Closing Date or related to non-business related activities; or (b) any liability of others described in the preceding clause (a) that such Person has Guaranteed, that is recourse to such Person or any of its assets or that is otherwise its legal liability or that is secured in whole or in part by the assets of such Person. For purposes of this Agreement, "Indebtedness" includes (A) any and all accrued interest, success fees, prepayment premiums, make whole premiums or penalties and fees or expenses actually incurred (including attorneys' fees) associated with the prepayment of any Indebtedness, (B) all "cut" but uncashed checks issued by any Seller that are outstanding as of the Closing Date, (C) cash, book or bank account overdrafts and (D) any and all amounts owed by any Seller to any of its Affiliates. The Financial Certificate sets forth the entire amount of Sellers' Indebtedness (indicating the amount of each individual component of Indebtedness and the Person to whom such Indebtedness is owed).

"**Indemnified Party**" has the meaning set forth in Section 12.4(a).

"**Indemnifying Party**" has the meaning set forth in Section 12.4(a).

"**Intellectual Property Rights**" has the meaning set forth in Section 3.22.

"**IRCA**" has the meaning set forth in Section 3.11(e).

[REDACTED]

"**Knowledge**" shall, with respect to the particular provision it qualifies, mean (a) all matters with respect to which any such Person or its Affiliates have received written notice, or (b) with respect to any Seller, (i) the actual knowledge of such Seller's president and/or chief executive officer and chief financial officer, including, with respect to each, the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer or chief financial officer, as the case may be, or (ii) the actual knowledge of any member of the congregation of SOC appointed to the governing board or any office of such Seller.

"**Leased Real Property**" has the meaning set forth in Section 3.9(a).

"**Leases**" means all rights, benefits and interests of any Seller, as the case may be, as the lessor, lessee or sublessee, as the case may be, in, to or under any lease or sublease relating to real property or the conduct of the Business.

"**Liability Claim**" has the meaning set forth in Section 12.4(a).

"**Lien**" **or** "**Encumbrance**" means any lien, pledge, claim, liability, interest, restriction or other encumbrance.

"**Litigation or Proceedings**" has the meaning set forth in Section 3.12.

"**Litigation Conditions**" has the meaning set forth in Section 12.4(b).

"**Loss**" or "**Losses**" means any debt, loss, damage, diminution in value, adverse claim, fines, penalties, liability or obligation (whether direct or indirect, known or unknown, asserted or unasserted, absolute or contingent, accrued or unaccrued, matured or unmatured, determined or determinable, disputed or undisputed, liquidated or unliquidated, or due or to become due, and whether in contract, tort, strict liability or otherwise), and including all costs and expenses relating thereto (including all fees, disbursements and expenses of legal counsel, experts, engineers and consultants and costs of investigation) to the extent not covered by insurance proceeds actually received.

"**Lukan**" has the meaning set forth in Section 5.12.

"**Lukan SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit F.

"**March 31, 2011 Balance Sheet**" means the balance sheet included in the March 31, 2011 Financial Statements.

"**March 31, 2011 Financial Statements**" has the meaning set forth in Section 3.19.

"**Material Adverse Effect**" means any occurrence, condition, change, development, circumstance, effect, event or fact, occurring after the Effective Date (a "**Matter**"), that individually or in the aggregate, has resulted in, would result in or could reasonably be expected to result in (a) the inability of Sellers to timely and fully perform their obligations under this Agreement or to timely and fully consummate the transactions contemplated hereby; or (b) the inability of Sellers, after giving effect to the transactions contemplated hereby, to satisfy the Retained Liabilities. Any Matter specifically disclosed on the Disclosure Schedules at the Effective Time shall not be deemed to constitute a Material Adverse Effect and shall not be considered in determining whether a Material Adverse Effect has occurred.

"**Material Contracts and Leases**" has the meaning set forth in Section 3.8.

"**Maximum Liability Amount**" has the meaning set forth in Section 12.3(b).

"**Medical Hazards**" means all biological and chemical materials that under applicable Environmental Laws or industry standards are required to be handled in accordance with certain

procedures, and all other materials that may contain or be contaminated with such biological or chemical materials, and all devices or materials that could puncture or cut the skin (including, without limitation, those commonly known as "sharps").

"**Net Assets**" means Total Assets less Total Liabilities.

"**Nonassignable Contract**" has the meaning set forth in Section 2.1(b).

[REDACTED]

"**Noncompete Period**" has the meaning set forth in Section 10.18(a).

"**Notice to Tenants**" has the meaning set forth in Section 9.2(q).

"**Owned Real Property**" has the meaning set forth in Section 3.9(a).

"**Patient Receivables**" means accounts receivable of HSR arising from the provision of services, drugs, items and supplies to patients at the Facilities through Closing and relating to Government Reimbursement Programs or other third party payors.

"**Permitted Encumbrances**" means (a) Liens or Encumbrances created by Buyer or securing any indebtedness specifically assumed by Buyer as an Assumed Liability; (b) Liens or Encumbrances for Taxes, assessments or other similar governmental charges which are not due and payable as of the Closing Date; (c) Liens or Encumbrances set forth on Schedule 3.9(a) Part A, and (d) rights of counterparties under Assumed Contracts and Assumed Leases.

"**Person**" means any individual, sole proprietorship, partnership, corporation, limited liability company, limited partnership, joint venture, unincorporated society or association, trust, estate or other entity or organization, or any division of such Person.

"**Personal Property**" means tangible personal property (including, without limitation, equipment, fixtures, vehicles, furniture, tools, furnishings, machinery, instruments, spare parts, supplies, pharmacueticals and inventory).

"**Pharmacy License**" means HSR's license to operate a retail pharmacy issued by the Connecticut Department of Consumer Protection's Commission of Pharmacy.

"**Physician**" means any licensed doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry or chiropractor, or any group, partnership, corporation, of whatever form, made up of one more such persons.

"**Physician Contract**" means any Contract, direct or indirect, including unwritten or unexecuted financial arrangements and agreements, regardless of amount or payment, entered between or among parties, one of which is a Seller or an Affiliate thereof, and the other of which is one or more Physician(s), Physician group(s) and/or other entities owned in whole or in part, by one or more Physicians (or any member of the Immediate Family of a Physician) and/or Physician groups, where one or more Physicians makes Referrals, including, without limitation,

physician employment agreements, medical director agreements, administrative services agreements, professional services agreements, teaching services agreements, preceptorship agreements, call coverage agreements, moonlighting agreements, per-diem services agreements, research agreements, any lease agreement, (including leases of space or equipment), recruitment agreements, income guarantee arrangements, loan agreements, loan guarantee arrangements, billing services agreements, practice support agreements, management services agreements, agreements for the provision of personnel, agreements for the sale or purchase of assets, joint venture arrangements of any structure and risk-sharing or shared-savings agreements. For purposes of this definition "Referral" means a request or order for any item or services, including the request for a consultation with another Physician (and any test or procedure ordered by or performed by or under the supervision of the other Physician), provided to patients. For purposes of this definition, "Immediate Family" means husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister- in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

[REDACTED]

"**Pre-Closing Tax Period**" means a taxable period or portion thereof that ends on or prior to the Closing Date; if a taxable period begins on or prior to the Closing Date and ends after the Closing Date, then the portion of the taxable period that ends on and includes the Closing Date shall constitute a Pre-Closing Tax Period.

"**Purchase Price**" has the meaning set forth in Section 2.3.

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

"**Real Property**" has the meaning set forth in Section 3.9(a).

"**Real Property Lease**" has the meaning set forth in Section 3.9(a).

"**Rejection Notice**" has the meaning set forth in Section 5.15.

"**Restricted Entities**" has the meaning set forth in Section 10.18(a).

"**Retained Assets**" has the meaning set forth in Section 2.1(c).

"**Retained Liabilities**" has the meaning set forth in Section 2.2(b).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

"**Seller**" and "**Sellers**" have the meanings set forth in the introductory paragraph.

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.2.

"**Seller Tax Returns**" has the meaning set forth in Section 3.14(b).

"**SOC**" means the Sisters of Charity of Saint Elizabeth, a New Jersey nonprofit corporation.

"**Software**" has the meaning set forth in Section 3.23.

"**Solid Waste**" means any substance deemed under any applicable federal or state law or regulations as waste.

[REDACTED]

"**Sponsoring Organization**" means (a) SRHS as the sponsor of the Church Plan or (b) an organization designated and maintained by SRHS that shall be controlled by, or associated with, the Church.

"**SRHS**" has the meaning set forth in the introductory paragraph.

"**SRHSAP**" has the meaning set forth in the introductory paragraph.

"**Tail Insurance Policies**" has the meaning set forth in Section 10.13.

"**Tax**" or "**Taxes**" means all taxes, fees, levies or other assessments imposed by the United States or any state, country, local or foreign government or subdivision or agency thereof, including, without limitation, income, gross receipts, excise, real and personal property, premiums, municipal, capital, value-added, goods and services, consumption, sales, transfer, license, payroll and franchise taxes, and such term shall include any interest, penalties or additions to tax attributable to such taxes, fees, levies or other assessments.

"**Tax Returns**" means any report, return or other information required to be supplied to any federal, state or local taxing authority in connection with Taxes.

[REDACTED]

[REDACTED]

"**Title Company**" means First American Title Insurance Company.

"**Title Company Escrow Agent**" means First American Title Insurance Company in its capacity as closing escrow agent.

"**Title Company Escrow Funds**" means an amount equal to the amount required to be paid by Buyer to Sellers at Closing in accordance with Section 2.3 and as adjusted by Section 9.4 and Section 13.3.

"**Title Policies**" means ALTA Form Owner's Policy (6/17/06) owner policies of title insurance covering each of the Owned Real Property in the amounts set forth on Exhibit J, naming Buyer as the insured, and containing as exceptions to title only the Permitted Encumbrances.

"**Total Assets**" means, in the case of Caritas and Lukan, total assets per financial statements less premiums receivable, and in the case of HSR, restricted assets set aside for malpractice, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

"**Total Liabilities**" means, in the case of Caritas and Lukan, total liabilities less unearned premiums on premiums receivable, and in the case of HSR, its tail liability, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

[REDACTED]

"**Transfer Act**" means the Connecticut Transfer Act, Connecticut General Statutes Sections 22a-134 et seq.

"**Transition Services Agreements**" means the Transition Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and Buyer, substantially in the form attached hereto as Exhibit I-B.

"**Wind Down Plan**" has the meaning set forth in Section 7.9.

"**Wind Down Services Agreement**" means the Wind Down Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and YNHH, substantially in the form attached hereto as Exhibit I-A.

"**YNHHS**" has the meaning set forth in the introductory paragraph.

ARTICLE 2. PURCHASE AND SALE OF ASSETS

2.1 Purchase and Sale of Assets.

(a) On the terms and subject to the conditions set forth in this Agreement, at Closing, Buyer shall purchase from each Seller, and each Seller shall sell, assign, transfer, convey and deliver to Buyer or Buyer's Affiliate, all of each Seller's right, title and interest in, to and under all of the rights, properties and assets of every kind, character or description, wherever located and whether real, personal or mixed, or fixed, contingent or otherwise, that are owned, used or held for use by such Seller in the conduct of the Business, including, but not limited to, those assets identified in Section 2.1(a) of the Disclosure Schedule, but excluding the Retained Assets (collectively, the "**Purchased Assets**"), free and clear of any Liens or Encumbrances, other than the Permitted Encumbrances. Without limiting the generality or effect of the foregoing, at Closing, HSR shall transfer, convey and deliver to Buyer (i) good and marketable title to the Owned Real Property, together with all fixtures and Improvements thereon, (ii) all of each Seller's leasehold interests in the Leased Real Property (subject to the terms of the applicable leases and related instruments governing such interests, and (iii) all right, title and interest of each Seller to the other Purchased Assets (subject to the terms of any applicable Assumed Contract or Assumed Lease), in each case free and clear of any Liens or Encumbrances, other than Permitted Encumbrances.

(b) To the extent that any Assumed Contract or Assumed Lease to be assigned pursuant to the terms of Section 2.1(a) is not capable of being assigned without the consent of a third party or if such assignment or attempted assignment would constitute a breach thereof or a violation of any law (any such Assumed Contract or Assumed Lease being referred to herein as a "**Nonassignable Contract**"), nothing in this Agreement shall constitute an assignment or an attempted assignment thereof prior to the time at which all consents necessary for such assignment shall have been obtained. Each Seller shall use commercially reasonable efforts to obtain the consent to the assignment of any Nonassignable Contracts and Buyer shall reasonably cooperate with each Seller's efforts to obtain such consent. To the extent that such consents are not obtained, if and to the extent requested by Buyer, such Seller shall, during the term of the affected Nonassignable Contract, use reasonable best efforts to (i) provide to Buyer the benefits under any such Nonassignable Contract, (ii) cooperate in any reasonable and lawful arrangement designed to provide such benefits to Buyer, and (iii) enforce, at the written request of Buyer, for the account of Buyer, any rights of such Seller under the affected Nonassignable Contract (including the right to elect to terminate such Nonassignable Contract in accordance with the terms thereof upon the direction of Buyer). Buyer shall reasonably cooperate with such Seller in order to enable such Seller to provide the benefits contemplated by the immediately preceding sentence to Buyer. Buyer shall perform the obligations of each Seller arising under the affected Nonassignable Contracts, but only if and to the extent that such Seller provides to Buyer the benefits thereof pursuant to this Section 2.1(b).

(c) For purposes of this Agreement, the term "**Retained Assets**" means all of each Seller's right, title and interest in, to and under the following:

(i) the corporate record books of each Seller (other than medical records, all of which shall be Purchased Assets);

(ii) the Benefit Plans;

(iii) the Medicare, Medicaid and any other payor agreements and provider numbers of each Seller except for the Medicare, Medicaid and other payor agreements and provider numbers of Grimes Center identified as Purchased Assets in Section 2.1(a) of the Disclosure Schedule;

(iv) cash, cash equivalents, certificates of deposit, treasury bills, securities, accounts and accounts receivable (except for the amount held by HSR for the satisfaction of malpractice tail liabilities and except as otherwise set forth in Section 10.8 with respect to Patient Receivables);

(v) the Pharmacy License;

(vi) HSR's general acute care hospital license issued by the Connecticut Department of Public Health;

(vii) any surety bonds issued to cover workers' compensation claims with respect to any Seller;

(viii) any other assets identified in Section 2.1(c) of the Disclosure Schedule; and

(ix) all contracts and leases of any Seller that are not Assumed Contracts or Assumed Leases.

2.2 **Assumption of Liabilities.**

(a) At and after the Effective Time, Buyer agrees to assume, satisfy, discharge and perform as and when due, and to hold each Seller harmless against, the future payment and performance of only the following obligations and liabilities of each Seller related to the Purchased Assets (collectively, the "**Assumed Liabilities**"):

(i) all obligations and liabilities arising from and after the Effective Time under the Assumed Contracts and Assumed Leases;

(ii) all obligations and liabilities with respect to the ownership and operation of the Purchased Assets that arise from and after the Effective Time;

(iii) all workers' compensation liabilities;

(iv) the HSR malpractice tail liability; and

(v) all obligations and liabilities set forth on Section 2.2(a) of the Disclosure Schedule.

(b) Each Seller shall retain and be responsible and liable for, and Buyer shall not assume or be responsible or liable for, all of its obligations and liabilities that are not Assumed Liabilities (the "**Retained Liabilities**"), including, without limitation, (i) the obligations and liabilities described in Section 2.2(b) of the Disclosure Schedule; (ii) all contracts

and leases of any Seller that are not Assumed Contracts or Assumed Leases; and (iii) the Benefit Liabilities.

2.3 **Purchase Price**. In consideration of the purchase and sale of the Purchased Assets and consummation of the transactions contemplated by this Agreement, Buyer hereby agrees to pay (or cause to be paid) to Sellers an amount equal to $160,000,000 (the "**Purchase Price**"). The Purchase Price shall be paid in accordance with the payment schedule set forth on Exhibit L.

2.4 **Title Company Escrow.** At or before Closing, Buyer shall deliver to the Title Company Escrow Agent, by wire transfer of immediately available funds to the account designated for such purpose by the Title Company Escrow Agent, the Title Company Escrow Funds, and such Title Company Escrow Funds shall be paid to each appropriate Seller upon satisfaction of all conditions precedent to the Closing as described herein.

ARTICLE 3. REPRESENTATIONS AND WARRANTIES OF SELLERS

In order to induce Buyer to purchase the Purchased Assets it is purchasing hereunder, each Seller, jointly and severally, represents and warrants to Buyer that the statements contained in this Article 3 are correct and complete in all material respects as of the Effective Date and, subject to Section 5.15, will be correct and complete in all material respects through and including the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 3); provided, however, that the statements contained in Section 3.18 will be made only as of the Closing Date and not as of the Effective Date.

3.1 **Organization; Authority.** Each Seller is a corporation duly formed, validly existing and in good standing under the laws of its state of incorporation and has the requisite power and authority to conduct its Business as now being conducted. Each Seller is duly qualified or licensed to do business and is in good standing in each jurisdiction in which the nature of its business or the ownership or leasing of its properties makes such qualification or licensing necessary.

3.2 **Powers; Consents; Absence of Conflicts.** Except as set forth in Section 3.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement, the Caritas SPA, the Lukan SPA and the Transition Services Agreements by each Seller, as applicable, and the consummation of the transactions contemplated hereunder and thereunder by such Sellers: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of each Seller and have been duly authorized by all appropriate corporate action (including by any Affiliate, as applicable); (b) do not and will not require any approval or consent of, or filing with, any Governmental Authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any Contract or Lease to which any Seller is a party or by which any Seller or any Purchased Asset is bound or subject; and (e) do not and will not

violate any judgment, order or decree of any court or other Governmental Authority to which any Seller or any Purchased Asset may be subject. This Agreement has been duly executed and delivered by each Seller and, as to each Seller, is valid and binding on each such Seller with respect to its obligations hereunder, enforceable against it in accordance with its terms, except to the extent enforceability may be limited by bankruptcy, insolvency, moratorium or similar laws affecting creditors rights and remedies.

3.3 **Absence of Certain Changes.** Except as otherwise set forth in Section 3.3 of the Disclosure Schedule, since September 30, 2010, each Seller has operated the Business in the ordinary course of business and there has not been any:

(a) damage to, destruction or loss of, any portion of the Purchased Assets having an aggregate value of $250,000 or more, whether or not covered by insurance;

(b) sale, lease or other disposition of any portion of the Purchased Assets having an aggregate value of $250,000 or more (except in the ordinary course of business and the disposition of obsolete and worn out equipment or materials), or imposition of any material Lien or Encumbrance on any of the Purchased Assets other than Permitted Encumbrances;

(c) grant by any Seller to any of its non-management employees or independent contractors of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits or establishment of any new compensation or benefit plans or arrangements or amendment to any existing plans, except in the ordinary course of business or as may be contemplated under any existing agreements or required by Applicable Law;

(d) grant by any Seller to any of its management employees (i.e., assistant vice president or above), directors or officers of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, except in the ordinary course of business or as may be contemplated by existing agreements or required by Applicable Law;

(e) entry into, termination of or receipt of written notice of termination of (i) any material license, joint venture, credit or similar agreement, or (ii) any Material Contract or Lease or Real Property Lease except such terminations as are non-discretionary and contemplated by the terms of the Material Contract, Lease or Real Property Lease;

(f) any merger or consolidation with, any material capital investment in, any material loan to, any material advance to or material acquisition of the securities, assets or Indebtedness of, any other Person;

(g) any distribution of cash or other property by a Seller to its members, or any payment or transfer of cash or other property to any of its Affiliates;

(h) change in any method of accounting or accounting practice or policy;

(i) receipt of a notice of deficiency from any Governmental Authority or other regulator, including any consent orders or corrective action requests from the Connecticut Department of Public Health; or

(j) agreement, whether oral or written, by any Seller to do any of the foregoing.

3.4 **Compliance with Laws.** Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers are in compliance with all Applicable Laws that do not constitute Healthcare Laws. Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers have at all times during the past seven years operated the Business in accordance with all Healthcare Laws. Each Seller has timely filed all reports, data and other information required to be filed with Governmental Authorities with respect to the conduct of the Business or to the ownership and use of any of the Purchased Assets. Except as set forth in Section 3.4 of the Disclosure Schedule, Seller nor any Affiliate of any Seller has, with respect to the operation of the Business, received written notice from a Governmental Authority with respect to the operation of the Business, that it is under investigation with respect to any violation or alleged violation of, or that it has any obligation to take remedial action under: (a) any Applicable Law or Healthcare Laws, (b) any license, certificate or certificate of need issued or (c) any order, judgment or decree entered by any Governmental Authority relating to the Business.

3.5 **Licenses.** Section 3.5 of the Disclosure Schedule sets forth a list, as of the Effective Date, of all material licenses and permits held by each Seller in connection with the operation of the Business. Sellers have held and hold all licenses, permits, certifications, consents, approvals, authorizations, qualifications and orders of any Governmental Authority as are necessary for Sellers' conduct of the Business and ownership and use of the Purchased Assets. Except as set forth in Section 3.5 of the Disclosure Schedule, each such license, permit, certification, consent, approval, authorization, qualification and order is valid and in full force and effect, and each Seller is in compliance in all material respects with each such license, permit, certification, consent, approval, authorization, qualification and order. Except as set forth in Section 3.5 of the Disclosure Schedule, as of the Effective Date, no Seller has received any written notice from any Governmental Authority regarding (a) any non-compliance or alleged non-compliance under any such license, permit, certification, approval, authorization, qualification or order or any investigation or potential investigation of any Seller in connection with any such non-compliance or alleged non-compliance or (b) any obligation or alleged obligation of any Seller to take remedial action under any such license, permit, certification, approval, authorization, qualification or order.

3.6 **Accreditation; Government Reimbursement Programs.**

(a) Except as set forth in Section 3.6(a) of the Disclosure Schedule, each Seller, as applicable, is duly accredited by the Joint Commission for the period indicated in Section 3.6(a) of the Disclosure Schedule. No Seller has been excluded, debarred or otherwise deemed ineligible to participate in Medicare, Medicaid or any other federal or state health care programs or in any federal or state procurement or non-procurement programs, nor has any Seller been convicted of a criminal offense related to the provision of federal health care items or

services, nor, to Sellers' Knowledge, is an investigation or proceeding regarding the foregoing pending or threatened.

(b) Except as set forth in Section 3.6(b) of the Disclosure Schedule, each of the Sellers that provides services to beneficiaries of Government Reimbursement Programs is (i) qualified for participation in, and has current and valid provider contracts with, the Government Reimbursement Programs and/or their fiscal intermediaries or paying agents and is in material compliance with the conditions of participation or requirements applicable with respect to such participation and (ii) eligible for payment under the Government Reimbursement Programs for services rendered to qualified beneficiaries.

(c) The Cost Reports for each of the Sellers that provide services to beneficiaries of Government Reimbursement Programs were filed when due, and have been audited (with Notices of Program Reimbursement issued), for the Cost Report periods described in Section 3.6(c) of the Disclosure Schedule.

(d) Except as set forth in Section 3.6(d) of the Disclosure Schedule, all amounts shown as due from any of the Sellers in the Cost Reports either were remitted with such Cost Reports or will be remitted when required by Applicable Law, and all amounts shown in the Notices of Program Reimbursement as due have been or prior to Closing will be paid when required by Applicable Law. Except to the extent liabilities and contractual adjustments with respect to the Sellers under the Government Reimbursement Programs have been properly reflected and adequately reserved in the Financial Statements, or as set forth in Section 3.6(d) of the Disclosure Schedule, the Sellers have not received or submitted any claim for payment to the Government Reimbursement Programs (or their fiscal intermediaries or paying agents) in excess of the amount provided by Applicable Law or applicable provider contracts, and the Sellers have not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding any of the Sellers and the Government Reimbursement Programs or the participation by any of the Sellers in such programs.

(e) The Sellers have no, and are not subject to or the beneficiary of any, outstanding loan, grant or loan guarantee pursuant to the Hill Burton Act (42 U.S.C. Section 291a, et seq.).

3.7 **Medical Staff Matters.**

(a) Each Seller, as applicable, has previously delivered or made available to Buyer, with respect to the Business, (i) the forms generally used as of the Effective Date with respect to medical staff privilege and membership application, and (ii) all medical staff bylaws, policies, rules and regulations, as in effect on the Effective Date.

(b) Section 3.7(b) of the Disclosure Schedule sets forth a true and correct list as of the Effective Date of the name and specialty of each member of the medical staff of the Facilities. Except as set forth in Section 3.7(b) of the Disclosure Schedule and actions and appeals as to which disclosure is prohibited by federal or state law, there are no, and there have not been at any time during the five years prior to the Effective Date, (i) any pending or threatened disciplinary or corrective actions or appeals by any Seller with respect to its medical

staff members, other professional staff members or applicants to the medical staff of the Facilities or, to Sellers' Knowledge, with respect to such medical staff members, professional staff members or applicants at any other facility at which such member or applicant has or has applied for privileges; or (ii) any pending or threatened challenges to any decisions of the medical staff relating to delineation of privileges at the Facilities.

3.8 **Contracts and Leases.** Section 3.8 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of (a) all Leases, excluding Real Property Leases, involving annual payments of $250,000 or more and (b) all Contracts to which any Seller is a party or to which any of their assets are bound (i) governing the borrowing of money or the Guarantee or the repayment of Indebtedness of any Seller or granting of Liens on any property or asset of any Seller (including any such contract under which any Seller has incurred any Indebtedness); (ii) providing for the employment of any Person and, to the extent not subject to confidentiality restrictions, any settlements relating thereto; (iii) containing covenants limiting the freedom of any Seller to compete in any line of business or with any Person or in any geographic area or market; (iv) concerning the use of or restricting the use of any Intellectual Property Rights or other intellectual property; (v) with any members, trustees, directors, officers, employees of any Seller or their respective Affiliates or Affiliates of any Seller; (vi) providing for the purchase, maintenance or acquisition or the sale or furnishing, of materials, supplies, merchandise, equipment or services (including computer hardware, software, online hosting arrangements or other property or services) involving payments in excess of $250,000; (vii) granting to any Person a first refusal, first offer or similar preferential right to purchase or acquire any right, asset or property of any Seller; (viii) pertaining to the lease of equipment or other Personal Property and involving annual payments of $250,000 or more; (ix) providing for any offset, countertrade or barter arrangement; (x) involving a distributor, sales representative, broker, franchise or advertising arrangement; (xi) involving a joint venture, partnership or similar arrangement; (xii) involving non-employee management services, consulting services, independent contractor services, support services or any other similar services involving annual payments of $250,000 or more, including service agreements under which any Seller is required to provide services to insurers, self-insured employees or any governmental or private health plan, managed care plan or other similar Person; (xiii) involving the acquisition of any business enterprise whether via stock or asset purchase or otherwise; (xiv) as to which the breach, nonperformance, cancellation or failure to renew by any party thereto would have a Material Adverse Effect; (xv) concerning any Physician, Physician group or medical practice entity; and (xvi) with respect to Grimes Center, resident admission agreements and any other written agreements with residents (collectively, the "**Material Contracts and Leases**"). Each Seller has delivered or made available to Buyer true and correct copies of the Material Contracts and Leases. Except as set forth in Section 3.8 of the Disclosure Schedule, no Seller is in breach of, or has any Knowledge of any material breach or default under, any of the Material Contracts and Leases that are Assumed Contracts or Assumed Leases or has received any written notice from any party of the same, and, to Sellers' Knowledge, no other party to any such Assumed Contract or Assumed Lease is in breach thereof. Each Assumed Lease listed in Section 3.8 of the Disclosure Schedule (w) was negotiated on an arms-length basis, (x) is valid and existing in full force and effect, and (y) is not in default nor has any tenant thereunder received a written notice of default.

3.9 **Real Property; Condition of Facilities.**

(a) Part A of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property owned by Sellers in fee simple as more particularly described in the legal descriptions for such real property attached to such Disclosure Schedule as Schedule A (the "**Owned Real Property**"). Part B of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property with respect to which a Seller holds a leasehold interest as to all or a portion of such real property, as applicable (the "**Leased Real Property**") (subject to the terms of the applicable leases and related instruments governing such interest, collectively the "**Real Property Leases**"). The Owned Real Property and the Leased Real Property are referred to herein collectively as the "**Real Property**".

(b) Except as set forth in Section 3.9(b) of the Disclosure Schedule, there are no outstanding violations of any Applicable Law, order, or any condemnations, liens, pledges, claims or similar recorded liabilities or assessments, relating to any material portion of the Owned Real Property and Seller has not received any written notice of the same and to Sellers' Knowledge, there are no outstanding violations of any Applicable Law, order or any condemnations, Liens or assessments, relating to any material portion of the Leased Real Property and Seller has not received any written notice of the same.

(c) Except as set forth in Section 3.9(c) of the Disclosure Schedule, the Owned Real Property, and to Sellers' Knowledge, the Leased Real Property is in compliance with all Applicable Laws relating to zoning and land use, regulations and ordinances, including, but without limitation, all Applicable Laws relating to parking and Connecticut State Traffic Certificates.

(d) All water, sewer, gas, electricity, telephone and other utilities required for the use, occupancy, operation and maintenance of the Owned Real Property are connected thereto and are adequate to service the normal operations of the Owned Real Property, are supplied directly to the Owned Real Property by facilities of public utilities and the cost of installation and connection of such utilities has been fully paid.

(e) Seller has not received any written notice from any insurance company or inspection or rating bureau setting forth any requirements as a condition to the continuation of any insurance coverage on or with respect to the Real Property or the continuation thereof at premium rates existing at present which have not been remedied or satisfied.

(f) Except as set forth in Section 3.9(f) of the Disclosure Schedule, no services, material or work have been supplied to or have been performed in connection with, as applicable, the Owned Real Property, or in the case of the Leased Real Property, to Sellers with respect to the relevant leased premises, for which payment has not been made in full in a timely manner.

(g) Except as set forth in Section 3.9(g) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.9(g) of the Disclosure Schedule, (i) each of (A) the heating, ventilation and air conditioning system

(HVAC), (B) the mechanical, electrical and plumbing system (MEP) and (C) the roof of each Owned Real Property, and to Sellers' Knowledge the roof of each Leased Real Property, is in good working condition, was constructed in a good and workmanlike manner and is free from defects which would render it unfit for continued use in the manner in which it is presently used, subject, however, to ordinary wear and tear and (ii) the foundation, walls and all structural components of the buildings and other improvements of the Owned Real Property, and to Sellers' Knowledge of the Leased Real Property, are structurally sound and no Seller has Knowledge of any material defects or material damage to any of the foregoing.

(h) Each of the Real Property Leases and each of the leases relating to an Owned Real Property (i) was negotiated on an arms-length basis, (ii) is valid and existing in full force and effect and (iii) to Sellers' Knowledge, is not in default nor has any Seller received a written notice of default from the applicable landlord of such Leased Real Property.

3.10 Personal Property.

(a) Except as set forth in Section 3.10(a) of the Disclosure Schedule, all Personal Property used by Sellers in the operation of the Business is either owned by a Seller or leased by a Seller under a Lease.

(b) Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, there are no pending claims in an amount in excess of $250,000 by any Seller against a manufacturer, distributor or lessor of any Personal Property for warranty, repair, return or defective condition. All inventory and supplies, including pharmaceuticals, (i) are, and have been throughout their possession by Sellers, properly stored, inventoried and labeled, and are usable in accordance with their intended use, (ii) have been maintained in the ordinary course of business and (iii) at the Effective Time, shall be at levels consistent with operation of the Business in accordance with past practices of Sellers. Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, the improvements on the Real Property and the Personal Property have been reasonably maintained in the ordinary course of business, are in good operating condition (ordinary wear and tear excepted), and are reasonably suitable for the uses for which they are intended.

3.11 Labor and Employee Matters.

(a) Section 3.11(a) of the Disclosure Schedule sets forth each pension, profit sharing, deferred compensation or other employee pension or health or welfare benefit plan or arrangement, as defined in Section 3(3) of ERISA (or each such plan that is a church plan as defined in Section 414(e) of the Code), relating to the Business that is currently in effect or that has been in effect at any time during the past three years (the "**Benefit Plans**"). Except as set forth in Section 3.11(a) of the Disclosure Schedule: (i) no Benefit Plan is subject to Title IV of ERISA and no Benefit Plan is a Multiemployer Pension Plan within the meaning of Section 3(37) of ERISA; (ii) no prohibited transaction as defined in Section 4975 of the Code,

has occurred with respect to any Benefit Plan and there are no pending or, to any Seller's Knowledge, threatened claims by, on behalf of or against the Benefit Plans or by any employee of any Seller alleging a breach or breaches of fiduciary duties or violations of other applicable state or federal law that could result in liability on the part of any Seller or the Benefit Plans under ERISA or any state law applicable to any church plan listed in Section 3.11(a) of the Disclosure Schedule, nor to Sellers' Knowledge is there any basis upon which such a claim can reasonably be anticipated; and (iii) all returns, reports, disclosure statements and premium payments required to be made under ERISA and the Code with respect to the Benefit Plans have been timely filed or delivered.

(b) Except as specified in Section 3.11(b) of the Disclosure Schedule, (i) no Seller is a party to or bound by any union contract, collective bargaining agreement, employment contract, independent contractor agreement, consultation agreement or other similar type of contract; (ii) no Seller has agreed to recognize any union or other collective bargaining representative; (iii) no union or collective bargaining representative has been certified as representing the employees of any Seller; and (iv) to Sellers' Knowledge, no labor union or collective bargaining representative has made any attempt or threatened to organize any employees of any Seller. No Seller has experienced any labor strike, dispute, slowdown or stoppage or any other material labor difficulty during the past five years, and to Sellers' Knowledge, there are no facts or circumstances that might reasonably be expected to lead to any such labor dispute. Sellers have provided Buyer true and complete copies of all agreements listed on Section 3.11(b) of the Disclosure Schedule.

(c) Sellers have provided Buyer with a complete list of all employees and independent contractors of each Seller, their respective positions, locations, exempt or non-exempt status, applicable independent contractor agreements, information on the bases for concluding that any such Person qualifies as an independent contractor rather than an employee of the Seller(s), and the rates of all regular and additional compensation and commissions payable to each such Person in any and all capacities and any regular or special compensation or commissions that will be payable to each such Person in any and all capacities as of the Closing Date other than the then-current accrual of regular payroll compensation. Except as set forth in Section 3.11(c) of the Disclosure Schedule, the employees of each Seller are "at will," and no Seller employs or engages any employee or independent contractor who, subject to compliance with Applicable Law, cannot be dismissed immediately, whether currently or immediately after the Effective Time, without notice and without further liability to such Seller.

(d) With respect to the employees of Sellers, during the last 12 months, there has been no mass layoff, plant closing or shutdown that triggers application of the Worker Adjustment & Retraining Notification Act of 1988, as amended, or any similar law.

(e) Each Seller has completed and retained to the extent required by the Immigration Reform and Control Act of 1986 ("**IRCA**") the employment verification paperwork for all current and former employees. Further, at all times prior to the Effective Date, each Seller was in material compliance with both the employment verification provisions (including the paperwork and documentation requirements) and the anti-discrimination provisions of IRCA.

(f) No Seller is liable for any payment to any trust or other fund or to any Governmental Authority, with respect to unemployment compensation benefits, social security or other benefits or obligations for employees (other than routine payments to be made in the ordinary course of business and consistently with past practice). Except as set forth in Section 3.11(f) of the Disclosure Schedule, there are no pending claims against any Seller under any workers' compensation plan or policy or for long-term disability.

(g) To Sellers' Knowledge, no employee of any Seller is in violation, in any material respect, of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, noncompetition agreement or restrictive covenant to a former employer.

(h) Except as set forth in Section 3.11(h) of the Disclosure Schedule, no Seller is a party to, or otherwise bound by, any consent decree with, or citation by, any Governmental Authority relating to employees or employment practices. No Seller, including the officers thereof, has received within the past five years any written notice of intent by any Governmental Authority responsible for the enforcement of labor or employment laws to conduct an investigation relating to any Seller and, to Sellers' Knowledge, no such investigation is in progress.

(i) Except as set forth in Section 3.11(i) of the Disclosure Schedule, none of the execution and delivery of this Agreement or the consummation of any transaction contemplated hereby or any termination of employment or service in connection therewith at or prior to the Closing Date will (i) result in any payment (including severance, unemployment compensation, golden parachute, bonus or otherwise) becoming due to any Person, (ii) materially increase any benefits otherwise payable by any Seller, (iii) result in the acceleration of the time of payment or vesting of any such benefits, (iv) increase the amount of compensation due to any Person or (v) result in the forgiveness in whole or in part of any outstanding loans made by any Seller to any Person.

(j) To Sellers' Knowledge, no current director, officer, employee, manager or independent contractor of any Seller is a party to or is otherwise bound by, any agreement or arrangement, including any confidentiality, noncompetition or proprietary rights agreement, between such director, officer, employee, manager or independent contractor and any other Person that in any way materially and adversely affects (i) the performance of his or her duties as a director, officer, employee, manager or independent contractor of such Seller or (ii) the ability of such Seller to conduct its business as it is currently conducted and proposed to be conducted.

(k) Each Seller is in compliance with all Applicable Laws applicable to its respective employment and employment practices, including all Applicable Laws regarding terms and conditions of employment, health and safety, wages and hours, employee and independent contractor classifications, immigration, employment discrimination, disability rights or benefits, equal opportunity, plant closures and layoffs, affirmative action, workers' compensation, labor relations, employee leave issues and unemployment insurance. Except in the ordinary course of business, no Seller is delinquent in payments to any employee for any services or any amounts required to be reimbursed or otherwise paid.

3.12 Litigation or Proceedings. Except as set forth in Section 3.12 of the Disclosure Schedule, there are no claims, actions, suits, proceedings or, to Sellers' Knowledge, investigations ("**Litigation or Proceedings**") pending or, to any Sellers' Knowledge, threatened against or affecting any Seller with respect to the Business or the Purchased Assets, at law or in equity, before or by any court or federal, state, municipal or other governmental department, commission, board, bureau, agency or instrumentality wherever located. Except as otherwise set forth in Section 3.12 of the Disclosure Schedule, no matter disclosed in Section 3.12 of the Disclosure Schedule is reasonably anticipated by Sellers to result in any cost, expense, damage or liability (including court costs or attorneys' fees) to any Seller in an amount that exceeds the greater of $50,000 or the amount reserved by Sellers as set forth in the Financial Statements.

3.13 Special Funds. Except as set forth in Section 3.13 of the Disclosure Schedule, the Facilities are not subject to any liability in respect of amounts received for the purchase or improvement of the Facilities or any part thereof under restricted or conditioned grants or donations, including, without limitation, monies received under the Public Health Service Act, 42 U.S.C. Section 291 et seq.

3.14 Tax Matters. Except as set forth in Section 3.14 of the Disclosure Schedule:

(a) Each Seller is exempt from federal income tax as an organization described in Section 501(c)(3) of the Code by virtue of the fact that it is classified as an organization described in Section 501(c)(3) of the Code and is classified as a public charity under Section 509(a) of the Code. No Seller knows of any basis for a challenge by the Internal Revenue Service to revoke or terminate any such exemption from federal income taxation;

(b) All Tax Returns for periods ended prior to the Effective Date required to be filed by any Seller (collectively, the "**Seller Tax Returns**") have been filed within the time and in the manner provided by law (including any valid extensions thereof);

(c) None of the Seller Tax Returns is currently the subject of an audit;

(d) The Seller Tax Returns were correct in all material respects;

(e) All Taxes that are shown as due on the Seller Tax Returns have been paid or adequate reserves therefor have been established; and

(f) (i) no Tax Lien or Encumbrance exists with respect to any of the Purchased Assets except for Permitted Encumbrances, (ii) no Litigation or Proceeding is pending, or, to Sellers' Knowledge, threatened, against any Seller with respect to any Taxes, (iii) there are no matters under discussion between any Seller and any Governmental Authority relating to any Taxes in an amount in excess of $250,000 and (iv) there are no claims against any Seller for additional Taxes in an amount in excess of $250,000 asserted by any Governmental Authority.

3.15 Environmental Matters. Except as set forth in Section 3.15 of the Disclosure Schedule:

(a) each Seller has obtained all applicable permits, licenses and other authorizations required for Seller's operations at the Purchased Assets under applicable Environmental Laws (the "**Environmental Permits**") and has made all necessary filings for issuance or renewal of the Environmental Permits, and no actions are pending, or to Sellers' Knowledge, threatened, to amend, challenge, terminate, cancel, limit, restrict or appeal any such Environmental Permits that would have a Material Adverse Effect;

(b) each Seller and the operations of each Seller at the Purchased Assets are in compliance with all terms and conditions of the Environmental Permits and with all applicable Environmental Laws;

(c) no Seller has any Knowledge of or any basis to expect, nor has any of them, received, any citation, directive, inquiry, notice, order, summons, warning or other communication that relates to any alleged, actual or potential violation or failure to comply with any Environmental Law with respect to the Purchased Assets or with respect to any property or facility to which Hazardous Substances generated, manufactured, refined, transferred, imported, used or processed by Seller have been transported, treated, stored, handled, transferred, disposed, recycled or received;

(d) there are no conditions at, in, on, under or related to the Real Property that pose a hazard to human health or the environment other than such conditions that are in compliance with applicable Environmental Laws;

(e) there is no (nor has there been any) production, use, treatment, storage, transportation, handling, discharge, disposal, arrangement for disposal or release or threatened release of any Hazardous Substance or Solid Waste in violation of applicable Environmental Law at, in, on, under, from, over or related to the Real Property, or into or upon or over soil, surface water or groundwater at, on, under or related to the Real Property;

(f) there are no underground tanks, collection sumps or pits, land disposal facilities or surface impoundments at, on or under the Real Property;

(g) the Owned Real Property and to Sellers' Knowledge the Leased Real Property does not have any (i) asbestos containing material that is damaged or friable in a form or condition which requires removal, abatement or repair as of the date hereof under applicable Environmental Laws, (ii) electrical transformers or other equipment or machinery that contain PCBs in regulated concentrations or (iii) radon in indoor air in excess of four picocuries per liter;

(h) each Seller and the Real Property is in compliance with all applicable Environmental Laws; and

(i) no Seller has received written notice from any Governmental Authority regarding any investigation or proceeding concerning the presence or alleged presence of any Hazardous Substances or Solid Waste on the Real Property or violation of any applicable Environmental Law.

3.16 Insurance. Section 3.16 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of all insurance policies or self-insurance funds of any nature

whatsoever in effect that insure the business, operations or employees of each Seller or affect or relate to the ownership, use or operation of any of the Purchased Assets and Business and that have been issued to any Seller or issued to an Affiliate of any Seller for the benefit of any Seller, which such Section 3.16 of the Disclosure Schedule reflects the policies' numbers, terms, identity of insurers, amounts and coverages. No written notice of cancellation or termination has been received by any Seller with respect to any policy listed in Section 3.16 of the Disclosure Schedule and all such policies are in full force and effect. There is not outstanding any requirement or recommendation by any insurance company that issued any such policy or by any Board of Fire Underwriters or other similar body exercising similar functions or by any Governmental Authority exercising similar functions which requires or recommends any repairs or other work to be done to any of the Purchased Assets. Each Seller has given to its insurer in a timely manner all notices required to be given under its insurance policies with respect to all claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions or reserved its rights in respect of or rejected any such claims.

3.17 **Brokers**. No broker, finder, investment banker or other Person is entitled to any brokerage, finder's or other fee or commission in connection with this Agreement or the transactions contemplated hereby based upon any agreements, arrangements or commitments made by or on behalf of any Seller.

3.18 [REDACTED]

3.19 **Financial Statements.** Section 3.19 of the Disclosure Schedule sets forth the following financial statements (collectively, the "**Financial Statements**"): (a) an unaudited balance sheet for each of the Sellers as of the Balance Sheet Date and unaudited statement of operations for each of the Sellers for the six-month period ended on the Balance Sheet Date (collectively, the "**March 31, 2011 Financial Statements**"); and (b) audited balance sheets of each of the Sellers as of September 30, 2009 and September 30, 2010 and the related statements of operations for the 12-month period then ended. The Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto and normal year end adjustments. The balance sheets included in the Financial Statements fairly present, in all material respects, the financial condition of such Seller as of the dates indicated thereon, and the statements of operations included in the Financial Statements fairly present, in all material respects, the results of operations of such Seller for the periods indicated thereon, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto

and normal year end adjustments. Except as set forth in Section 3.19 of the Disclosure Schedule, since the Balance Sheet Date, there have occurred no material adverse changes in the financial condition, results of operations or business of such Seller as reflected in such Financial Statements, other than changes in the ordinary course of business.

3.20 **Assets; Sufficiency of Assets.**

(a) Except as set forth in Section 3.20 of the Disclosure Schedule, each Seller, as applicable, owns good and marketable title to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances and HSR Financing Agreements, and, at the Closing, will sell, transfer and assign to Buyer, good and marketable title in and to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances.

(b) Except as set forth in Section 3.20 of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.20 of the Disclosure Schedule, all of the Purchased Assets are in good condition and repair except for ordinary wear and tear and are usable in the ordinary and normal course of business, consistent with past practices of Sellers, and the Purchased Assets include all assets necessary to conduct the Business in the ordinary and normal course of business, consistent with past practices of Sellers.

3.21 **Equipment.** Section 3.21 of the Disclosure Schedule sets forth a depreciation schedule as of March 31, 2011 that lists all the equipment associated with, or constituting any part of, the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, since March 31, 2011, no Seller has sold or otherwise disposed of any item of equipment having a replacement cost in excess of $250,000 constituting any part of the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, all of the Purchased Assets consisting of equipment, whether reflected in the Financial Statements or otherwise, are well maintained and in good operating condition, except for reasonable wear and tear. Except as set forth on Section 3.21 of the Disclosure Schedule, each Seller has good and marketable title to the equipment and all of such equipment is free and clear of any Lien or Encumbrance, except for Permitted Encumbrances. No person other than Sellers owns any equipment or other tangible assets situated on the Real Property.

3.22 **Intellectual Property.** Sellers have made available to Buyer complete and correct lists all of the patents, patent applications, names, trademark and trade name registrations and service mark registrations owned by any Seller (collectively, "**Intellectual Property Rights**"). Sellers own or have valid rights to use all such Intellectual Property Rights without conflict with the rights of others. The Intellectual Property Rights are not subject to any Liens or Encumbrances, except for Permitted Encumbrances. The Intellectual Property Rights are not subject to any restriction or limitation regarding use or disclosure other than pursuant to written license agreements. To Sellers' Knowledge, Sellers have not infringed upon or misappropriated any intellectual property or intellectual property rights of any other person. To Sellers' Knowledge, the conduct of the Business does not infringe upon any intellectual property owned or controlled by any other Person and no Person has made or, to Sellers' Knowledge, threatened to make, any claim that the operation of the Business or the use of the Intellectual Property

Rights is in violation of or infringes upon any patent, patent application, trademark, trade name, service mark or any other proprietary or trade rights of any third party.

3.23 **Software.** The operating and applications computer software programs and databases used by Sellers are listed and briefly described in Section 3.23 of the Disclosure Schedule (collectively, the "**Software**"). Sellers own outright or hold valid licenses to all copies of the Software used by Sellers. To Sellers' Knowledge, none of the Software, and no use thereof, infringes upon or violates any patent, copyright, trade secret or other proprietary right of any other Person, and no claim with respect to any such infringement or violation is threatened.

3.24 **Absence of Default.** Except as described on Section 3.24 of the Disclosure Schedule, no Seller is in default of any term or condition of any Indebtedness or liability, including any trade payable.

3.25 **Charitable Funds.** HSR and the Foundation have solicited, received, held, invested, expended and applied charitable funds donated to them, including the Charitable Funds (as defined below), in accordance with all restrictions placed thereon by donors, the terms of any applicable solicitation and Applicable Laws. No Seller has received written notice of any, whether actual or alleged, misuse of funds, failure to comply with any donor-imposed restriction, breach of duty related to the funds, or violation of any Applicable Laws, nor to Sellers' Knowledge, has any such misuse, failure, breach or violation occurred.

3.26 **Bank Accounts.** Section 3.26 of the Disclosure Schedule lists the name of each bank, savings and loan or other financial institution, in which an account, including cash contribution accounts, or a safe deposit box related the operations of any Seller is maintained and, to the extent practicable, the names of all persons authorized to draw thereon or to have access thereto.

3.27 **No Undisclosed Liability.** Except (a) as set forth on in Section 3.27 of the Disclosure Schedule, or as disclosed, set forth or reserved for in the Financial Statements (including the notes thereto), (b) for liabilities and/or obligations incurred in the ordinary course of business after the Balance Sheet Date or (c) for liabilities and/or obligations arising under any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which any Seller is a party that is entered into in the ordinary course of business (other than any such liabilities or obligations arising out of a breach by any Seller of any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which a Seller is a party), no Seller has any liability or obligation of any nature, whether or not accrued, contingent or otherwise.

3.28 **No Untrue or Inaccurate Representations or Warranties.** The representations and warranties of each Seller contained in this Agreement together with the Disclosure Schedule do not, and the statements of each Seller contained in the certificate delivered by Sellers to Buyer pursuant to Section 9.2(e) will not, contain any misstatement of a material fact or omit to state a material fact necessary in order to make the information contained therein not misleading.

ARTICLE 4. REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to Sellers that the statements contained in this Article 4 are correct and complete as of the Effective Date and will be correct and complete as of the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 4).

4.1 Organization; Authority. Buyer is a nonprofit corporation duly formed, validly existing and in good standing in the State of Connecticut and has the requisite power and authority to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts. Except as set forth in Section 4.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement by Buyer and the consummation of the transactions contemplated hereby by Buyer: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of Buyer and have been duly authorized by all appropriate corporate action; (b) do not and will not require any approval or consent of, or filing with, any governmental agency or authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any contract, agreement, indenture, mortgage, deed of trust, lease or other instrument to which Buyer is a party or by which Buyer is bound or subject; and (e) do not and will not violate any judgment, order or decree of any court or other governmental agency or authority to which Buyer may be subject. This Agreement has been duly executed and delivered by Buyer and constitutes a valid and binding obligation of Buyer, enforceable against it in accordance with its terms.

4.3 Brokers. No broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement based upon arrangements made by or on behalf of Buyer.

ARTICLE 5. CERTAIN COVENANTS OF SELLERS

5.1 Information. From the Effective Date to the Closing Date, each Seller shall continue to afford to those certain officers and representatives and agents of Buyer, designated by written notice to Sellers by Buyer, access upon reasonable notice and during normal business hours, to the Purchased Assets, including for purposes of conducting environmental and other property condition inspections, and, to the extent necessary, to Key Employees of Sellers, and all properties, books, contracts, commitments and records of each Seller relating to the Purchased Assets and the Business, the Retained Assets and the Retained Liabilities (regardless of where such information may be located), and promptly furnish Buyer with such additional available financial and operating data and other information relating to the same as Buyer may from time to time reasonably request, except to the extent any Seller is restricted from providing such information by Applicable Law or as a result of confidentiality agreements with third parties and except for Litigation or Proceedings where Buyer and Seller are both defendants. Buyer shall exercise its rights under this Section 5.1 in such a manner as not to interfere unreasonably with

the operation of Sellers. Any environmental and property condition inspections shall be limited to non-invasive testing unless Sellers have agreed to the scope of such invasive testing prior to commencement of the same; provided, however, that Buyer shall be permitted to perform Phase I Environmental Assessments and asbestos inspections of the Owned Real Property. If any Seller fails to fully, completely and promptly respond to Buyer's reasonable request for information and/or meetings with such Seller's officers to review the same, or any of such Seller's officers fail to fully, completely, honestly and promptly provide such requested information, the Agreement may be terminated as follows: Buyer's chief executive officer shall provide written notice to the chief executive officer of SRHS of Buyer's election to terminate this Agreement, and, upon the giving of such notice, Sellers shall be entitled to 15 business days after the receipt of such notice from Buyer to cure any such failure to respond to any request submitted by Buyer under this Section 5.1 so long as SRHS' chief executive officer provides Buyer's chief executive officer notice of such intention to cure within five business days of the receipt of Buyer's chief executive officer's election to terminate this Agreement. Seller's termination of employment of any non-compliant officer and the provision of the information requested if otherwise available to Seller shall constitute a cure. If (a) Sellers do not cure, within the aforementioned 15-day cure period (or such longer reasonable period permitted by Buyer's chief executive officer if such failure cannot be cured within 15 days and Sellers are diligently pursuing a cure within such 15-day period) any failure to respond to any request submitted by Buyer, or (b) Buyer, in the exercise of its reasonable judgment, determines that Sellers cannot cure such failure to respond, then Buyer may terminate this Agreement forthwith.

5.2 **Operations.** From the Effective Date through the Closing Date, except as otherwise contemplated by this Agreement, each Seller shall:

(a) carry on its business in substantially the same manner as such Seller has heretofore and not make any material change in personnel, operations, finance, accounting policies or real or Personal Property of the Business;

(b) maintain the Purchased Assets and all parts thereof in good working order and condition, ordinary wear and tear excepted, which shall include, without limitation, making capital expenditures in respect of the Facilities in the ordinary course of business consistent with past practices;

(c) perform all of its obligations under the Assumed Contracts, Assumed Leases and all agreements relating to or affecting the Purchased Assets or the Business, except where such failure would not reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(d) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between any Seller and any of the foregoing;

(e) take all actions necessary and appropriate to render title to the Purchased Assets free and clear of all Liens and Encumbrances (except for the Permitted Encumbrances)

and to obtain appropriate releases, consents, estoppels and other instruments as Buyer may reasonably request;

(f) keep in full force and effect present insurance policies or other comparable insurance;

(g) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be promptly provided to Buyer;

(h) conduct and provide to Buyer a quarterly update of the Wind Down Plan (commencing December 31, 2011);

(i) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the draft annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year and the final audited financial statement will be delivered by Sellers to Buyer within five business days of Seller's receipt of such statement from their auditor;

(j) provide Buyer with notice, and a description thereof, of any entry into, assumption, amendment or termination of any Physician Contract; and

(k) provide Buyer with notice, and a description thereof, of any grant of any increase in merit-based compensation or market adjustments to compensation with respect to any non-management employee(s).

5.3 **Negative Covenants.** Without limiting the generality or effect of Section 5.2, from the Effective Date to the Closing Date, except as expressly provided in this Agreement or as set forth in Section 5.3 of the Disclosure Schedule, no Seller shall, without requesting, in writing from the chief executive officer of SRHS, and receiving the written consent of Buyer's chief executive officer, not to be unreasonably withheld or delayed (and any failure by Buyer's chief executive officer to respond to any such request for consent within five business days will be deemed to be such written consent):

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to enter into or carry out its obligations hereunder or to own the Purchased Assets or operate the Business;

(b) enter into, assume, amend or terminate any Material Contract (other than Physician Contracts and agreements with third party payors) or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease, in accordance with any limitations and procedures mutually agreed upon by the parties' legal counsel;

(c) grant any material waiver or give any material consent with respect to any Material Contract or Lease or any Real Property Lease that is to be any Assumed Contract or Assumed Lease except in the ordinary course of business and except to the extent doing so would not have a Material Adverse Effect;

(d) assign, abandon, cancel or terminate before the stipulated expiration of its term any Material Contract or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease;

(e) acquire, make any investment in, or make any capital contributions to, any Person, except for another Seller, for a price or with a value in excess of $250,000;

(f) acquire or lease any material assets or sell, lease or otherwise dispose of any material asset or property, or create, assume or permit to exist any Lien or Encumbrance on any material asset or property constituting a part of the Purchased Assets, (other than any Permitted Encumbrance) in an amount in excess of $250,000, individually or in the aggregate;

(g) sell, lease or otherwise dispose to a third party of any assets other than in the ordinary course of business that have a value in excess of $50,000, individually or in the aggregate, and except for the disposition of obsolete or worn out assets;

(h) (i) incur any Indebtedness or (ii) make any loans or advances to any Person other than inter-company advances in the ordinary course of business to another Seller;

(i) enter into any compromise or settlement of any Litigation or Proceeding (other than any Litigation or Proceeding to which both Buyer and one or more Sellers are party) involving a payment by any Seller exceeding the greater of (i) $50,000 or (ii) the amount reserved, if any, with respect to such Litigation or Proceeding in Sellers' financial statements;

(j) grant or agree to grant to any of its non-management employees any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish for any of its employees new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans, except to preserve the status of the Church Plan, or as required by Applicable Law or technical, administrative or design amendments that do not increase the cost of providing benefits; provided, however, that any grant of any increase in merit-based compensation or market adjustments to compensation, in each case as consistent with past practices and in the ordinary course of business, shall not require Buyer's consent as long as Sellers provide notice of the same to Buyer;

(k) grant or agree to grant to any of its management employees (i.e., assistant vice president or above), directors or officers any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish any new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans;

(l) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(m) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables other than in the ordinary course of business;

(n) enter into any agreement that restrains, limits or impedes any Seller's ability to compete with or conduct any business or line of business;

(o) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates, except in the ordinary course of business or pursuant to a contract in existence on December 31, 2010 or to another Seller; or

(p) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 5.3.

Notwithstanding anything to the contrary contained in this Section 5.3, Sellers may, with the prior written consent of Buyer, liquidate the assets of the Foundation in accordance with the plan of liquidation set forth on Exhibit G.

5.4 **Governmental Approvals**. Without limiting the generality or effect of Section 5.7, each Seller shall use its reasonable best efforts to (a) obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities as are necessary for each Seller to consummate the transactions contemplated hereby, including, without limitation, the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda, and (b) assist Buyer, to the extent reasonably requested by Buyer, and to the extent they are legally transferable, in the transfer of each Seller's licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities other than those set forth in Section 5.4 of the Disclosure Schedule.

5.5 **Charitable Funds**. Buyer acknowledges and agrees that certain of the Sellers, including HSR and the Foundation, have received grants and hold other funds (the "**Charitable Funds**") for the benefit of Sellers or the Facilities. Buyer and Sellers acknowledge and agree that such Charitable Funds shall be used by Sellers to satisfy the Retained Liabilities of Sellers that exist after Closing. Sellers acknowledge and agree that, to the extent any Charitable Funds are available for transfer after Closing, Sellers shall work with Buyer to identify the Charitable Funds that may be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets at Closing, which such transferred Charitable Funds shall be used at or for the benefit of the Facilities. With respect to such Charitable Funds, Sellers acknowledge and agree that, to the extent permitted under Applicable Law, any Charitable Funds that cannot be transferred to Buyer or Buyer's Affiliate at Closing as part of the Purchased Assets shall be used by Sellers at or for the benefit of the Facilities; provided, however, that if such Charitable Funds cannot be used at or for the benefit of the Facilities, such Charitable Funds shall be used by Sellers to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. At Buyer's request, Sellers shall seek approval from donors, Governmental Authorities and courts of competent jurisdiction to permit the transfer and use of Charitable Funds as contemplated by this Agreement. With respect to any Charitable Funds identified by Buyer and Sellers pursuant to this Section 5.5 for which the stated or intended use thereof, or any restriction thereon, becomes unlawful, impracticable, impossible to achieve or wasteful as a result of this Agreement or otherwise, Sellers shall request that a court of competent jurisdiction provide relief to the parties

by applying cy pres to modify or terminate the instrument pursuant to which such Charitable Funds were or are to be transferred to Sellers in a manner such that any such funds may be transferred to and used by Buyer in a manner acceptable to Buyer or used to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. After the Effective Time, no Seller shall solicit grants, donations or other charitable funds.

5.6 Church Approvals. Without limiting the generality or effect of Section 5.7, from the Effective Date until the Closing Date, each Seller shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders (collectively, the "**Church Approvals**") of the Archdiocese of Hartford and the Holy See (collectively, the "**Church**") as are necessary for each Seller to consummate the transactions contemplated hereby.

5.7 Closing Conditions. From the Effective Date until the Closing Date, each Seller shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Buyer in doing, all things necessary, proper, or advisable to consummate, in a timely manner, the transactions contemplated hereby, including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

5.8 Payment of Obligations. Without limiting any other provision of this Agreement, each Seller shall, in the ordinary course of business: (a) pay all liabilities and obligations incurred by any Seller in connection with the ownership of the Purchased Assets and the operation of the Business, including, but not limited to, any and all liabilities and obligations arising under the HSR Financing Agreements and the Retained Liabilities; (b) maintain the Purchased Assets in good order and repair, normal wear and tear excepted; and (c) file all Tax Returns and pay on a timely basis Taxes owed, if any, as set forth on such Tax Returns.

5.9 No-Shop Clause. From the Effective Date until Closing, no Seller shall, without the prior written consent of Buyer: (a) offer for sale, or receive or consider any offer to purchase, the Purchased Assets (or any portion thereof) or any ownership or control interest of or in any Seller, (b) solicit, receive or consider offers to buy all or any portion of the Purchased Assets or any ownership or control interest of or in any Seller, (c) hold discussions with any Person or organization (other than Buyer) looking toward such an offer or solicitation or looking toward a merger or consolidation of or in any Seller or (d) enter into any agreement with any Person or organization (other than Buyer) with respect to the sale, management, operation or other disposition of the Purchased Assets (or any portion thereof) or any ownership or control interest in any Seller, or with respect to any merger, consolidation or similar transaction involving any Seller.

5.10 Transfer of Assets. In the event that the parties determine before or after Closing that any asset owned by any Seller or Affiliate of any Seller is used primarily in, or relates primarily to, the operation of the conduct of the Business, such Seller shall, or shall cause such Affiliate to, transfer, convey and deliver to Buyer such Seller's or such Affiliate's right, title and interest in, to and under such asset, free and clear of any Liens or Encumbrances, other than Permitted Encumbrances, at or after Closing, as applicable.

5.11 **Real Property.** Within 30 days of the Effective Date, Sellers shall (a) deliver to Buyer a certified rent roll for each parcel of Owned Real Property under lease to tenants; (b) provide to Buyer the most current operating expense information with respect to the Leased Real Property; (c) deliver to Buyer copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed as of the Effective Date; and (d) use their best efforts to obtain estoppel certificates in the form attached hereto as Exhibit M confirming lease information from third party tenants and landlords of the Leased Real Property, such best efforts of Sellers to continue after said 30-day period.

5.12 **Insurance Coverage.** Except as otherwise set forth on Section 5.12 of the Disclosure Schedule, Sellers shall maintain assignable reinsurance coverage applicable for all years during which professional or hospital liability claims may arise and for which the applicable statute of limitations has not run. At all times, Sellers shall continue to satisfy all required conditions of such reinsurance coverage, including, without limitation, carrier notification and cooperation requirements. Seller agrees to use its best efforts to cooperate with any regulatory approval from any Governmental Authority necessary for Buyer to acquire any interest of Sellers or their Affiliates in Lukan Indemnity Company, Ltd. ("**Lukan**") and Caritas Insurance Company ("**Caritas**").

5.13 [REDACTED]

5.14 **Pharmacy License.** Sellers agree to use reasonable best efforts to sell the Pharmacy License, on or before the Closing Date, to a third party that is not an Affiliate of any Seller.

5.15 **Disclosure Supplements.** From time to time at least as often as quarterly after the Effective Date and immediately prior to Closing, Sellers shall supplement or amend the Disclosure Schedule with respect to any matter first existing or occurring after the Effective Date that (a) if existing or occurring at or prior to the Effective Date, would have been required to be set forth or described in the Disclosure Schedule, or (b) is required to correct any information contained in the Disclosure Schedule or any representation or warranty of any Seller; provided, however, that if any such matter could reasonably be expected to result in a Material Adverse Effect or significant Loss, Sellers shall deliver such supplement or amendment promptly following their becoming aware of any such matter. In the event prior to Closing, there is damage or destruction to all or any portion of the Owned Real Property and such damage or destruction is not repaired by Sellers and for which there is insufficient insurance available to fund such repair, Seller shall deliver to Buyer supplement(s) or amendment(s) to the Disclosure Schedule disclosing the Losses resulting therefrom and the provisions of this Section 5.15 shall apply. The Disclosure Schedule shall be deemed modified in accordance with any such supplement or amendment for all purposes of this Agreement, provided that if any supplement(s) or amendment(s) to the Disclosure Schedules to this Agreement that discloses any matter or matters that could reasonably be expected to result in Losses, individually or in the aggregate, in excess of $15,000,000, Buyer shall have the right to terminate this Agreement, by giving written notice to Sellers of its election to so terminate within seven days of Buyer's receipt of such supplement or amendment; provided, however, that in the event Buyer so gives Sellers written notice of its election to terminate this Agreement, Sellers shall be entitled to 40 days after the effective date of such notice from Buyer to cure any such matter so disclosed by such supplement or amendment so long as Sellers provide Buyer notice of such intention to cure within five business days of Sellers' receipt of Buyer's election to terminate this Agreement. If Buyer, in the exercise of its reasonable judgment and taking into account Sellers' diligence in their attempt to cure, determines that Sellers cannot cure such deficiency, then Buyer may terminate this Agreement by written notice to Sellers within 30 days of Buyer's receipt of such supplement or amendment. If such deficiency is susceptible of cure, following the expiration of the aforementioned 40-day cure period, Buyer shall send Sellers a notice informing Sellers whether Buyer accepts or rejects the adequacy of Sellers' cure efforts (any such notice of rejection being referred to herein as a "**Rejection Notice**"). If Buyer accepts such cure efforts or fails to timely send a Rejection Notice, such Disclosure Schedule shall be modified as contemplated by such supplement or amendment for all purposes of this Agreement. If Buyer rejects any supplement or amendment to such Disclosure Schedule, then this Agreement shall be deemed terminated by Buyer pursuant to Section 11.1(g) and Buyer shall have no further rights relating to such deficiency or arising from such termination. If such deficiency is susceptible of cure and Sellers cure such deficiency within such 40-day period, the Disclosure Schedule shall be deemed modified for all purposes of this Agreement.

5.16 **Continuation of Group Health Plan Coverage and COBRA Continuation Coverage.** During the term of the Transition Services Agreements, Seller will continue to provide group health plan coverage to the employees of Seller. With respect to each group health plan that is subject to Code Section 4980B, Seller has complied with the continuation

coverage requirements contained in Code Section 4980B and Part 6 of Title I of ERISA. As of and after the Effective Time, Seller will provide group health plan coverage to all COBRA Qualified Beneficiaries of Seller (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4). To the extent that Seller ceases to provide any group health plan benefits to any employee of Seller or any organization in any controlled group that includes Seller (within the meaning of Code Section 414(b) or (c)), Buyer will provide group health plan coverage to all persons who are COBRA Qualified Beneficiaries of Buyer (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4).

5.17 [REDACTED]

5.18 **Notice of Breach.** In the event that any Seller breaches, in any material respect, any of its covenants contained in this Article 5, such Seller shall immediately deliver written notice of such breach to Buyer in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by such party.

ARTICLE 6. CERTAIN COVENANTS OF BUYER

6.1 **Governmental Approvals.** Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any governmental agencies or authorities as are necessary for Buyer to consummate the transactions contemplated hereby and to operate the Business from and after the Closing Date, including, without limitation, the Hart-Scott-Rodino Act filing and filings relating to the approval of the Connecticut Department of Public Health, the Connecticut Office of Health Care Access and the Centers for Medicare and Medicaid Services for consolidation of the Facilities, other than Grimes Center, under Buyer's hospital license and Medicare, Medicaid, TRICARE and other provider agreements and identification numbers and, with respect to Grimes Center, for issuance of an approval letter to Buyer or Buyer's designee and certificate of need approval for a chronic and convalescent nursing home license to operate Grimes Center and for assignment of the Grimes Center Medicare and Medicaid provider agreements to Buyer or Buyer's designee, a filing with the appropriate Governmental Authority in the State of Vermont with respect to the Caritas SPA and a filing with the appropriate Governmental Authority in Bermuda with respect to the Lukan SPA.

6.2 **Church Approvals.** Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall cooperate with Seller, as is commercially reasonable, to obtain all Church Approvals pursuant to Section 5.6.

6.3 **Closing Conditions.** From the Effective Date until the Closing Date, Buyer shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Sellers in doing, all things necessary, proper or

advisable to consummate, in a timely manner, the transactions contemplated hereby including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

6.4 **Notice of Breach**. In the event that Buyer breaches, in any material respect, any of its covenants contained in this Article 6, Buyer shall immediately deliver written notice of such breach to Sellers in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by Buyer.

6.5 **Real Property Reports**. Upon Sellers' reasonable request, Buyer shall provide Seller with copies of any property condition and environmental reports of the Real Property, excluding any portion of such reports which contain financial data or financial analysis, in Buyer's possession or control to the extent not already disclosed, including, without limitation, any reports created by or at the direction of Buyer through and including Closing.

ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer hereunder are subject to the satisfaction or written waiver, on or prior to the Closing Date, of the following conditions:

7.1 **Representations/Warranties**. The representations and warranties of each Seller contained in this Agreement (as supplemented or amended as provided in Section 5.15) that are qualified by materiality or reference to "Material Adverse Effect" shall be true in all respects, and those that are not so qualified shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

7.2 **Covenants**. Each covenant contained in this Agreement to be complied with or performed by each Seller on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects. Each Seller shall have duly performed and complied in all material respects with all agreements and conditions required by this Agreement to be performed or complied with by it prior to or on the Closing Date.

7.3 **Officers' Certificate**. Buyer shall have received from each Seller an officers' certificate, executed on behalf of each such party by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date and stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, as the case may be, that the conditions in Section 7.1 and Section 7.2 have been satisfied.

7.4 **Litigation or Proceedings**. No Litigation or Proceedings before a court or any other Governmental Authority or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions

contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

7.5 **Governmental Approvals**. All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, certificates of need, approvals, authorizations, clearances, qualifications or orders required to be obtained prior to Closing by Buyer or any Seller from, any Governmental Authority for the consummation of the transactions contemplated hereby, including, without limitation, such notices, reports, filings, licenses, permits, consents, certificates of need, approvals, authorizations, qualifications and orders set forth in Section 6.1, shall have been made or obtained.

7.6 **Church Approvals**. All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by any Seller from, the Church for the consummation of the transactions contemplated hereby shall have been made or obtained.

7.7 **Closing Deliveries**. Each Seller shall have made the deliveries required to be made by it under Section 9.2.

7.8 **Third Party Consents**. Each Seller shall have obtained consents from third parties for the assignment of the Assumed Contracts and Assumed Leases listed in Section 7.8 of the Disclosure Schedule.

7.9 **Satisfaction of Retained Liabilities**. At Closing, Sellers shall have submitted to Buyer, in writing and in form and substance reasonably satisfactory to Buyer, a plan for the orderly and timely satisfaction of all Retained Liabilities of each Seller substantially in the form of Exhibit N (the "**Wind Down Plan**"). Any portion of the Purchase Price or any other amounts held by Sellers, including any interest or earnings on or attributable to the Purchase Price or such other amounts that are at any time determined to be in excess of the amount necessary to satisfy the Retained Liabilities, shall be promptly paid by Sellers to Buyer or returned to Buyer as soon as legally permissible after any such determination.

7.10 **Charitable Funds**. Between the Effective Date and the Closing Date, Seller and Buyer shall have identified the Charitable Funds, and Seller shall have developed, in writing and in a form and substance reasonably satisfactory to Buyer, and implemented to the reasonable satisfaction of Buyer, a plan for the disposition of such Charitable Funds.

7.11 **Grimes Center Medical Rate**. Sellers shall have obtained all necessary approvals and waivers from the Connecticut Office of Policy and Management and the Connecticut Department of Social Services, pursuant to Connecticut General Statutes Section 17b-340(a), to prevent the rescission and recovery for affected rate years of any interim Medicaid rate established for Grimes Center, including without limitation, the Grimes Center interim Medicaid rate established effective July 1, 2008; provided, however, that the satisfaction of the condition set forth in this Section 7.11 shall be a condition only to Buyer's obligation to (a) purchase from Grimes Center the Purchased Assets owned by Grimes Center and (b) assume the Assumed Liabilities of Grimes Center.

7.12 [REDACTED]

7.13 Captives' Assets. The aggregate Net Assets of Caritas, Lukan, and HSR as set forth on the certificate delivered pursuant to Section 9.2(u) shall be equal to or greater than $11,700,000 on the Closing Date.

ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS

The obligations of Sellers hereunder are subject to the satisfaction, on or prior to the Closing Date, of the following conditions:

8.1 Representations/Warranties. The representations and warranties of Buyer contained in this Agreement shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

8.2 **Covenants.** Each covenant contained in this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects.

8.3 **Officers' Certificate.** Sellers shall have received from Buyer an officers' certificate, executed by Buyer by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date, stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, that the conditions in Section 8.1 and Section 8.2 have been satisfied.

8.4 **Litigation or Proceedings.** No Litigation or Proceedings before a court or any other governmental agency or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

8.5 **Governmental Approvals.** All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, any Governmental Authority in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

8.6 **Closing Deliveries.** Buyer shall have made the deliveries required to be made by it under Section 9.3.

8.7 **Church Approvals.** All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, the Church in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

ARTICLE 9. CLOSING

9.1 **Closing.** Subject to the satisfaction or waiver of all the conditions set forth in Article 7 and Article 8, the consummation of the sale and purchase of the Purchased Assets contemplated by this Agreement ("**Closing**") shall take place at the offices of Wiggin and Dana LLP, One Century Tower, 265 Church Street, New Haven, Connecticut, at 10:00 a.m., local time, on or before the 60th day following the satisfaction or waiver of the conditions set forth in Article 7 and Article 8 (other than those conditions that are to be fulfilled at Closing) or at such other location and/or on such other date as the parties hereto may mutually designate in writing (the "**Closing Date**"). The Closing shall be effective as of 12:01 a.m., local time, on the day following the Closing Date (the "**Effective Time**").

9.2 **Actions of Sellers at Closing.** At Closing, each Seller, as applicable, shall deposit into escrow with the Title Company Escrow Agent the following:

(a) a copy of the Assignment and Assumption of Leases executed by each Seller, together with necessary consents to such assignments, as applicable;

(b) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by each Seller, as applicable;

(c) copies of the Deeds executed by each Seller, as applicable, together with a signed standard seller's affidavit sufficient for the Title Policies to delete exceptions for third parties in possession (other than the Assumed Leases with respect to the Owned Real Property) and mechanic's liens and a Real Estate Conveyance Tax for each Deed;

(d) copies of resolutions duly adopted by the members and boards of directors of each Seller, authorizing and approving its performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of each Seller;

(e) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that the conditions set forth in Article 7 have been satisfied;

(f) a FIRPTA certificate executed by each Seller, as applicable;

(g) certificates of incumbency for the respective officers or directors, as the case may be, of each Seller executing this Agreement or certificates delivered to Buyer pursuant to this Section 9.2;

(h) all such termination statements and releases as are necessary to remove from the Purchased Assets all Liens and Encumbrances, other than the Permitted Encumbrances;

(i) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that all approvals of each Seller and their Affiliates have been obtained that are necessary to consummate the transactions contemplated by this Agreement;

(j) a written good faith estimate of Sellers setting forth, in sufficient detail acceptable to Buyer, the aggregate amount of Indebtedness of Sellers as of the Closing Date as well as the Retained Liabilities as of the Closing Date (the "**Financial Certificate**");

(k) evidence that all closing conditions set forth in Article 8 of the Caritas SPA have been satisfied or waived in accordance with the terms therein;

(l) evidence that all closing conditions set forth in Article 8 of the Lukan SPA have been satisfied or waived in accordance with the terms therein;

(m) copies of the Transition Services Agreement and Wind Down Services Agreement executed by SRHS;

(n) [REDACTED]

(o) a certified rent roll for each parcel of Owned Real Property under lease to tenants specifying in addition to rent due and owing, any other outstanding amounts due between landlord and tenant, including, without limitation, amounts relating to tenant improvements;

(p) copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed;

(q) a letter to all tenants notifying them of the change of ownership of the Owned Real Property and directing such tenants to pay all future rentals to Buyer or Buyer's designee and further advising tenants that specific security deposits, advance rents and interest thereon, if any, have been transferred to Buyer (the "**Notice to Tenants**"), executed by Sellers;

(r) [REDACTED]

(s) the Wind Down Plan;

(t) copies of the Caritas SPA and Lukan SPA executed by SRHS;

(u) A certificate of the president or chief financial officer of Caritas, Lukan and HSR (solely in his or her capacity as such), dated as of the Closing Date, setting forth the Net Assets as of the Closing Date, presented in substantially the form attached hereto as Exhibit O;

(v) A release from each Seller of all claims and causes of action that any of them may hold against Caritas and Lukan, in such form and substance as SRHS and Buyer shall mutually determine; and

(w) such other certificates, instruments, and documents as Buyer may reasonably request.

9.3 **Actions of Buyer at Closing.** At Closing, Buyer shall deposit into escrow with the Title Company Escrow Agent the following:

(a) (i) an amount equal to the amount required to be paid at Closing in accordance with Section 2.3, (ii) conveyance taxes due in connection with the Deeds, (iii) prorations pursuant to Section 9.4(c), (iv) the cost of the Owner's Title Policy and any endorsements thereto, (v) the cost of recording the Deeds to the Owned Real Property, (vi) Title Company Escrow Agent's fee, and (vii) survey costs;

(b) a copy of the Assignment and Assumption of Leases executed by Buyer;

(c) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by Buyer;

(d) copies of resolutions duly adopted by the governing board of Buyer, authorizing and approving Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of Buyer;

(e) a certificate of Buyer, dated as of the Closing Date and signed by an authorized officer of Buyer, certifying that the conditions set forth in Article 8 have been satisfied;

(f) certificates of incumbency for the respective officers of Buyer executing this Agreement or any certificates delivered to Sellers pursuant to this Section 9.3;

(g) copies of the Transition Services Agreement and Wind Down Services Agreement executed by Buyer;

(h) a Notice to Tenants executed by Buyer;

(i) copies of the Caritas SPA and Lukan SPA executed by Buyer; and

(j) such other certificates, instruments and documents as Sellers may reasonably request.

9.4 **Close of Title Company Escrow.**

(a) The Title Company Escrow Agent will close escrow (the "**Close of Escrow**") on the Closing Date if all conditions specified in this Agreement have been satisfied or waived by (i) delivering the Deeds for recording, with instructions to deliver the Deeds to Buyer after recording, (ii) paying to each appropriate Seller the portion of the Title Company Escrow Funds due to such Seller, by wire transfer of immediately available funds to an account designated by SRHS, (iii) delivering to Sellers the deliveries required to be made by Buyer under Section 9.3 and (iv) delivering to Buyer the deliveries required to be made by Sellers under Section 9.2 (other than the Deed) and a copy of the Deed.

(b) Simultaneously with the Close of Escrow, Seller will deliver to Buyer, outside of the closing escrow, originals or, if originals are not in Sellers' possession, copies of (i) all service contracts assigned to Buyer, (ii) only to the extent in Sellers' possession, certificates of occupancy for the Owned Real Property, and documents evidencing other permits,

licenses, approvals, utility rights, development rights and similar rights related to the Owned Real Property, if any, transferred to Buyer that are in the possession of Sellers, (iii) all Leases and all Guarantees of Leases, if any, (iv) all assignable warranties and Guarantees covering all or any part of the Owned Real Property that are transferred to Buyer, if any, and (v) keys and security codes for all security devices necessary to the operation and maintenance of the Owned Real Property.

(c) Sellers and Buyer shall prorate between them as of the Closing Date all income and expense related to the normal operation, maintenance and repair of the Owned Real Property and, as applicable, the Leased Real Property, with the following clarifications and Encumbrances:

(i) The following are to be apportioned as of 12:01 a.m., local time, on the Closing Date:

(A) Real property and personal property taxes upon the Owned Real Property and Personal Property for the current calendar or fiscal year shall be prorated as of the Closing Date, Sellers' pro rata portion of such taxes shall be based upon taxes actually assessed for the current calendar or fiscal year. If, for any reason, such taxes for the current calendar year have not been assessed on the Owned Real Property, such proration shall be estimated based upon such taxes for the immediately preceding calendar or fiscal year, and thereafter adjusted when actual amounts become available;

(B) With respect to the Owned Real Property, water charges, storm water charges and sewer charges on the basis of the calendar year for which assessed;

(C) With respect to the Owned Real Property, fuel, including steam, oil and coal, if any, at the price charged therefor by Sellers' supplier;

(D) Amounts paid or payable under service contracts and similar agreements affecting the Owned Real Property;

(E) With respect to the Owned Real Property, rents, not in arrears, and any prepaid rent under the Assumed Leases; and

(F) With respect to the Leased Real Property, rents, any prepaid rent, any additional rent, escalations, taxes, utility payments and other payments made under the Real Property Leases.

(ii) Buyer shall be credited at Closing with an amount equal to the security deposits, if any, in connection with the Assumed Leases relating to the Owned Real Property, or Sellers shall turn such security deposits over to Buyer at Closing.

(iii) Sellers shall be credited at Closing with an amount equal to the security deposits, if any, and any utility deposits in connection with the Real Property Leases.

(iv) All charges for electric and gas service supplied to the Owned Real Property prior to the Closing Date shall be the obligation of Sellers, and Sellers agree to pay the invoices rendered in connection with such services promptly upon receipt thereof, whether such receipt is received before or after the Closing.

(v) If there is a water meter on the Owned Real Property, Sellers shall furnish a reading or readings to a date not more than three days before the Closing Date and the unfixed meter charge and sewer rent, if any, shall be apportioned on the basis of such last reading.

(vi) Sellers shall have the option to credit Buyer as an adjustment of the cash portion of the Purchase Price with the amount of any unpaid water charges and sewer rents, together with any interest and penalties thereon.

(vii) Real estate tax refunds and credits received after the Closing Date which are attributable to the fiscal or calendar year during which the Closing occurs shall be apportioned between Sellers and Buyer, after deducting reasonable expenses of collection thereof; provided, that Buyer shall not be obligated to pay Sellers their share of the same to the extent that Buyer determines, in the exercise of its reasonable judgment, that tenants under the Assumed Leases are entitled to the same and Buyer pays the same to such tenants.

(viii) Any errors or omissions in computing apportionments at the Closing shall be corrected as soon after discovery as possible. The provisions of this Section 9.4(c) shall survive the Closing for a period of 12 months.

(ix) Sellers shall forthwith turn over to Buyer any rental, additional rental and any other amounts received by Sellers in respect of the Owned Real Property at any time after the Closing and properly allocable to the period after the Closing. Buyer shall forthwith turn over to the Sellers any rental, additional rental and other amounts received by Buyer in respect of the Owned Real Property and properly allocable to the period prior to the Closing. Buyer shall use reasonable efforts after the Closing for a period of one year to collect delinquent rents for the period up to the Closing Date. If any tenant of Owned Real Property is in arrears in the payment of rent on the Closing Date, rents received from such tenant after the Closing shall be applied in the following order of priority: (A) first to the month preceding the month in which the Closing occurred; (B) then to the month in which the Closing occurred; (C) then to any month or months following the month in which the Closing occurred; and (D) then to the period prior to the month preceding the month in which the Closing occurred. If rents or any portion thereof received by Sellers or Buyer after the Closing are payable to the other party by reason of this allocation, the appropriate sum, less the proportionate share of any reasonable attorneys' fees, costs and expenses of collection thereof,

shall be promptly paid to the other party, which obligation shall survive the Closing. Buyer shall provide to Sellers an accounting of such collection activities 60 days thereafter for a period of one year from the Closing Date. Sellers shall have the right to pursue any delinquent rents for the period up to the Closing Date provided Sellers shall not have the right to commence any dispossess actions against such tenants.

(x) Brokerage commissions and tenant costs shall be apportioned and such obligations shall be assumed by Buyer as set forth on the rent roll for each Owned Real Property, as updated for Closing.

(xi) All prorations and payments to be made under the foregoing provisions shall be made on the basis of a written statement or statements delivered to Buyer by Sellers and approved by Buyer. In the event any prorations, apportionments or computation shall prove to be incorrect for any reason, then either party shall be entitled to an adjustment to correct the same, provided that it makes written demand on the one from who it is entitled to such adjustment within one year after Closing. The provisions of this Section 9.4(c) shall survive the Closing.

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS

10.1 [REDACTED]

10.2 **Preservation of Catholic Heritage.** In light of the parties' understanding of and respect for the commitment of Sellers to the principle that care for the sick, the poor and the dying has deep roots in its Catholic ministry, Buyer will continue to provide patient care at the

Facilities in a manner that respects its Catholic heritage and this ethical principle as described herein. Buyer agrees that it will, after the Effective Time:

(a) cause the appointment of a Catholic Heritage Committee. The Catholic Heritage Committee shall be formed to ensure that the clinical services provided at the Facilities are consistent with the Directives, as adapted to the conditions of modern science and medicine and as deemed appropriate by SOC from time to time. The Catholic Heritage Committee will engage in self-evaluation, education and policy review, and may collaborate with other community organizations around mutually held goals. The Catholic Heritage Committee shall meet no less than twice annually and shall review clinical services provided at the Facilities, including, if applicable, any inquiry made by an employee, physician, patient or other regarding such clinical services. The Catholic Heritage Committee shall be composed of five staff members, including three staff members nominated by SOC. The Yale-New Haven Hospital Executive for Catholic Heritage and Pastoral Care shall serve on the Catholic Heritage Committee as one of the five staff members;

(b) modify the existing Community Advisory Committee in order to continue to support the parties' shared mission to provide services to improve access to health care services by including members nominated by SOC. Such members shall compose not less than 25% of the membership of the Community Advisory Committee;

(c) engage an individual selected by Buyer in consultation with SOC as the Executive for Catholic Heritage and Pastoral Care at the Facilities, whose duties will include mission and values. The Executive shall also have responsibility for Catholic heritage and pastoral care activities at the Facilities and shall be a member of Buyer senior team;

(d) amend the medical staff bylaws, employee code of conduct and other documents, as appropriate and as agreed to by the parties, to state the requirement to adhere to the Directives at the Facilities;

(e) provide annual education for medical staff members and other personnel at the Facilities concerning the Directives;

(f) maintain the Chapel at the Facilities as a place for Catholic, ecumenical and interreligious services as needed and appropriate for the benefit of staff, patients and families, and maintain appropriate signage and other symbols of Catholic identity at the Facilities, including, but not limited to, the name "The Hospital of Saint Raphael in the tradition of the Sisters of Charity of Saint Elizabeth" to the fullest extent permitted by 42 CFR Section 413.65 and other applicable state or federal law. Such Chapel, signage and religious symbols as SOC wishes to remain both within and on the external walls of the Facilities will so remain; provided, however, that in the event such signage and religious symbols cease to be used for any reason, they shall be transferred to SOC; and

(g) host a celebration of Founder's Day at the Facilities on an annual basis in order to honor SOC.

The commitments set forth in this Section 10.2 shall continue except as may be modified in accordance with this paragraph. If, as a result of changes in clinical services or programs,

practices or locations, or as a result of changes in the interpretation of the Directives, Buyer finds, acting reasonably and in good faith, that continued compliance with certain Directives will create a significant operational or patient care burden on Buyer, then Buyer shall work in good faith with the Catholic Heritage Committee to mitigate the burden while preserving the other commitments described in this Section 10.2. If, after working together for a period of at least 90 days, Buyer and the Catholic Heritage Committee have not found a practical way to reconcile mitigation of the burden with compliance with the Directives at issue, then the matter will be presented to Buyer's board of trustees for consideration and resolution. The decision by Buyer's board of trustees with respect to such matter shall be final. SOC may, at any time, terminate the mutual commitments set forth in this Section 10.2 by providing 90 days prior written notice to Buyer's board of trustees. Upon the effect of such termination, SOC may reclaim any religious symbols utilized at the Facilities.

10.3 **Preservation and Access to Records After Closing.**

(a) With regard to patient records relating to the Business, from and after the Effective Time, Buyer shall maintain the patient records held at the Facilities as of the Effective Time relating to periods prior to Closing in accordance with Applicable Law, and in a manner consistent with the policies and procedures of Buyer governing maintenance of patient records generated at the Facilities after the Effective Time.

(b) Each party acknowledges that, as a result of operating the Facilities, it will gain access to patient and other information that is subject to statutes, laws, rules and regulations regarding confidentiality, and agrees to abide by such statutes, laws, rules and regulations with regard to such confidential information.

(c) Each party hereto acknowledges that subsequent to Closing, the other parties may need access to information or documents in the control or possession of such party for the purposes of concluding the transactions contemplated hereby, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, each Seller, on one hand, and Buyer, on the other hand, agree that after Closing each shall make reasonably available to the other's representatives or agents, independent auditors and/or governmental agencies or authorities, upon written request, consistent with Applicable Law, and at the expense of the requesting party, such documents and information as may be available relating to the Business for periods prior and subsequent to Closing to the extent necessary to facilitate concluding the transaction herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

10.4 [REDACTED]

10.5 Tax Matters.

(a) From and after Closing, in connection with the preparation of Tax Returns, audit examinations and any administrative or judicial proceedings relating to any Tax liabilities imposed on any Seller or Buyer for Pre-Closing Tax Periods, Buyer shall cooperate with Sellers, and Sellers shall cooperate with Buyer, including, without limitation, furnishing or making available during normal business hours records, personnel (as reasonably required and at no cost to the other party), books of account, powers of attorney or other materials necessary or helpful for the preparation of such Tax Returns, the conduct of audit examinations, or the defense of claims by Tax authorities as to the imposition of Taxes. From and after Closing, Sellers shall retain all Tax Returns, schedules and work papers and all material records or other documents relating to all Taxes of Sellers for the Pre-Closing Tax Periods until the later of (i) the expiration of the statute of limitations of the taxable periods to which such Tax Returns and other documents relate, without regard to extension, except to the extent notified by another party in writing of such extensions for the respective taxable periods, or (ii) seven years following the due date (without extension) for such Tax Returns, and Sellers shall maintain such Tax Returns, schedules, work papers, records and documents in the same manner and with the same care it currently uses in maintaining its Tax Returns, schedules, work papers, records and documents. Sellers shall give Buyer reasonable written notice prior to destroying or discarding any such books or records and, if the notified party so requests, the notified party shall be permitted to take possession of such books and records. Any information obtained under this Section 10.5(a) shall be kept confidential, except as may be otherwise necessary in connection with the filing of Tax Returns or claims for refund or in conducting an audit or other proceeding.

(b) Buyer shall pay, and indemnify Sellers from and against, to the extent paid by Sellers, any sales, use, transfer, value added, stamp, registration, real property transfer or gains, recording or other similar Taxes, together with any conveyance fees, recording charges and other charges, payable as a result of the transactions provided for by this Agreement. Sellers shall cooperate with Buyer to the extent reasonably requested to reduce or eliminate such Taxes, fees or charges. Buyer and Sellers, as applicable, at Buyer's own expense, shall file or cause to be filed all necessary Tax Returns and other documentation with respect to all such Taxes.

10.6 Sellers' Cost Reports. Sellers shall be solely responsible for and shall prepare and timely file all cost reports and all other filings which are required to be filed with any Governmental Authority under the Medicare, Medicaid or TRICARE programs with respect to the operation of the Business preceding the Effective Time. Sellers shall be solely responsible for any pending or potential audit or examination, and any and all payments, interest, fines and penalties related to any such cost reports and filings.

10.7 [REDACTED]

10.8 **Patient Receivables.**

(a) Sellers hereby authorize Buyer or Buyer's designee, and Buyer agrees to perform or cause its designee to perform, the services specified herein with respect to the Patient Receivables relating to the rendering of services and provision of medicine, drugs and supplies by Sellers after the Effective Date and prior to the Effective Time to patients admitted to the Facilities on or before the Effective Time but from whom payment has not been received as of the Effective Time. In connection therewith, on or before Closing, Buyer and Sellers shall establish an account of Sellers at a financial institution in New Haven, Connecticut selected by Sellers and reasonably acceptable to Buyer. After Closing, the Patient Receivables shall be received in Sellers' name and on Sellers' behalf, and Buyer or its designee shall deposit in such account cash, checks, drafts or other similar items of payment allocable to Sellers' Patient Receivables.

(b) Sellers shall be the owner of the account and shall have control over that account. However, Sellers shall execute a standing transfer order causing amounts on deposit in the account to be swept on a periodic basis (designated by Buyer) to an account owned and controlled solely by Buyer. Amounts deposited into the account are to be swept to Buyer's designated account.

(c) Sellers shall cooperate with Buyer in the execution of such documents, instruments, authorizations and consents as Buyer reasonably may request from time to time to carry out the purposes and intent of this Section 10.8. Neither Buyer nor its designee shall have any duty with respect to the Patient Receivables other than as specifically set forth herein.

10.9 **Return of Payments.** If Sellers or Buyer receives any amount from patients or third-party payors which under the terms of this Agreement, belongs to the other party, the party receiving such amount shall , upon confirmation of ownership of the amount, remit within 10 business days said full amount to the other party.

10.10 **Title.**

(a) Sellers shall be obligated to remove or bond over all liens and monetary encumbrances to title (meaning mortgages and deeds of trust, mechanics liens and judgments) other than non-delinquent real property taxes prior to the Closing and to remove any encumbrances to title created by Sellers between the Effective Date and the Closing Date unless approved by Buyer in writing. Sellers may utilize the closing proceeds to secure release of any such lien or monetary encumbrance.

(b) The title herein required to be furnished by the Seller shall be marketable, subject only to the items set forth in Schedule A of Disclosure Schedule 3.9(a) Part A and the Permitted Encumbrances, and the marketability thereof shall be determined in accordance with those provisions of the Connecticut General Statutes addressing marketability of title and the Standards of Title of the Connecticut Bar Association. Any and all defects in or encumbrances against the title which come within the scope of such provisions of the General Statutes and/or

the Standards of Title shall not constitute valid objections on the part of the Buyer, if such Statutes or Standards do not so provide, and provided the Seller furnishes any affidavits or other instruments which may be required by the applicable Statutes or Standards, and further provided title will be insurable at standard premiums by the Title Company or such other title insurance company licensed in the State of Connecticut reasonably satisfactory to Buyer.

10.11 Property Planning Review.

(a) Buyer shall have the right to conduct, at its sole expense, a property planning review of the Owned Real Property after the Effective Date. Such review may include environmental inspections and site assessments, a survey of the Owned Real Property, a review of the status of compliance of the Owned Real Property with applicable laws, ordinances, codes and regulations, architectural and engineering inspections and tests, soils, building condition, zoning status, real estate tax bills, review of leases, and any and all other matters relating to the Owned Real Property and its condition, legal status and operations and such other tests and inspections as Buyer determines in consultation with Buyer's consultants, subject to the provisions of clause (b) of this Section.

(b) Upon reasonable advance notice to Sellers, Sellers shall grant Buyer, or Buyer's agent, the right to enter upon the Owned Real Property during normal business hours at times mutually acceptable to Buyer and Sellers for the purposes of the performance of any of the inspections, tests or evaluations set forth above. No invasive testing or boring shall be done without prior notification to Sellers of the scope of the invasive testing and Sellers' written permission of the same, which permission shall not be unreasonably conditioned, withheld or delayed. Buyer will not interfere unreasonably with the activity of tenants or any persons occupying or providing service at the Owned Real Property. Buyer shall be liable for any damages resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents during the period of Buyer's inspection, testing of, and access to, the Owned Real Property. Within 30 days following the completion of any such inspections, tests or evaluations or such earlier date in the event this Agreement is terminated, Buyer shall make such repairs and perform such restoration with respect to portions of the Owned Real Property affected by the activities or inspections of Buyer to the same condition as existed prior to such activities or inspections performed by or on behalf of Buyer.

(c) Prior to commencement of any investigative activities on the Owned Real Property, Buyer shall obtain at Buyer's sole cost and expense a policy of commercial general liability insurance with limits of not less than $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage liability, containing the insurer's standard provision regarding waiver of subrogation and shall name Sellers as an additional insureds. Buyer shall provide a certificate of insurance reasonably approved by Sellers, which such approval shall not be unreasonably withheld. Sellers approve GEI as Buyer's enviornmental consultant. Any consultants retained by Buyer shall be reasonably satisfactory to Sellers. If Buyer retains consultants to perform investigative activities on the Owned Real Property, Buyer shall cause consultant(s) to provide certificates of insurance from each consultant prior to entering the Owned Real Property. Consultant(s) certificates of insurance shall provide limits of insurance not less than $1,000,000 combined single limit for bodily injury and property damage

and, if appropriate, professional liability with limits of not less than $1,000,000 and shall name Buyer and Sellers as additional insureds. Certificates of insurance and the insurance carrier providing those certificates shall be reasonably satisfactory to Sellers. Buyer shall also cause such consultants to provide evidence of workmens' compensation insurance and to enter into indemnification agreements in form and substance reasonably acceptable to Sellers.

(d) Buyer shall protect, indemnify, defend and hold the Owned Real Property, Sellers and Sellers' officers, directors, shareholders, participants, affiliates, employees, representatives, invitees, agents and contractors free and harmless from and against any and all claims, damages, liens, stop notices, liabilities, losses, costs and expenses, including reasonable attorney's fees and court costs for personal injury or property damage resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents (collectively, the "**Claims**") including, without limitation, repairing any and all damages to any portion of the Owned Real Property arising out of or related (directly or indirectly) to Buyer's conducting such inspections, surveys, tests, and evaluations, but Buyer shall not be liable for any diminution in Owned Real Property value resulting from Buyer's discovery of any matters by such inspection and testing nor shall Buyer be liable for any existing conditions or for any personal injury or property damage attributable to the negligence or misconduct of Sellers or its representatives. Buyer shall keep the Owned Real Property free and clear of any mechanic's liens or materialmen's liens related to Buyer's right of inspection and the activities contemplated by this Section. Notwithstanding anything to the contrary contained in this Agreement, the Buyer's indemnification obligations set forth herein shall survive the Closing or termination of this Agreement prior to the Closing for a period of two years.

10.12 Confidentiality. It is understood by the parties hereto that this Agreement, the information, documents and instruments exchanged by the parties or the parties' agents in connection with the transactions contemplated hereby, and the information, documents and instruments delivered in connection with the transactions contemplated hereby (collectively, the "**Confidential Information**") are of a confidential and proprietary nature. Each of the parties hereto agrees that, to the extent permitted by Applicable Law, both prior and subsequent to Closing, they shall maintain the confidentiality of the Confidential Information and, without the prior written consent of the other party, shall disclose the Confidential Information only to their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them and applicable Governmental Authorities), exercising the same care in handling such Confidential Information as would be exercised by such party in connection with similar information of its own. Each of the parties hereto further agrees that if the transactions contemplated hereby are not consummated or if this Agreement is terminated in accordance with its terms, it shall return any and all written Confidential Information and all copies thereof in the possession of their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them) to the other party to this Agreement at such other party's request. Each of the parties hereto recognizes that any breach of this Section 10.12 would result in irreparable harm to the other parties to this Agreement and their Affiliates and that therefore either 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 their other legal and equitable remedies. Prior to Closing, except as otherwise required by law or legal process, any release to the public of information respecting the matters set forth herein (including, without limitation, press releases and other media

contacts), will be made only in the form and manner approved by the parties and their respective counsel (which approval may be withheld only for good reason or cause). If Closing fails to occur for any reason or if this Agreement is terminated in accordance with its terms, the parties hereto agree to keep confidential and not disclose the Confidential Information for a period of five years from the Effective Date.

10.13 Tail Insurance.

(a) At Buyer's expense, Sellers shall arrange or shall cause its Affiliates to arrange for Buyer to either (i) purchase tail insurance policies for the insurance policies listed in Section 10.13(a) of the Disclosure Schedule providing continued coverage for a period of three years following the Closing (the "**Tail Insurance Policies**"), or (ii) be named as an additional insured on the Tail Insurance Policies. Buyer shall be entitled to file claims and receive payment pursuant to the terms of the Tail Insurance Policies after Closing.

(b) Except as otherwise agreed to by Buyer, HSR shall cause Lukan to offer a Tail Insurance Policy to each Physician (other than Physicians employed by Sellers) on commercially reasonable terms and conditions.

10.14 Press Releases. Buyer and Sellers shall jointly determine and agree upon the form, timing and content of all public announcements, press releases or other public statements concerning the transactions described in this Agreement, and neither Buyer nor Sellers shall independently make such statements without the prior consent of the other.

10.15 Compliance with the Transfer Act. Buyer and Sellers acknowledge that the property located at 1450 Chapel Street, New Haven is an "establishment" as that term is defined in the Transfer Act. Buyer agrees to be solely responsible for compliance with the Transfer Act and the performance of all obligations under the Transfer Act and specifically covenants to perform the following acts:

(a) determine the applicability of the Transfer Act;

(b) sign and file any appropriate Transfer Act form with the Connecticut Department of Environmental Protection as a "Certifying Party" and make all required submissions in connection with the Transfer Act;

(c) pay any Transfer Act form filing fee and all other related fees and costs; and

(d) conduct any additional environmental assessment, remediation and/or monitoring that may be required pursuant to the Transfer Act.

10.16 Post Effective Time Operations. From the Effective Time through the winding down of the affairs of each Seller, each such Seller shall:

(a) wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) conduct and provide to Buyer a quarterly update of the Wind Down Plan;

(c) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between and Seller and any of the foregoing;

(d) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the final annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year; and

(e) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be immediately provided to Buyer.

10.17 Post Effective Time Negative Covenants. Without limiting the generality or effect of Section 10.16, from the Effective Time through the winding down of the affairs of each Seller, no such Seller shall, except in accordance with the Wind Down Plan or with the written consent of Buyer:

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) acquire, make any investment in, or make any capital contributions to any Person;

(c) acquire or lease any material assets;

(d) sell, lease or otherwise dispose to a third party of any assets;

(e) (i) incur any Indebtedness or (ii) make any loans or advances to any Person;

(f) enter into any compromise or settlement of any Litigation or Proceeding involving a payment by any Seller exceeding $50,000;

(g) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(h) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables;

(i) enter into any agreement that restrains, limits or impedes any Seller's authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(j) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates; or

(k) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 10.17.

10.18 Restrictive Covenants.

(a) Sellers recognize and acknowledge that: (i) Buyer's entering into this Agreement is induced because of the covenants and assurances made by Sellers hereunder; (ii) the covenant not to compete of Sellers and their Affiliates is necessary to insure the continuation of the business of Buyer in respect of the Purchased Assets subsequent to Closing; and (iii) irreparable harm and damage will be done to Buyer in the event that any Seller or any of their Affiliates compete with Buyer within the area or areas specified in this Section 10.18. Therefore, in consideration of the premises and as a necessary inducement for Buyer to enter into this Agreement and consummate the transactions set forth herein, Sellers, on their own behalf and on behalf of their Affiliates (collectively, the "**Restricted Entities**"), agree that for a period of five years from and after the Closing Date (the "**Noncompete Period**"), the Restricted Entities shall not, directly or indirectly, in any capacity own, manage, operate, control, participate in the management or control of, be employed by, extend credit to, provide consulting services for or maintain or continue any interest whatsoever in any enterprise that is located within 35 miles of any of the Facilities and which is engaged in any health care services other than community outreach services provided without reimbursement as part of a charitable, educational or religious mission.

(b) Sellers agree and acknowledge that the restrictions contained in this Section 10.18 are reasonable in scope and duration, and are necessary to protect Buyer. If any Seller breaches or violates any provision of this Section 10.18, the Noncompete Period shall be extended by the amount of time that such breach or violation continues, as determined by Buyer in its reasonable discretion. Sellers agree and acknowledge that any breach of this Section 10.18 will cause irreparable injury to Buyer and upon any breach or threatened breach of any provision of this Section 10.18, Buyer shall be entitled to injunctive relief, specific performance or other equitable relief, without the necessity of posting bond; provided, however, that this shall in no way limit any other remedies which Buyer may have as a result of such breach, including the right to seek monetary damages. Sellers further acknowledge and agree that the payment of the Purchase Price shall constitute, among other things, full consideration for the restrictive covenants contained in this Section 10.18. The parties agree that Buyer may assign, without limitation, the foregoing restrictive covenants to any successor of Buyer. The provisions of this Section 10.18 shall be construed as an agreement on the part of Sellers independent of any other part of this Agreement or any other agreement, and the existence of any claim or cause of action of any Seller against Buyer, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement by Buyer of the provisions of this Section 10.18.

ARTICLE 11. TERMINATION

11.1 [REDACTED]

11.2 [REDACTED]

11.3 [REDACTED]

11.4 [REDACTED]

11.5 [REDACTED]

ARTICLE 12. INDEMNIFICATION

12.1 **Indemnification by Sellers.** Subject to the other provisions of this Article 12, from and after the Closing Date, Sellers, jointly and severally, shall defend and indemnify Buyer and its Affiliates (the "**Buyer Indemnified Parties**") and hold the Buyer Indemnified Parties wholly harmless from and against any and all Losses that a Buyer Indemnified Party incurs as a result of (i) any breach of any representation and warranty of any Seller contained in this Agreement; (ii) any breach of any covenant of any Seller contained in this Agreement; (iii) any failure of any Seller to pay, perform or otherwise satisfy or discharge any of the Retained Liabilities; (iv) the ownership of the Purchased Assets, the operation of the Facilities and the conduct of the Business prior to the Effective Time; and (v) any breach of any representation, warranty or covenant of HSR contained in (A) the Lukan SPA or (B) the Caritas SPA.

12.2 **Indemnification by Buyer.** Subject to the other provisions of this Article 12, from and after the Closing Date, Buyer shall defend and indemnify Sellers and its Affiliates (the "**Seller Indemnified Parties**") and hold the Seller Indemnified Parties wholly harmless from and against any and all Losses that a Seller Indemnified Party incurs as a result of or with respect to (a) any breach of any representation and warranty of Buyer contained in this Agreement, (b) any breach of any covenant of Buyer contained in this Agreement, (c) any failure of Buyer to pay, perform or otherwise discharge any of the Assumed Liabilities, except to the extent that such

Losses arise from events that entitle a Buyer Indemnified Party to indemnification by Sellers pursuant to Section 12.1.

12.3 **Time and Amount Limitations.**

(a) The representations and warranties made by the parties in or pursuant to this Agreement (except Section 3.1, Section 3.2, Section 3.6, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a)) or in any document delivered pursuant hereto shall survive the Closing until, and will expire upon, the second anniversary of the Closing Date; provided, however, that the representations and warranties made in Section 3.6 shall survive the Closing until, and will expire upon, the fourth anniversary of the Closing Date; provided, further, that the representations and warranties made in Section 3.1, Section 3.2, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a) shall survive until the expiration of the applicable statute of limitations with respect to the subject matter relating thereto. All covenants and agreements made or created herein shall, unless otherwise specifically provided herein, survive the Closing.

(b) Except as specified in Section 12.3(f), the aggregate liability of any Seller for indemnification pursuant to Section 12.1(i) or Section 12.1(iv) shall not exceed the Purchase Price (the "**Maximum Liability Amount**"), and the aggregate liability of Buyer for indemnification pursuant to Section 12.2 shall not exceed the Maximum Liability Amount.

(c) Except as specified in Section 12.3(f), no claim for indemnification pursuant to this Article 12 shall be made unless the Losses incurred by Sellers or Buyer (as applicable) as a result of a single breach (or, multiple breaches arising from the same facts or circumstances) exceed $50,000 (the "**De Minimis Threshold**"). Notwithstanding the foregoing, no Seller will have any liability to any one or more of the Buyer Indemnified Parties until the aggregate amount payable by Sellers to the Buyer Indemnified Parties in respect of all such Losses sustained by such Buyer Indemnified Parties exceeds $1,600,000 (the "**Basket Amount**"), in which case the Sellers will be obligated to indemnify the Buyer Indemnified Parties for the aggregate amount of all such Losses, regardless of the De Minimis Threshold.

(d) Neither Sellers nor Buyer shall have any obligation or liability under Section 12.1 or Section 12.2, respectively, with respect to any Losses that are caused, contributed to or exacerbated by the actions of Buyer Indemnified Parties (in the case of Sellers' indemnification obligations and liabilities) or Seller Indemnified Parties (in the case of Buyer's indemnification obligations and liabilities). Any exclusion, recovery or offset contemplated by the immediately preceding sentence shall reduce the amount of Losses incurred by any Indemnified Party for all purposes of this Agreement, including Section 12.3(c).

(e) After Closing, except for any nonmonetary, equitable relief to which either of the parties hereto may be entitled and except for the rights and remedies to which either of the parties hereto may be entitled based on a claim against the other for fraud in connection with the execution and delivery of this Agreement or the consummation of the transactions contemplated hereby, the rights and remedies set forth in this Article 12 shall constitute the sole and exclusive rights and remedies of the parties hereto under or with respect to the subject matter of this Agreement.

(f) Notwithstanding anything contained in this Agreement to the contrary, the limitations on recovery of Losses set forth in this Section 12.3 shall not apply to reduce the obligation of Sellers to (i) make payments or deliver checks or funds under Section 10.8, or (ii) indemnify the Buyer Indemnified Parties under Section 12.1(ii), Section 12.1(iii) or 12.1(v). It is the intent of the parties that any payment required to be made pursuant to such sections shall not be limited by this Section 12.3.

12.4 **Notice and Control of Litigation.**

(a) Notice of Asserted Liability. As soon as is reasonably practicable after a Seller Indemnified Party or a Buyer Indemnified Party becomes aware of any direct or third party claim that such party has under this Article 12 that may result in Losses for which such party is entitled to indemnification hereunder (a "**Liability Claim**"), such party (the "**Indemnified Party**") shall give notice of such Liability Claim (a "**Claims Notice**") to the other party (the "**Indemnifying Party**"). A Claims Notice must describe the Liability Claim in reasonable detail and must indicate the amount, calculated in good faith and to the extent feasible, of the Losses that have been or may be suffered by the Indemnified Party. No delay in or failure to give a Claims Notice by the Indemnified Party to the Indemnifying Party pursuant to this Section 12.4(a) will adversely affect any of the other rights or remedies that the Indemnified Party has under this Agreement or alter or relieve the Indemnifying Party of its obligation to indemnify the Indemnified Party to the extent that such delay or failure has not materially prejudiced the Indemnifying Party.

(b) Opportunity to Defend. The Indemnifying Party has the right, exercisable by written notice to the Indemnified Party within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12, to assume and conduct the defense of such Liability Claim in accordance with the limits set forth in this Agreement with counsel selected by the Indemnifying Party and reasonably acceptable to the Indemnified Party, provided that the (i) defense of such Liability Claim by the Indemnifying Party will not, in the reasonable judgment of the Indemnified Party, have a material adverse effect on the Indemnified Party; (ii) the Liability Claim solely seeks (and continues to seek) monetary damages; (iii) the Liability Claim does not include criminal charges; and (iv) the Indemnifying Party expressly acknowledges in writing its responsibility for all Losses relating to such Liability Claim (the conditions set forth in clauses (i) through (iv) are, collectively, the "**Litigation Conditions**"). If the Indemnifying Party does not assume the defense of a Liability Claim in accordance with this Section 12.4(b) within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12 the Indemnified Party may continue to defend the Liability Claim. The Indemnifying Party or the Indemnified Party, as the case may be, has the right to participate in (but not control), at its own expense, the defense of any Liability Claim that the other is defending as provided in this Agreement. The Indemnifying Party, if it has assumed the defense of any Liability Claim as provided in this Agreement, may, with the prior written consent of the Indemnified Party, not to be unreasonably withheld, consent to a settlement of, or the entry of any judgment arising from, any such Liability Claim; provided, however, that the Indemnifying Party may not consent to any such settlement or judgment to the extent that any such settlement or judgment (I) does not include as an unconditional term thereof the giving by the claimant or

the plaintiff to the Indemnified Party of a complete and irrevocable release from all liability in respect of such Liability Claim, (II) grants any injunctive or equitable relief or (III) may reasonably be expected to have an adverse effect on the affected business of the Indemnified Party. The Indemnified Party has the right to settle any Liability Claim, the defense of which has not been assumed by the Indemnifying Party.

(c) Jurisdiction; Process. Each party consents to the non-exclusive jurisdiction of any court in which a Proceeding is brought by another Person not party to this Agreement against any Indemnified Party for purposes of any claim that such Indemnified Party may have under this Agreement with respect to the Proceeding or the matters alleged therein. Each party consents and agrees that process may be served on it with respect to such a claim anywhere in the United States of America.

ARTICLE 13. GENERAL

13.1 **Choice of Law.** THE PARTIES AGREE THAT THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF CONNECTICUT, REGARDLESS OF LAWS THAT MIGHT OTHERWISE GOVERN UNDER APPLICABLE PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

13.2 **Assignment.** This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns. No party may assign, delegate or otherwise transfer its rights and obligations under this Agreement; provided, however, Buyer has the right to assign, delegate or otherwise transfer, in whole or in part, its rights and obligations under this Agreement to any of its Affiliates. Notwithstanding the foregoing, to the extent that Buyer assigns, delegates or otherwise transfer any of its rights and obligations to any of its Affiliates, Buyer shall remain liable for the performance of all such rights and obligations in accordance with the terms of this Agreement.

13.3 **Cost of Transaction.** Except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, whether or not the transactions contemplated hereby shall be consummated and except as otherwise provided herein, the parties agree as follows: (a) Sellers shall pay the fees, expenses and disbursements of Sellers and their agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing the consummation of such transaction; and (b) Buyer shall pay: (i) the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing consummation of such transaction; (ii) conveyance taxes due in connection with the Deeds; (iii) prorations pursuant to Section 9.4(c); (iv) the cost of the Owner's Title Policy and any endorsements thereto; (v) the cost of recording the Deeds to the Owned Real Property; (vi) Title Company Escrow Agent's fee; (vii) survey costs; and (viii) all other costs and expenses associated with the transactions contemplated by this Agreement not otherwise expressly set forth in this Section 13.3. Each party shall be responsible for their respective filing fees associated with the Hart-Scott-Rodino Act. Notwithstanding the foregoing and except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, Buyer and Sellers have agreed to bear the fees and expenses of jointly retained consultants as set forth on Exhibit K.

13.4 **Notice.** Any notice, demand or communication required, permitted or desired to be given hereunder shall be in writing and deemed effectively given when personally delivered in hand, or when received if sent by a nationally recognized overnight delivery service, addressed as follows:

Buyer or YNHHS:

Marna P. Borgstrom
President and Chief Executive Officer
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

cc (which shall not constitute notice):

William J. Aseltyne
Senior Vice President and General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Any Seller:

Christopher M. O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System, Inc./Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

cc (which shall not constitute notice):

Janeanne C. Lubin-Szafranski, Esq.
Vice President/General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511-4405

Jeffrey L. Heidt, Esq.
Verrill Dana, LLP
One Boston Place, Suite 2330
Boston, MA 02108

or to such other address, and to the attention of such other person or officer, as any party may designate. Receipt of a courtesy copy shall not be necessary in order for the notice, demand or communication to be deemed to have been effectively given.

13.5 **Severability.** In the event any term or other provision of this Agreement is held by any court or other tribunal of competent jurisdiction to be invalid, illegal or unenforceable for any reason and 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, and enforceable in accordance with its terms so long as the

economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adversely to any party.

13.6 **Gender, Number and Inferences.** 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. 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, any party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such party.

13.7 **Divisions and Headings.** The division of this Agreement into articles and sections 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.

13.8 **No Third-Party Beneficiaries.** The terms and provisions of this Agreement are intended solely for the benefit of the parties hereto and their respective permitted successors or 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, including but not limited to a Sponsoring Organization, any current or former employee of the Sellers, or any labor organization representing any of the Sellers' current or former employees.

13.9 **Entire Agreement.** Unless the context clearly otherwise requires, as used herein, the term "Agreement" means this Agreement, the Exhibits hereto and the Disclosure Schedules, as supplemented in accordance with Section 5.15. This Agreement and the agreements referenced as Exhibits to this Agreement supersede and constitute the entire agreement existing between the parties with respect the subject matter hereof and thereof, and no party shall be entitled to benefits other than those specified herein or therein. As between the parties, no oral statement or prior written material not specifically incorporated herein shall be of any force and effect. The parties specifically acknowledge that in entering into this Agreement and the agreements referenced as Exhibits to this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and the agreements referenced as Exhibits to this Agreement and no others. This Agreement may be amended, supplemented or modified only by an agreement in writing signed by each of the parties hereto. All Exhibits attached to or delivered in connection with this Agreement are integral parts of this Agreement as if fully set forth herein.

13.10 **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.

13.11 **Amendment.** This Agreement may not be amended or modified except with the written consent of all of the parties hereto and compliance herewith may not be waived except in writing by the party waiving compliance.

13.12 **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 other provision hereof. No waiver of any provision or

condition of this Agreement shall be valid unless in writing signed by such party or operational by the terms of this Agreement.

13.13 Other Interpretative Matters. In this Agreement, unless the context otherwise requires: (a) words such as "herein" and "hereof" refer to the entire Agreement and not to a particular article or section of this Agreement; (b) references to articles and sections are references to articles and sections of this Agreement; and (c) references to any party to this Agreement shall include references to its successors and permitted assigns. ALL RELEASES, DISCLAIMERS, LIMITATIONS ON LIABILITY AND INDEMNITIES SET FORTH IN THIS AGREEMENT SHALL APPLY AND OPERATE IN ACCORDANCE WITH THEIR RESPECTIVE TERMS NOTWITHSTANDING ANY SOLE, JOINT AND/OR CONCURRENT NEGLIGENCE, STRICT LIABILITY OR OTHER FAULT OR BASIS FOR LIABILITY OF THE PARTY WHOSE LIABILITY IS RELEASED, DISCLAIMED, LIMITED OR INDEMNIFIED. The Disclosure Schedule referred to herein is hereby incorporated in and made a part of this Agreement as if set forth in full herein.

13.14 Reproduction of Documents. This Agreement and all documents relating thereto, including, without limitation, (a) consents, waivers, amendments and modifications that may hereafter by executed, (b) the documents delivered at Closing and (c) other written information previously or hereafter furnished to any party, may be reproduced by such party by any photographic, photostatic, microfilm, micro-card, miniature photographic or other similar process and the parties may destroy any original documents so reproduced. The parties agree and stipulate that any such reproduction shall be admissible in evidence as the original itself in any Litigation or Proceeding (whether or not the original is in existence and whether or not such reproduction was made by any party in the regular course of business) and that any enlargement, facsimile or further reproduction of such reproduction shall likewise be admissible in evidence.

13.15 Waiver of Jury Trial. Each of the parties hereto hereby knowingly, voluntarily and intentionally, after opportunity for consultation with independent counsel, waives its right to trial by jury in any action or proceeding to enforce or defend any rights or obligations under this Agreement. No party hereto will seek to consolidate any such action in which a jury trial has been waived with any other action in which a jury trial has not been or cannot be waived. The provisions of this Section 13.15 have been fully negotiated by the parties hereto, and these provisions shall be subject to no exceptions. No party hereto has in any way agreed with or represented to any other party that the provisions of this Section 13.15 will not be fully enforced in all instances; and this Section 13.15 is a material inducement for the Buyer to enter into this Agreement.

13.16 Time of the Essence. The parties agree that time is of the essence in the execution and performance of this Agreement.

[*Remainder of page intentionally left blank. Signature pages follow.*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers or directors, as the case may be, all as of the Effective Date.

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

By: _____
Name: _____
Title: _____

SAINT REGIS HEALTH CENTER, INC. D/B/A SISTER ANNE VIRGINIE GRIMES HEALTH CENTER

By: _____
Name: _____
Title: _____

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC. D/B/A AFFILIATED PHYSICIANS OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

DEPAUL HEALTH SERVICES CORPORATION, INC.

By: _____
Name: _____
Title: _____

SAINT RAPHAEL FOUNDATION, INC.

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HEALTH SERVICES CORPORATION D/B/A YALE NEW HAVEN HEALTH SYSTEM

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: _____
Title: _____

EXHIBIT A

Facilities and Service Lines 2011

Property Location	HOSPITAL SERVICES
NEW HAVEN	
CHAPEL STREET	SERVICE LINES
1450 Chapel Street	Inpatient/Outpatient Acute Care Services
	Fr. Michael J. McGivney Center for Cancer Care
	Cyberknife
	Looking Forward/Project Brotherhood
	Family Health Center
	Smiles to Go Dental Van
1441 Chapel Street	Chapel Pediatrics
	Center for Women's Health & Midwifery
1294 Chapel Street	Outpatient Psych Services
1354 Chapel Street New Haven, CT	St. Regis d/b/a Sr. Anne Virginie Grimes Health Center (skilled nursg facility)
	Senior Assessment Center
1401 Chapel Street New Haven, CT	Women, Infants & Childrens (WIC)Program
ORCHARD STREET	
200 Orchard Street	Comm Health & Outreach/Carecard
330 Orchard Street	Priority Testing Center
	Center for Obesity Surgery (suite 309)
	Women's Center for Breast Health
	Wound and ID Clinic
	Trauma Clinic/Orch Surg Specialists
	Magnetic Resonance Imaging (MRI)
	Gastroenterology Outpt Clinic
	Gynecology Clinic
	Dermatology Clinic
	Nutrition Clinic
	Oral and Maxillofacial Surgery

Property Location	St Raphael Dialysis Center Partnership
MILFORD	
50 Commerce Park Drive	Outpt Dialysis Services
NORTH HAVEN	
266 State Street North Haven	Outpt Dialysis Services
BRANFORD	
34 East Industrial Road	Outpt Dialysis Services
NEW HAVEN	
137 Water Street	Outpt Dialysis Services

EXHIBIT A

	Orthopedic Clinic									
	Plastic Surgery									
	Foot & Ankle Specialty Clinic									
	Pain Management									
	Minor Operative Procedures									
	Neurology (Suite 205)									
	Podiatry Clinic									
	Prenatal Clinic									
	Surgical Clinic									
	Urology									
	Menopause Center									
	Vascular									
	General Thoracic Surgeons									
	Endocrinology Clinic									
DERBY AVENUE										
170 Derby Avenue	School Based Hlth Clin/Barnard School									
EDGEWOOD AVE										
259 Edgewood Ave	School Based Hlth Clin/Troop School									
GEORGE STREET										
646 George	Child & Adolescent Day Hospital									
SHERMAN AVE										
175 Sherman Ave New Haven	Takeheart/Cardiac Rehab									
	Lunglife									
	Occupational Health Plus									
	Outpatient Rehab Services									
	Cholesterol Management Center									
	Cardiology									
	Pulmonary									
WHALLEY AVE										
1453 Whalley Ave	Amity Patient Service Center (blood-draw)									
TOWERS										
18 Tower Lane #3	Eldercare/Surfside Apartments									
114 Bristol St, 2nd floor	Eldercare/Edith Johnson Towers									
	Project Mothercare Services									
SR CENTER										
26 Atwater Street	Atwater Sr Center/Elderdare									

EXHIBIT A

	Project Mothercare Services								
SYLVAN AVENUE									
135 Sylvan Avenue	Eldercare/Casa Otonal								
HAMDEN									
2080 Whitney Avenue	McGivney Cancer Center								
	Laboratory Pt Service Center								
	Occ Health Plus								
	Outpatient Rehab								
	Eldercare Clinic (held in OHS)								
	Chapel Pediatrics - Hamden Office								
(planning phase)	Cardiology								
(planning phase)	Nuerology								
(planning phase)	Geriatrics								
(planning phase)	Pulmonary								
1100 Sherman Ave	Outpatient Psychiatric Services								
BRANFORD									
84 North Main Street	Occupational Health Plus								
	Outpatient Rehab								
	Priority Testing Center								
	Lunglife Pulmonary Rehab (Suite 200)								
	Sr Assessment Center								
	Midwifery Services								
21 Business Park Dr	Branford Adolescent Day Hospital								
NORTH HAVEN									
163 Universal Drive	Blood Draw Station - Urgent Care Ctr								
ORANGE									
109 Boston Post Rd	Orange Blood Draw Center-Urgent Care								
SHELTON									
2 Ivy Brook Road	Midwifery Services								
	Chapel Pedi (Shelton Location)								
WEST HAVEN									
674 Washington Ave	Project Mothercare								

Attachment IV

Key Personnel CVs

MARNA PARKE BORGSTROM

Home: 458 Three Mile Course
Guilford, Ct. 06437

(203) 453-8782

Business: Yale-New Haven Hospital
20 York Street
New Haven, CT 06510
(203) 688-2608

EDUCATION

1977-1979 Yale University School of Medicine
Department of Epidemiology and Public Health
Program in Hospital Administration, M.P.H.

1972-1976 Stanford University
Bachelor of Arts in Human Biology awarded June, 1976

EXPERIENCE

2005-Present President and Chief Executive Officer: Yale New Haven Health System (YNHHS)

Yale New Haven Health System is a regional, integrated health care delivery system composed of three local health care delivery networks,as well as a physician foundation, Northeast Medical Group. Anchored by Yale-New Haven Hospital, the Yale-New Haven Children's Hospital, and the Yale-New Haven Psychiatric Hospital totaling 1008-beds, the System includes a Bridgeport network led by the 425-bed Bridgeport Hospital and a Greenwich network anchored by 180-bed Greenwich Hospital. Westerly Hospital (Rhode Island) is a network participant.

Feb. 2012 - Present Chief Executive Officer: Yale-New Haven Hospital and Delivery Network (YNHH)

2005- Feb. 2012 President and Chief Executive Officer: Yale-New Haven Hospital and Delivery Network (YNHH)

Yale-New Haven, a private not-for-profit 1008-bed hospital founded in 1826. It serves as the primary teaching hospital for the Yale University School of Medicine and provides tertiary and quaternary patient care for patients referred, as well as general acute care services for the Greater New Haven metropolitan area.

1993-2005 Executive Vice President & Chief Operating Officer: Yale-New Haven Hospital
Executive Vice President and Secretary: Yale-New Haven Health Services Corporation

Responsible for New Haven Delivery Network operations including Yale-New Haven Hospital operations, finance, human resources and planning and marketing; and Yale-New Haven Ambulatory Services Corporation, which operates two independent surgery centers and a large, full-service radiology business in New Haven and Guilford. Served as the senior Hospital interface for Yale School of Medicine operational issues.

Represented the YNHH Delivery Network in all Health System strategic and operational activities.

1992-1993 Senior Vice President, Administration: Yale-New Haven Hospital
Senior Vice President and Secretary: Yale-New Haven Health Services Corporation

Responsible for Hospital strategic planning and marketing, facilities planning and design, risk management and medicolegal affairs, managed care contracting, Service Quality Improvement, Community Relations, Public Affairs and Engineering.

Project Executive for implementation of Yale-New Haven's $156 million Facilities Renewal Project.

1985-1992 Vice President, Administration: Yale-New Haven Hospital

Responsible for Hospital strategic planning and marketing, facilities planning and design, risk management and medicolegal affairs, managed care contracting, Service Quality Improvement, Community Relations, Public Affairs and Engineering. Provided administrative leadership to Yale-New Haven Health Services Corporation corporate affairs and strategic initiatives.

1984-1985 Assistant Vice President: Yale-New Haven Hospital

Directed the development and implementation of annual Hospital business plan format derived from strategic plan. Completed $6 million renovation of Hospital clinical laboratories. Represented Hospital on underwriting and eligibility and finance activities in malpractice insurance captive.

Dec. 1982-1984 Associate Administrator: Yale-New Haven Hospital

Responsible for Hospital planning activities, including Strategic Planning and general facilities planning and related capital budget activities. Also responsible for Clinical Laboratories ($23 million gross revenue and $11 million expense) and Risk Management and Medicolegal Affairs.

Dec. 1980-Nov. 1982 Assistant Administrator: Yale-New Haven Hospital

Responsible for planning and implementing $11 million renovation program done in concert with major facility replacement project, and for planning and overseeing the move of five major departments and three clinical services (including 80 ICU beds) to a new $73 million facility, during the Spring of 1982. Prepared and presented to the Health Systems Agency and Commission on Hospitals and Health Care, three Certificates of Need; all were approved. Also responsible for Hospital space planning and management, and provided general staff support to the Executive Vice President.

Jan. 1980-Dec. 1980 Administrative Associate: Yale-New Haven Hospital

Provided general staff support to Executive Vice President. Major activities included employee fundraising and campaign to support $73 million facility replacement and renovations program (50% of Hospital employees contributed almost $500,000) and preparation of capital and operating budget materials.

Jan. 1979-Dec. 1980 Administrative Resident: Yale-New Haven Hospital

Summer 1978 Administrative Intern: Alexian Brothers Hospital, San Jose, California

PROFESSIONAL AWARDS:

1992 Up and Comers Award - Sponsored by Modern Healthcare and 3M Health Systems
Women In Leadership Award, 1993 - YWCA
Junior Achievement Hall of Fame, 1998
20 Noteworthy Women, New Haven Business Times, 1999
Gateway Community College Hall of Fame, 2002

Hill Health Center Leadership Award, 2006
Connecticut Women in Leadership, 2009 (Women & Families Center Award)
Girl Scouts of Connecticut Women of Achievement Award, 2010
Anti-Defamation League Torch of Liberty Award, 2010
Business New Haven's Business Person of the Year, 2010
American Hospital Association 2010 Grassroots Champion Award
Doctor of Humane Letters, Quinnipiac University, 2011

MAJOR PROFESSIONAL AFFILIATIONS, BOARDS AND ACTIVITIES:

Yale-New Haven Hospital Board of Trustees (1994 – present)
Yale New Haven Health System Board of Directors (2005 - present)
The Connecticut Hospital Association, Chair, Board of Trustees (2008-2010); Vice Chair (2006-2008); Member, Executive Committee (2006-), Secretary and Member, Executive Committee (1999-2001)
VHA, Inc. (Dallas, Texas), Board of Directors (2009 -)
Council of Teaching Hospitals (COTH) Administrative Board (2008 - present); Chair-elect (2010)
Healthcare Executives Study Society (2006-present)
Greater New Haven Regional Leadership Council (2005-present)
The Hole in the Wall Gang Camp Board of Directors (2007 - 2010)
Northwestern Mutual Policyowners' Examining Committee (2009)
Fellow – American College of Healthcare Executives
Association of American Medical Colleges Board of Directors, 2010-present
Coalition to Protect America's Health, 2011-present

University Appointments

Yale University – Lecturer, Department of Epidemiology & Public Health, Health Policy & Administration Division.

PERSONAL:
Married: Eric N. Borgstrom (5/27/78)
Children: Christopher (4/14/85) and Peter (8/4/89)

CURRICULUM VITAE

RICHARD D'AQUILA
282 Boston Post Road
Westbrook, CT 06498
Telephone: (860) 669-0871

PERSONAL DATA:
Married
U.S. Citizen
Birth Date: 6/29/55

BUSINESS ADDRESS:

Yale-New Haven Hospital
20 York Street
New Haven, CT 06510
Telephone: (203)-688-2606

PROFESSIONAL EXPERIENCE:

February, 2012

President and Chief Operating Officer
Yale-New Haven Hospital
Executive Vice President
Yale New Haven Health System

May, 2006 to
February, 2012

Executive Vice President and Chief Operating Officer
Yale-New Haven Hospital/Yale New Haven Health System

Organizational Profile
Yale New Haven Health System (YNHHS) is a 1545-bed delivery network formed in 1995 which consists of Yale-New Haven, Bridgeport and Greenwich Hospitals. YNHHS has revenues in excess of $1.1 billion in FY '05 based on 80,000 discharges and 1.3 million outpatient visits. Yale-New Haven Hospital is a 944-bed tertiary referral medical center that includes the 201-bed Yale New Haven Children's Hospital and the 76-bed Yale New Haven Psychiatric Hospital. Both Yale New Haven Health System and Yale-New Haven Hospital are formally affiliated with Yale University School of Medicine.

Responsibilities
Overall responsibility for all aspects of day to day operations for Yale-New Haven Hospital (YNHH) and the senior network leader at the Yale New Haven Health System representing the YNHH delivery network. Hospital leadership responsibilities include direct accountability for the senior leadership team, strategic planning, organizational performance, quality improvement, labor relations and human resources management, system integrations, external relations and service line development. Senior leadership and implementation responsibility for all aspects of the hospital's annual business (operating) plan. Senior level oversight of the hospital's facility plan including

construction of a 112-bed, $450 million Comprehensive Cancer Pavilion commencing construction in the fall of 2006.

August, 2000 to April, 2006

Senior Vice President/Chief Operating Officer
New York Presbyterian Hospital/
Weill Cornell Medical Center
New York, New York

Organizational Profile
New York Presbyterian Hospital is a 2,369 bed Academic Medical Center created from the merger between the New York Hospital and the Presbyterian Hospital in the City of New York. The Weill Cornell Medical Center consists of an 880 bed acute care facility in Manhattan and the 239 bed Westchester Division campus in White Plains specializing in behavioral health.

Responsibilities
Overall responsibility for all aspects of day to day operations for the Weill Cornell Medical Center and the Westchester Division, a two campus Academic Medical Center of 1120 beds. Direct responsibility for a total operating expense budget in excess of $450,000,000 and revenues of $850,000,000. Senior leadership and implementation for all aspects of the Medical Center's operating plan including quaternary and tertiary service development, medical staff relations and recruitment, employee relations and labor strategy. System level member of the Corporate Management Team with involvement in strategic and facilities planning, service line development, information technology and performance improvement.

May 1992 to June 2000

Executive Vice President/Chief Operating Officer
St. Vincent's Medical Center
Bridgeport, Connecticut

President
Vincentures, Inc.

President
St. Vincent's Development Corporation, Inc.

Chief Operating Officer of 391 bed, university-affiliated acute care hospital and health system. President/CEO of affiliated subsidiaries with management responsibility at

the Medical Center and corporate level. Medical Center responsibilities including day to day operations oversight for patient care services; support services and facilities planning and development. Corporate responsibilities including information systems, ambulatory network development, managed care contracting network oversight and real estate/satellite facility development.

January 1987-April 1992

President/CEO
Health Initiatives Corporation
Providence, Rhode Island

Chief Executive Officer of a consulting practice specializing in strategic planning, business development and project implementation assistance for acute care and specialty hospitals, state planning agencies and private investors. Specific responsibilities included:

- Practice Leadership
- Engagement Planning and Management
- Project Supervision and Control
- Client Interface
- Practice Marketing and Business Development

June 1984-December 1986

Vice President
The Mount Sinai Hospital Corporation
Hartford, Connecticut

June 1981-June 1984

Vice President, Division of Planning and Community Services
The Mount Sinai Hospital
Hartford, Connecticut

June 1979-June 1981

Assistant Executive Director
The Mount Sinai Hospital
Hartford, Connecticut

January 1979-May 1979

Administrative Resident
The Mount Sinai Hospital
Hartford, Connecticut

OTHER APPOINTMENTS:

November 2000
To Present

Member, Board of Directors
Voluntary Hospitals of America/Metro New York
New Rochelle, New York

January 1995- June 2000	**Member, Board of Directors** Goodwill Industries Bridgeport, Connecticut
December 1993- June 2000	**Founding Board Member** Park City Primary Care Center Bridgeport, Connecticut
May, 1992- June 2000	**Member, Board of Directors** St. Vincent's Development Corporation Vincentures, Inc. Omicron, Inc. Connecticut Health Enterprises Bridgeport, Connecticut
January 1992- December 1994	**Member, Board of Directors** Visiting Nurses Association of Fairfield County Bridgeport, Connecticut
January 1989- December 1991	**Member, Board of Directors** Easter Seal Society/Meeting Street Rehabilitation Center, Inc. of Rhode Island Providence, Rhode Island
January 1980- December 1989	**Member, Board of Directors** Combined Hospitals Alcohol Program Hartford, Connecticut
September 1985- December 1986	**President, Board of Directors** Regional Alcohol and Drug Abuse Resources, Inc. Hartford, Connecticut
September 1981- December 1986	**Adjunct Faculty/Lecturer** University of Hartford, Barney School of Business and Public Administration West Hartford, Connecticut
January 2001 - Present	**Adjunct Faculty/Residency Preceptor and Lecturer** Robert F. Wagner Graduate School of Public Service New York University New York, N.Y.
December 2000 - Present	**Adjunct Faculty/Lecturer** Weill Medical College of Cornell University Department of Public Health, New York New York, N.Y.

EDUCATION:

Yale University School of Medicine
Graduate Program in Hospital Administration
Academic Distinctions: Research Excellence Award (1979)
1979 Graduate

Central Connecticut State University
Bachelor of Arts: Economics/Business
Academic Distinctions: Omicron Delta Epsilon
Economics Honor Society
1977 Graduate

PROFESSIONAL AFFILIATIONS:
Fellow, American College of Health Care Executives
Yale Hospital Administration Alumni Association
Connecticut Hospital Association
Habitat of Greater New Haven

CURRICULUM VITAE

NAME: James M. Staten
BIRTHDATE: September 26, 1958
EDUCATION: 1980 – B.S. – Business / Economics / State University College of NY

Yale New Haven Health System (YNHHS) and Yale-New Haven Hospital (YNHH)

October 2000 - Present

Executive Vice President of Finance and Corporate Services, YNHHS
Senior Vice President and CFO, YNHH

Yale New Haven Health system is a regional, integrated health care system composed of three regional health care delivery networks. The New Haven-based delivery system is anchored by Yale-New Haven Hospital, the Yale-New Haven Children's Hospital, and the Yale-New Haven Psychiatric Hospital, which total 944-beds. The system includes a Bridgeport-based delivery system led by the 425-bed Bridgeport Hospital and Greenwich-based delivery system anchored by 160-bed Greenwich Hospital. The System is also affiliated with the Westerly Hospital in Rhode Island. The Yale New Haven Health System has a formal affiliation with the Yale University School of Medicine, as does Yale-New Haven Hospital which serves as the Medical School's primary teaching hospital. System services include acute care hospitals, ambulatory surgery and outpatient diagnostic imaging centers, as well as primary care centers. In total, the System has 1,500 beds, 74,000 admissions, 10,000 employees, assets of $1.6 billion, and annual net revenues of over $1.4 billion.

Responsible for financial and corporate services of YNHHS including managed care, information systems, materials management, admitting/registration, and medical records, as well as all financial responsibilities such as accounting, budgeting, financial and operational reporting, tax, reimbursement, and treasury.

OTHER EMPLOYMENT

New York-Presbyterian Hospital (NYPH) and New York-Presbyterian Healthcare System (NYPHS)

July 1999 – October 2000 Senior Vice President of Finance

Responsible for assuring the financial viability of a $3 billion Health System, including monitoring financial condition of approximately 15 corporately-controlled Sponsored/Member Hospitals and other healthcare related organizations. Report regularly to the NYPHS Board and NYPH Board Executive Committee on financial performance.

January 1997 - June 1999 Vice President of Financial Planning
June 1993 - December 1996 Director of Financial Planning

Responsible for complete integration of financial planning at all Sponsored Hospital Members including NYPH and leading the financial group of approximately 70 professionals in performing budget, reimbursement, managed care contracting, decision support and business plan development functions.

Ernst & Young

January 1991 - June 1993 Senior Manager - Consulting Services

Directed and coordinated Ernst & Young's New York State Reimbursement Consulting Services.

Pannell Kerr Forster

October 1980 – December 1990 Partner

Elected Partner in June 1990 after working 10 years in the firm's large healthcare practice as a certified public accountant. 11th Largest Public Accounting Firm in United States during late 1980s.

PROFESSIONAL MEMBERSHIPS

American Institute of Certified Public Accountants (1982 – 1998)
New York State Society of Certified Public Accountants (1982 – 1996)
- Healthcare Committee (1988 – 1991)
- Chairman of the Hospital Sub-Committee (1990/1991)

Healthcare Financial Management Association (1984 – 1994)
- Chairman of various Committees (1984 – 1994)
- Trustee (1990/1991)
- President Elect (1993/1994)

Greater New York Hospital Association
- Fiscal Policy Committee (1993 – 2000)
- Managed Care Committee (1995 – 2000)

Connecticut Hospital Association
- Finance Committee (2000 – 2004)
- Special Committee on Medicaid Reimbursement (2000 – 2004)

Blue Ribbon Committee on the Future of Healthcare in Connecticut (2000 – 2003)

OTHER PROFESSIONAL ACTIVITIES

Presenter at New Jersey Health Care Financing Authority on Medicare Payment System
Presenter on Hospital Reimbursement Issues for the NYS Society of CPAs
Presenter on Accounts Receivable Issues for the Connecticut Hospital Association
Guest Speaker at NYU's graduate program in Hospital Administration on Healthcare Financing
Guest speaker at Cornell University's Sloan Program in Health Services on Managed Care
Presenter on Mergers and Acquisitions to New York State Hudson Valley HFMA
Guest speaker at Chicago Municipal Bond Analysts Society on New York State Hospital Deregulation
Guest speaker at Yale's School of Epidemiology and Public Management on Health Systems

CURRICULUM VITAE

BIOGRAPHICAL

NAME:	Peter N. Herbert	BIRTHDATE:	December 8, 1941
HOME ADDRESS:	57 Island View Avenue Branford, CT 06405	BIRTH PLACE: CITIZENSHIP:	Troy, New York U.S.A.
BUSINESS ADDRESS:	Yale-New Haven Hospital CB1063 20 York Street New Haven, CT 06504	PERSONAL:	Married, 4 children
BUSINESS PHONE:	(203) 688-2604		
NPI #:	1033191465		

EDUCATION AND TRAINING

UNDERGRADUATE:		
1959-1963	Rensselaer Polytechnic Institute, Troy, NY	B.S., 1963 Biology
GRADUATE:		
1963-1967	Yale University School of Medicine New Haven, CT	M.D., 1967 Medicine Dr. Patrick J. Mulrow, Thesis Advisor
POSTGRADUATE:		
1967-1969	Intern and Resident Yale-New Haven Hospital New Haven, CT	Phillip K. Bondy, M.D. Internal Medicine
1969-1972	Clinical Associate National Heart, Lung and Blood Institute Bethesda, MD	Donald S. Fredrickson, M.D. Robert I. Levy, M.D. Molecular Disease Branch

APPOINTMENTS AND POSITIONS

ACADEMIC:		
1973-1977	Molecular Disease Branch NHLBI Bethesda, MD	Section Chief
1974-1977	Clinical Service Molecular Disease Branch NHLBI Bethesda, MD	Chief
1977-1983	Brown University Providence, RI	Associate Professor
1983-1986	Brown University Providence, RI	Program Director, General Clinical Research Unit, (GCRC)
1983-1990	Brown University Providence, RI	Professor

1986-1990	Brown University Providence, RI	Associate Program Director GCRC and Director, GCRC Nutrition Center
1990-2004	Brown University Providence, RI	Adjunct Professor
1991-Present	Yale University New Haven, CT	Clinical Professor

HOSPITAL APPOINTMENTS:

1977-1990	Miriam Hospital Providence, R.I.	Attending Staff
1990-1995	Miriam Hospital Providence, R.I.	Courtesy Staff
1990-present	Hospital of Saint Raphael New Haven, CT	Attending Staff
1991-present	Yale-New Haven Hospital New Haven, CT	Attending Staff
1993-1999	Veterans Affairs Medical Center West Haven, CT	Attending Staff

NON-ACADEMIC POSITIONS:

1969-1977	United States Public Health Service	Surgeon
1977-1990	The Miriam Hospital Providence, RI	Director, Division of Nutrition & Metabolism
1990-1999	Hospital of Saint Raphael New Haven, CT	Chairman, Department of Medicine
1999-present	Yale-New Haven Hospital	Chief of Staff/Senior Vice President, Medical Affairs
1999-present	Yale-New Haven Health System	Senior Vice President Medical Affairs

SPECIALTY CERTIFICATION:

1972	American Board of Internal Medicine No. 38937

MEDICAL OR OTHER PROFESSIONAL LICENSURE:

1977-1994	State of Rhode Island and Providence Plantations Department of Health No. MD5749
1989-1991	Commonwealth of Pennsylvania No. MD-044076-E
1968-present	State of Connecticut No. 13647

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

American Federation of Clinical Research
American College of Physicians (Fellow) No. 027692 (1972)
American Heart Association (RI Board of Governors)
Council on Epidemiology, AHA (Fellow) (1985)
American Diabetes Association
American Society for Clinical Investigation (1986)
American Association for the Advancement of Science
New York Academy of Sciences
American College of Nutrition (Fellow) (1986)
Society of Behavioral Medicine (Fellow) (1985)

Updated: 7/27/05

PUBLICATIONS

Refereed Articles

1. Philip, B.A., Herbert, P., and Hollingsworth, J.W.: Separation of contaminating pyrogenic material from commercial bovine serum albumin. Proc. Soc. Exp. Biol. Med. 123: 774-778, 1968.

2. Anderson, R.C., Herbert, P.N., and Mulrow, P.J.: A comparison of properties of renin obtained from the kidney and uterus of the rabbit. Am. J. Physiol. 215: 774-778, 1968.

3. LaRosa, J.C., Levy, R.I., Herbert, P.N., Lux, S.E., and Fredrickson, D.S.: A specific apoprotein activation for lipoprotein lipase. Biochem. Biophys. Res. Commun. 41: 57-62, 1970.

4. Herbert, P.N., Levy, R.I., and Fredrickson, D.S.: Correction of COOH-terminal amino acids of human plasma very low density apolipoproteins. J. Biol. Chem. 246: 7068-7069, 1971.

5. Windmueller, H.G., Herbert, P.N., and Levy, R.I.: Biosynthesis of lymph and plasma lipoprotein apoproteins by isolated perfused rat liver and intestine. J. Lipid Res. 14: 215-223, 1973.

6. Herbert, P.N., Shulman, R.S., Levy, R.I., and Fredrickson, D.S.: Fractionation of the C-apoproteins from human plasma very low density lipoproteins: artifactual polymorphism from carbamylation in urea-containing solutions. J.Biol. Chem. 248: 4941-4946, 1973.

7. Levy, R.I., Fredrickson, D.S., Stone, N.J., Bilheimer, D.W., Brown, W.V., Glueck, C.J., Gotto, A.M., Herbert, P.N., Kwiterovich, P.O., Langer, T., LaRosa, J., Lux, S.E., Rider, A.K., Shulman, R.S., and Sloan, H.R.: Cholestyramine in type II hyperlipoproteinemia: a double-blind trial. Ann. Int. Med. 79: 51-58, 1973.

8. Krauss, R.M., Herbert, P.N., Levy, R.I., and Fredrickson, D.S.: Further observations on the activation and inhibition of lipoprotein lipase by apolipoproteins. Circ. Res. 33: 403-411, 1973.

9. Shulman, R.S., Herbert, P.N., Fredrickson, D.S., Wehrly, K., and Brewer, H.B., Jr.: Isolation and alignment of the tryptic peptides of alanine apolipoprotein, and apolipoprotein from human plasma very low density lipoproteins. J. Biol. Chem. 249: 4969-4974, 1974.

10. Brewer, H.B., Jr., Shulman, R.S., Herbert, P.N., Ronan, R., and Wehrly, K.: The complete amino acid sequence of alanine apolipoprotein (apo C-III), an apolipoprotein from human plasma very low density lipoproteins. J. Biol. Chem. 249-4975-4984, 1974.

11. Herbert, P.N., Windmueller, H.G., Bersot, T.P., and Shulman, R.S.: Characterization of the rat apolipoproteins: I. The low molecular weight proteins of rat plasma high density lipoproteins. J. Biol.Chem. 249: 5718-5724, 1974.

12. Shulman, R.S., Herbert, P.N., Wehrly, K., and Fredrickson, D.S.: The complete amino acid sequence of C-I (apo Lp-Ser), and apolipoprotein from human very low density lipoproteins. J. Biol. Chem. 250: 182-190, 1975.

13. Herbert, P.N., Forte, T.M., Shulman, R.S., LaPiana, M.J., Gong,E.L., Levy, R.I., Fredrickson, D.S., and Nichols, A.V.: Structural and compositional changes attending the ultracentrifugation of very low density lipoproteins. Prep. Biochem. 5: 93-129, 1975.

14. Yee, R.D., Herbert, P.N., Bergsma, D.R., and Biemer, J.J.: Atypical retinitis pigmentosa in familial hypobetalipoproteinemia. Am. J. Ophthalmol. 82: 64-71, 1976.

15. Witters, L.A., Herbert, P.N., Shulman, R.S., Krauss, R.M., and Levy, R.I.: Therapeutic failure in familial type II hyperlipoproteinemia. Metabolism. 25: 1017-1026, 1976.

16. Rosseneu, M., Soetewey, F., Peeters, H., Bausserman, L.L., and Herbert, P.N.: Interaction of the apoproteins of very low density and high density lipoproteins with synthetic phospholipids. Eur. J. Biochem. 70: 285-289, 1976.

17. Papadopoulos, N.M., and Herbert, P.N.: The beta-lipoprotein doublet in type 3 hyperlipoproteinemia. Clin. Chem. 23: 978-981, 1977.

18. Assmann, G., Herbert, P.N., Fredrickson, D.S., and Forte, T.: Isolation and characterization of abnormal high density lipoprotein in Tangier disease. J. Clin. Invest. 60: 242-252, 1977.

19. Musliner, T.A., Church, E.C., Herbert, P.N., Kingston, M.J., and Shulman, R.S.: Lipoprotein lipase cofactor activity of a carboxylterminal peptide of apolipoprotein C-II. Proc. Natl. Acad. Sci. (USA) 74: 5358-5362, 1977.

20. Henderson, L.O., Herbert, R.N., Fredrickson, D.S., Heinen, R.J., and Easterling, J.F.: Abnormal concentration and anomalous distribution of apolipoprotein A-I in Tangier disease. Metabolism. 27: 165-174, 1978.

21. Heinen, R.J., Herbert, P.N., Fredrickson, D.S., Forte, T., and Lindgren, F.T.: Properties of the very low and low density lipoproteins in Tangier disease. J. Clin. Invest. 61: 120-132, 1978

22. Dyck, P.J., Ellefson, R.D., Yao, J.K., and Herbert, P.N.: Adult-onset Tangier disease: I. Morphometric and pathologic studies suggesting delayed degradation of neutral lipids after fiber degeneration. J. Neuropath. & Exptl. Neurol., Vol. XXXVII, No. 2, 119-137, 1978

23. Yao, J.K., Herbert, P.N., Fredrickson, D.S., Ellefson, R.D., Heinen, R.J., Forte, T., and Dyck, P.J.: Biochemical studies in a patient with a Tangier syndrome. J. Neuropath. & Expt1.., Vol. XXXVII, No. 2, 138-154, 1978.

24. Herbert, P.N., Forte, T., Heinen, R.J., and Fredrickson, D.S.: Tangier disease: One explanation of lipid storage. The N. Engl. J. Med. 299: 519-521, 1978.

25. Musliner, T.A., Herbert, P.N., and Church, E.C.: Activation of lipoprotein lipase by native and acylated peptides of apolipoprotein C-II. Biochim. Biophys. Acta 573-: 501-509, 1979.

26. Rosseneu, M., Vercaemst, R., Caster, H., Lievens, M.-J., Van Tornout, P., and Herbert, P.N.: Fluorescence depolarization studies of fluidity and phase transition in human apoprotein phospholipid complexes. Eur. J. Biochem. 96: 357-362, 1979.

27. Herbert, P.N., and Henderson, L.O.: Plasma triglycerides do not regulate high density lipoprotein levels. The Lancet i: 1368-1369, 1979.

28. Musliner, T.A., Herbert, P.N., and Kingston, M.J.: Lipoprotein substrates of lipoprotein lipase and hepatic triglyceride lipase from human post-heparin plasma. Biochim. Biophys. Acta 575: 277-288, 1979.

29. Henderson, L.O., LaGarde, E., and Herbert, P.N.: Artifactual reduction of HDL cholesterol estimates after dextran sulfact-Mg2+ precipitation. Am. J. Clin. Pathol. 73: 664-668, 1980.

30. Thompson, P.D., Cullinane, E., Henderson, L.O., and Herbert, P.N.: Acute effects of prolonged exercise on serum lipids. Metabolism 29: 662-665, 1980.

31. Henderson, L.O., Saritelli, A.L., LaGarde, E., Herbert, P.N., and Shulman, R.S.: Minimal within-day variation of high density lipoprotein cholesterol and apolipoprotein A-I levels in normal subjects. J. Lipid Res. 21: 953-955, 1980.

32. Bausserman, L.L., Herbert, P.N., and McAdam, K.P.W.J.: Heterogeneity of human serum amyloid A. proteins. J. Exp. Med. 152: 641-656, 1980.

33. Cullinane, E., Lazarus, B., Thompson, P.D., Saritelli, A., and Herbert, P.N.: Acute effects of a single exercise session on serum lipids in untrained men. Clin. Chim. Acta l09: 341-344, 1981.

34. Rosseneu, M., Vercaemst, R., Vinaimont, N., Van Tornout, P., Henderson, L.O., and Herbert, P.N.: Quantitative determination of human plasma apolipoprotein A-I by laser immunonephelometry. Clin. Chem. 27: 856-859, 1981.

35. Bausserman, L.L., Herbert, P.N., and McAdam, K.P.W.J.: Serum amyloid A polymorphism in a subject with a naturally occurring inflammatory response. Clin. Chim. Acta 118: 201-207, 1982.

36. Musliner, T.A., Garner, P.A., Henderson, L.O., and Herbert, P.N.: Radioimmunoassay of apolipoprotein A-II. Arteriosclerosis 2: 160-169, 1982.

37. Friedland, M.L., and Herbert, P.N.: Lipoprotein abnormalities associated with a viral syndrome. JAMA 248: 82, 1982.

38. Bausserman, L.L., Saritelli, A.L., Herbert, P.N., McAdam, K.P.W.J., and Shulman, R.S.: NH2-terminal analysis of four of the polymorphic forms of human serum amyloid A proteins. Biochim. Biophys. Acta 704: 556-559, 1982.

39. Ansbacher, L.E., Singsen, B.H., Hosler, M.W., Grimminger, H., and Herbert, P.N.: Familial erythrophagocytic lymphohistiocytosis: an association with serum lipid abnormalities. Pediatrics 102: 270-273, 1983.

40. Shulman, R.S., Herbert, P.N., Capone, R., McClure, D., Hawkins, C., Henderson. L.O., Saritelli, A.L., and Campbell, J.L.: Effects of propranolol on blood lipids and lipoproteins in myocardial infarction. Circulation 67:6 Part 2: I-19-21, 1983.

41. Thompson, P.D., Lazarus, B., Cullinane, E., Henderson, L.O., Musliner, T., Eshleman, R., and Herbert, P.N.: Exercise, diet, or physical characteristics as determinants of HDL-levels in endurance athletes. Atherosclerosis 46: 333-339, 1983.

42. Bausserman, L.L., Herbert, P.N., Forte, T., Klausner, R.D., McAdam, K.P.W.J., Osborne, J.C., Jr., and Rosseneu, M.: Interaction of the serum amyloid A proteins with phospholipid. J. Biol. Chem. 258: 10681-10688, 1983.

43. Kantor, M.A., Cullinane, E.M., Herbert, P.N., and Thompson, P.D.: Acute increase in lipoprotein lipase following prolonged exercise. Metabolism 33: 454-457, 1984

44. Rosseneu, M., Vinaimont, N., Musliner, T.A., Bernier, D., Herbert, P.N., and Belpaire, F.: Immunonephelometry of apolipoprotein A-II in plasma. Clin Chem. 30/2: 234-237, 1984.

45. Thompson, P.D., Cullinane, E., Eshleman, R., and Herbert, P.N.: Lipoprotein changes when a reported diet is tested in distance runners. Am. J. Clin. Nutr. 39: 368-374, 1984.

46. Bausserman, L.L., and Herbert, P.N.: Degradation of serum amyloid A and apolipoproteins by serum proteases. Biochemistry 23: 2241-2245, 1984.

47. Thompson, P.D., Cullinane, E.M., Eshleman, R., Sady, S.P., and Herbert, P.N.: Effects of caloric restriction or exercise cessation on the serum lipid and lipoprotein concentrations of endurance athletes. Metabolism 33: 943-950, 1984.

48. Bausserman, L.L., Herbert, P.N., Rodger, R., and Nicolosi, R.J.: Rapid clearance of serum amyloid A from high density lipoproteins. Biochim. Biophys. Acta 792: 186-191, 1984.

49. Follick, M.J., Abrams, D.B., Smith, T.W., Henderson, L.O., and Herbert, P.N.: Contrasting short- and long-term effects of weight loss on lipoprotein levels. Arch. Intern. Med. 144: 1571-1574, 1984.

50. Herbert, P.N., Bernier, D.M., Cullinane, E.M., Kantor, M.A. and Thompson, P.D.: High density lipoprotein metabolism in runners and sedentary men. JAMA 252: 1034-1037, 1984.

51. Thompson, P.D., Cullinane, E.M., Eshleman, R., Kantor, M.A., and Herbert, P.N.: The effects of high carbohydrate and high fat diets on the serum lipid and lipoprotein concentrations of endurance

athletes. Metabolism 33:1003-1010, 1984.

52. Sady, S.P., Cullinane, E.M., Herbert, P.N., Kantor, M.A., and Thompson, P.D.: Training, diet and physical characteristics of distance runners with low or high concentrations of high density lipoprotein cholesterol. Atherosclerosis 53: 273-281, 1984.

53. Jonas, A., Sweeny, S.A., and Herbert, P.N.: Discoidal complexes of A and C apolipoproteins with lipids and their reactions with lecithin: cholesterol acyltransferase. J. Biol. Chem. 259: 6369-6375, 1984.

54. Herbert, P.N., Hyams, J.S., Bernier, D.N., Berman, M.M., Saritelli, A.L., Lynch, K.M., Nichols, A.V., and Forte, T.M.: Apolipoprotein B-I00 deficiency: intestinal steatosis despite apolipoprotein B-48 synthesis. J. Clin. Invest. 76: 403-412, 1985.

55. Thompson, P.D., Kantor, M.A., Cullinane, E.M., Sady, S.P., Saritelli, A., and Herbert, P.N.: Postheparin plasma lipolytic activities in physically active and sedentary men after varying and repeated doses of intravenous heparin. Metabolism 35: 999-1004, 1986.

56. Kantor, M.A., Cullinane, E.M., Sady, S.P., Herbert, P.N., and Thompson, P.D.: Exercise acutely increases HDL-cholesterol and lipoprotein lipase activity in trained and untrained men. Metabolism 36: 188-192, 1987.

57. Herbert, P.N., and Friedland, M.L.: Reversible deficiency of serum high density lipoproteins in Hodgkin's disease. Cancer Investigation 4(4): 301-303, 1986.

58. Sady, S.P., Thompson, P.D., Cullinane, E.M., Kantor, M.A., Domagala, E., and Herbert, P.N.: Prolonged exercise augments plasma triglyceride clearance. JAMA 256: 2552-2555, 1986.

59. Hegele, R.A., Huang, L-S., Herbert, P.N., Blum, C.B., Buring, J.E., Hennekens, C.H., and Breslow, J.L.: Apolipoprotein B-gene DNA polymorphisms associated with myocardial infarction. N. Engl. J. Med. 315: 1509-1515, 1986.

60. Bausserman, L.L., Saritelli, A.L., Van Zuiden, P., Gollaher, C.J., and Herbert, P.N.: Degradation of serum amyloid A by isolated perfused rat liver. J. Biol. Chem. 262: I583-1589, 1987.

61. Zannie, E.E., Zannis, V.I., Blum, C.B., Herbert, P.N., and Breslow, J.L.: Effect of egg cholesterol and dietary fats on plasma lipids, lipoproteins and apoproteins of human subjects consuming natural diets. J. Lipid Res. 28: 518-527, 1987.

62. Chong, K.S., Nicolosi, R.J., Rodger, R.F., Arrigo, D.A., Yuan, R.W., MacKey, J.J., and Herbert, P.N.: Effect of dietary fat saturation on plasma lipoproteins and high density lipoprotein metabolism of the rhesus monkey. J. Clin. Invest. 79: 675-683, 1987.

63. Herbert, P.N., Bausserman, L.L., Lynch, K.M., Saritelli, A.L., Kantor, M.A., Nicolosi, R.J., and Shulman, R.S.: Homologues of the human C and A apolipoproteins in the M.fasicularis (cynomolgus) monkey. Biochemistry 26: 1457-1463, 1987.

64. Stacpoole, P.W., Alig, J., Kilgore, L.L., Ayala, C.M, Herbert, P.N., Zech, L.A., and Fisher, W.R.: Lipodystrophic diabetic mellitus. Investigations of lipoprotein metabolism and the effects of omega-3 fatty acid administration in two patients. Metabolism 37: 944-951, 1988.

65. Smith, S.J., Cooper, G.R., Henderson, L.O., Hannon, W.H., and the Apolipoprotein Standardization Collaborating Group: Alaupovic, P., Assmann, G., Bachorik, P.S., Calvert, G.D., Connelly, P.W., Demacker, P.N.M., Dolphin, P.J., Fruchart, J.C., Gauldie, J., Ginsberg, H., Goldberg, R.B., Havekes, L., Herbert, P.N., et al. An international collaborative study on standardization of apolipoproteins A-I and B. Part I. Evaluation of a lyophilized candidate reference and calibration material. Clin. Chem. 33: 2240-2249, 1987.

66. Thompson, P.D., Cullinane, E.M., Sady, S.P., Flynn, M.M., Bernier, D.N., Kantor, M.A., Saritelli, A.L., and Herbert, P.N.: Modest changes in high-density lipoprotein concentration and metabolism with prolonged exercise training. Circulation 78: 25-34, 1988.

67. Bausserman, L.L., Bernier, D.N., McAdam, K.P.W.J., and Herbert, P.N.: Serum amyloid A and high-

density lipoproteins during the acute phase response. Eur. J. Clin Invest. 18: 619-626, 1988.

68. Thompson, P.D., Cullinane, E.M., Sady, S.P., Chenevert, C., Saritelli, A.L., Sady, M.A., and Herbert, P.N.: Contrasting effects of testosterone and oral anabolic steroids on serum lipoproteins. JAMA 261: 1165-1168, 1989.

69. Sady, S.P., Hanumara, R.C., and Herbert, P.N.: Mathematical models of the relationship between HDL-cholesterol and serum triglycerides: an empirical evaluation. Mathl. Comput. Modeling 12: 1103-1112, 1989.

70. Bausserman, L.L., Sadaniantz, A., Saritelli, A.L., Martin, V.L., Nugent, A.M., Sady, S.P., and Herbert, P.N.: Time course of serum amyloid A response in myocardial infarction. Clin. Chim. Acta 184: 297-306, 1989.

71. Hyams, J.S., Treem, W.R., Andrews, W.S., and Herbert, P.N.: Lipid abnormalities in pediatric hepatic allograft recipients. J. Pediatr. Gastroenterol. Nutr. 9: 441-444, 1989.

72. Terpstra, A.H.M., Nicolosi, R.J., and Herbert, P.N.: In vitro incorporation of radiolabeled cholesterol esters into high and low density lipoproteins. J. Lipid Res. 30: 1663-1671, 1989.

73. Longcope, C., Herbert, P.N., McKinlay, S.M., and Goldfield, S.R.W.: The relationship of total and free estrogens and sex hormone-binding globulin with lipoproteins in women. J. Clin. Endocrin. Metab. 71: 67-72, 1990.

74. Levinson, P.D., Iosiphidis, A.H., Saritelli, A.L., Herbert, P.N., and Steiner, M.: Effects of n-3 Fatty Acids in Essential Hypertension. Am. J. Hypertension. 3:754-760, 1990.

75. Thompson, P.D., Cullinane, E.M., Sady, Stanley P., Flynn, M.M., Chenevert, C.B. and Herbert, P.N. HDL metabolism in endurance athletes and sedentary men. Circulation, 84:140-152, 1991.

76. Thompson, P.D., Gadaleta, P.A., Yurgalevitch, S., Cullinane, E.M. and Herbert, P.N. The effects of exercise and lovastatin on serum creatine kinase activity. Metabolism, 40:1333-1336, 1991.

77. Niaura, R., Herbert, P., Saritelli, A., Goldstein, M., Flynn, M., Follick, M., Gorkin, L., Ahern, D. Lipid and lipoprotein responses to episodic occupational and academic stress. Arch. Intern. Med. 151: 2172-2179, 1991.

78. Buring, J.E., O'Connor, G.T., Goldhaber, S.Z., Rosner, B., Herbert, P.N., Blum, C.B., Breslow, J. and Hennekens, C.H.: Decreased HDL2 and HDL3 cholesterol, apo-AI and apo-AII and increased risk of myocardial infarction. Circulation, 85:22-9, 1992.

79. Niaura, R., Herbert, P.N., McMahon, N., and Sommerville, L.: Repressive coping and blood lipids in men and women. Psychosomatic Medicine, 54:698-706, 1992.

80. Levinson, P.D., McGarvey, S.T., Carlisle, C.C., Eveloff, S.E., Herbert, P.N., and Millman, R.P. Adiposity and cardiovascular risk factors in men with obstructive sleep apnea. CHEST, 103:1336-1342, 1993.

81. Boden, W.E., Moss, A.J., Herbert, P.N., Saritelli, A., Oakes, D., Eberly, S. and the Multicenter Diltiazem Post-Infarction Trial Research Group. Effect of long-term diltiazem administration on serum lipids in post- infarction survivors, Am J Cardiol, 73(7):513-14, 1994.

82. Saliba, B., Herbert, PN. Oxacillin Hepatoxicity in H IV-infected Patients. Ann Int Med, 120(12);1048, 1994.

83. Cullinane, EM, Yurgalevitch S.M., Saritelli, A.L., Herbert, P.N., and Thompson, P.D. Variations in plasma volume affect total and LDL cholesterol concentrations during the menstrual cycle. Metabolism, 44(8): 965-971, 1995.

84. Thompson, P.D., Yurgalevitch, S.M., Flynn, M.F., Zmuda, J.M., Spannus-Martin, D., Saritelli, A., Herbert, P.N. and Bausserman, L. The effect of prolonged exercise training without weight loss on high density lipoprotein metabolism in overweight men. Metabolism 46:217-223, 1997.

85. Bausserman, L.L., Saritelli, A.L., and Herbert, P.N. Effects of stanozolol on serum lipoproteins in hepatic lipase deficiency. Metabolism 46(9):992-996, 1997.

86. Flynn, M.M., Zmuda, J.M., Milosavljevic, D., Caldwell, M.J., and Herbert, P.N. Lipoprotein response to a National Cholesterol Education Program Step II diet with and without energy restriction. Metabolism 48(7):822-826, 1999.

87. Zmuda, J.M., Yurgalevitch, S.M., Flynn, M.M., Bausserman, L.L., Saratelli, A., Spannaus-Martin, D.J., Herbert, P.N., Thompson, P.D. Exercise training has little effect on HDL Levels and Metabolism in Men with Initially Low HDL Cholesterol. Artherosclerosis 137:215-221, 1998.

Reviews, Invited Published Papers, Proceedings of Conference and Symposia, Monographs, Books and Book Chapters

1. Brewer, H.B., Jr., Shulman, R., Herbert, P.N., Ronan, R., and Wehrly, K.: The complete amino acid sequence of an apolipoprotein obtained from human very low density lipoprotein (VLDL). In Zambotti, V., Tettamanti, G., and Arrigoni, M. (Eds.): Glycolipids, Glycoproteins and Mucopolysaccharides of the Nervous System (Advances in Experimental Medicine Biology), New York, Plenum Publishing Corp., 1972, vol. 25, pp. 280-281.

2. Fredrickson, D.S., Lux, S.E., and Herbert, P.N.: The apolipoproteins. In Holmes, W., Paoletti, R., and Kritchevsky, D. (Eds.): Pharmacological Control of Lipid Metabolism (Advances in Experimental Medicine & Biology), New York, Plenum Publishing Corp., 1972, vol. 26. pp. 25-56.

3. Levy, R.I., Fredrickson, D.S., Shulman, R., Bilheimer, D.W., Breslow, J.L., Stone, N.J., Lux, S.E., Sloan, H.R., Krauss, R.M., and Herbert, P.N.: Dietary and drug treatment of primary hyperlipoproteinemia. Ann. Int. Med. 77: 267-294, 1972

4. Herbert, P.N., and Frederickson, D.S.: The hypobetalipoproteinemias. In Schettler, G., Greten, H., Schlierf, G., and Swidel, D. (Eds.): Handbuch der Inneren Medizin 7/4: Fettstoffwechsel, Heidelberg, Springer-Verlag, 1976, pp. 485-521.

5. Herbert, P.N.: Hyperlipoproteinemia: a return to the basics. In Rose, L., and Lavine, R. (Eds.): New Concepts in Endocrinology and Metabolism, New York, Grune & Stratton, Inc., 1977, pp. I53-I66.

6. Herbert, P.N., Gotto, A.M., and Fredrickson, D.S.: Familial lipoprotein deficiency (abetalipoproteinemia, hypobetalipoproteinemia and Tangier disease). In Stanbury, J.B., Wyngaarden, J.B., and Frederickson, D.S. (Eds.): The Metabolic Basis of Inherited Disease, New York, McGraw-Hill, 1978, pp. 544-588 (Ch. 28).

7. Herbert, P.N., Bausserman, L.L., Henderson, L.O., Heinen, R.J., LaPiana, M.J., Church, E.C., and Shulman, R.S.: Apolipoprotein Quantitation. In Peeters, H. (Ed.): The Lipoprotein Molecule, London, Plenum Pub. Corp., 1978, pp. 35-56.

8. Fredrickson, D.S., and Herbert, P.N.: Genetic dyslipoproteinemias. In Dietschy, J.M., Ontko, J.A., and Gotto, A.M. (Eds.): Disturbances in Lipid and Lipoprotein Metabolism, Bethesda, Maryland, American Physicological Society, 1978, pp. 199-212 (Ch. 12).

9. Herbert, P.N.: Is risk factor modification indicated after myocardial infarction? In Zohman, L.R., and Kattus, A.A. (Eds.): Progress in Cardiac Rehabilitation, New York, Stratton Intercontinental Medical Book Corp., 1979, vol. II, pp. 82-94 (Ch. 7).

10. Herbert, P.N., Heinen, R.J., Bausserman, L.L., Henderson, L.O., and Musliner, T.A.: Abetalipoproteinemia and hypobetalipoproteinemia: questions still exceed insights. In Gotto, A.M., Jr., Smith, L.C., and Allen, B. (Eds.): Atherosclerosis, V. Proceedings of the Fifth International Symposium on Atherosclerosis, New York, Springer-Verlag, 1980, pp. 684-688.

11. McAdam, K.P.W.J., Bausserman, L., Herbert, P.N., and Green, K.M.: Polymorphism of SAA within human high density lipoprotein. In Glenner, G., Pinho e Costa, P. and Falcao de Freitas, A. (Eds.): Amyloid and Amyloidosis. Proceedings of the Third International Symposium on Amyloidosis. Amsterdam Excerpta Medica, 1980, pp. 302-321.

12. Herbert, P.N., Henderson, L.O., Musliner, T.A., and Shulman, R.S.: Apolipoproteins - Analysis and possible impact on the early diagnosis of atherogenic risk. Munch. Med. Wschr. I22: S209-2I3, 1980.

13. McAdam, K.P.W.J., Li, J., Knowles, J., Foss, N.T., Dinarello, C.A., Rossenwasser, L.J., Selinger, M.J., Kaplan, M.M., Goodman, R., Herbert, P.N., Bausserman, L.L., and Nadler, L.M.: The biology of SAA: Identification of the inducer, in vitro synthesis and heterogeneity demonstrated with monoclonal antibodies. In Kushner, I., Volanakis, J.E., and Gewurz, H. (Eds.): C-Reactive Protein and the Plasma Protein Response to Tissue Injury, New York, The New York Academy of Sciences, 1980, pp. 126-136.

14. Herbert, P.N., Assmann, G., Gotto, A.M., Jr., and Fredrickson, D.S.: Familial lipoprotein deficiency (abetalipoproteinemia and Tangier disease). In Stanbury, J.B., Wyngaarden, J.B., Fredrickson, D.S., Goldstein, J.L., and Brown, M.S. (Eds.): The Metabolic Basis of Inherited Disease, New York, McGraw-Hill, 1982, pp. 589-621 (Chap. 29).

15. Herbert, P.N., Thompson, P.D., and Shulman, R.S: Determinants of plasma high density lipoprotein concentrations. In Peeters, H., and Gresham, G. (Eds.): Arterial Pollution, London, Plenum Publishing Corp.,1983, pp. 183-211.

16. Herbert, P.N., and Bausserman, L.L.: The apolipoproteins - taxonomy and functions. In Peeters, H., and Gresham, G. (Eds.): Arterial Pollution, London, Plenum Publishing Corp., 1983, pp. 143-182.

17. Herbert, P.N.: Abetalipoproteinemia and Tangier disease. In Dyck, P.J., Thomas, P.K., and Lambert, E.H. (Eds.): Peripheral Neuropathy, New York, McGraw-Hill, 1984, pp. 1728-1744.

18. Herbert, P.N.: Converting the diet-heart hypothesis to a theorem. In Perkins, E.G., and Visek, W.J. (Eds.): Dietary Fats and Health, American Oil Chemists' Society, 1983, Chap. 30, pp. 512-517.

19. Herbert, P.N.: Experience with individual lipid-lowering drugs: Probucol. Cardiovasc. Rev. & Reports January: 38-39, 1983.

20. Herbert, P.N., and Terpstra, A.H.M.: Diet and exercise in the treatment of hyperlipoproteinemia. Drug Therapy 14: 42-52, 1984.

21. Herbert, P.N.: Eating disorders. In Andreoli, T.E., Carpenter, C.C.J., Plum F., and Smith L.H. (Eds.): Cecil Essentials of Medicine, Philadelphia, W.B. Saunders Co., 1989, pp. 420-424 (Ch. 59).

22. Herbert, P.N.: Disorders of lipid metabolism. In Andreoli, T.E., Carpenter, C.C.J., Plum F., and Smith L.H. (Eds.): Cecil Essentials of Medicine, Philadelphia, W.B. Saunders Co., 1989, pp. 431-435 (Ch. 62).

23. Niaura, R., Stoney, C.M., and Herbert, P.N. Lipids in psychological research: The last decade. Bio. Psych. 34:1-43, 1992.

24. The Apoprotein and Antibody Standardization Program Planning Committee. The Apoprotein and Antibody Standardization Program. Arteriosclerosis 9:144-145, 1989.

25. Yao, J., Herbert, P.: Lipoprotein Deficiency and Neuromuscular Manifestations. In Dyck, P.J. and Thomas, P.K. (Eds.): Peripheral Neuropathy, Philadelphia, W.B. Saunders Co., 1993, pp. 1179-1193 (Ch. 62).

26. Flynn, M.M. and Herbert, P.N.: Effects of lowering dietary fat on health status. In Low-Calorie Foods Handbook, Ed. A.M. Altschul, 1993, pp. 479-495 (Ch. 23).

27. Herbert, P.N.: Section on Metabolic Diseases. Chap. 56, Introduction. Chap. 57, Eating Disorders. Chap. 58, Principles of Alimentation and Hyperalimentation. Chap. 59, Hyperuricemia and Gout. Chapt. 60, Disorders of Lipid Metabolism. Chap. 61, Disorders of Metals and Metalloproteins. Chap. 62, Disorders of Amino Acid Metabolism. Chap. 63, Disorders of Carbohydrate Metabolism. Chap. 64, Inherited Disorders of Connective Tissue. In Andreoli, T.E., Bennett, J.C., Carpenter, C.C.J., Plum, F. and Smith, L.H. (Eds.): Cecil Essentials of Medicine, Third Edition, Philadelphia, W.B. Saunders Co., 1993.

28. Herbert, P.N.: Section on Metabolic Diseases. Chap. 56, Introduction. Chap. 57, Eating Disorders. Chap. 58, Principles of Alimentation and Hyperalimentation. Chap. 59, Hyperuricemia and Gout. Chapt. 60, Disorders of Lipid Metabolism. Chap. 61, Disorders of Metals and Metalloproteins. Chap. 62, Disorders of Amino Acid Metabolism. Chap. 63, Disorders of Carbohydrate Metabolism. Chap. 64, Inherited Disorders of Connective Tissue. In Andreoli, T.E., Bennett, J.C., Carpenter, C.C.J., Plum, F. and Smith, L.H. (Eds.): Cecil Essentials of Medicine, Fourth Edition, Philadelphia, W.B. Saunders Co., 1996.

29. Herbert, P.N.: Section on Metabolic Diseases. Chap. 58, Principles of Alimentation and Hyperalimen-tation. Chap. 59, Hyperuricemia and Gout. Chap. 61, Disorders of Metals and Metalloproteins. Chap. 62, Disorders of Amino Acid Metabolism.. Chap. 64, Inherited Disorders of Connective Tissue. In Andreoli, T.E., Bennett, J.C., Carpenter, C.C.J., Plum, F. and Smith, L.H. (Eds.): Cecil Essentials of Medicine, Fifth Edition, Philadelphia, W.B. Saunders Co., 1999 (in press).

30. Citkowitz, E. and Herbert, P.N.: Lipoproteins and Apoproteins. In Gorlin, R., Dangas, M.D., Toutouzas, P.K., Konstadoulakis, M.M. (Eds.): Contemporary Concepts in Cardiology - Pathophysiology and Clinical Management, Kluwer Academic Publishers, 1999, pp. 28-68 (Ch. 3).

pnh:kfq (10/28/99)

PROFESSIONAL ACTIVITIES

TEACHING (1977-1989):

Undergraduate	**(Brown University)**
1984	Nutrition in Biology, Health and Politics (Summer, 2 Months, Course Director)
1984-1999	Biomed 6 - Introduction to Human Physiology (Lecturer)
1985-1989	Human Nutrition (Lecturer)
1980, 1982, 1983	Biomed 196 - Independent Study (Preceptor)
Graduate and Medical School	**(Brown University)**
1987-1989	Biomed 363B - Organ System Pharmacology (Lecturer)
1978-1981	Biomed 371 - Cardiology (Lecturer)
1986-1989	Biomed 130 - Medical Biochemistry (Section Lecturer)
1979-1981	Biomed 364 - Nutrition (Co-Director)
1977-1989	Biomed 301 - Medicine (Core Clerkship Preceptor)
1986-1989	Biomed 370 - Introduction to Clinical Medicine (Physical Diagnosis Course Preceptor)
1989-1999	Biomed 372 - Endocrinology (Lecturer)
Graduate and Medical School	**(Yale University)**
1991-present	Pharmacology 501 (Lecturer)
1991-1993	Introduction to Clinical Medicine (Nutrition Workshop Leader)
1991-1995	Clinical Examination Course (Clinical Tutor)
1991-present	Internal Medicine - Core Medical Clerkship
1992-1994	Cardiovascular Disease Epidemiology 522b Yale University School of Public Health (Lecturer)
1995-1999	Doctor-Patient Encounter Course
1997-1999	Clinical Advisor Program
1995-present	Professional Responsibility course (Seminar Leader)

Ph.D. Thesis Direction
Linda L. Bausserman (George Washington University)

Postgraduate

Preceptor, Primary Care Clinic, HSR
Preceptor for Cardiology and Endocrinology Fellows in Lipid Clinic
Internal Medicine Medical Director and Teaching Attending
Research Elective for Residents
Board Review and Other CME Lectures
Beeson/Peters Firm Attending, Yale-New Haven Hospital

Other

Board of Rhode Island Schools of Medicine Technology (Lipid Lectures)

RESEARCH

1. **Grants**

1979-1982	HL23789 - Lipids and lipoproteins in myocardial infarction	N.I.H.
1981-1988	HL26516 - Transport and catabolism of serum amyloid A	N.I.H.
1983-1985	Plasma cholesterol ester metabolism	A.H.A.
1979-1983	R.J. Reynolds multi-disciplinary program in cardiovascular disease	R.J. Reynolds
1981-1989	HL28467 - Lipoproteins in active men: Role of exercise and diet	N.I.H
1983	Development of Outpatient Nutrition Center	Champlin Foundation
1983-1990	RR02038 - The General Clinical Research Center; Program Director; Associate Program Director	N.I.H.
1987-1988	HL-32141 (sub grant) - Validation and field test for risk appraisal instruments	N.I.H.
1986-1988	Diet and coronary heart disease	A.H.A.
1980-1989	HL23269 (sub grant) - Pawtucket Heart Health Program	N.I.H.
1987-1989	Lipids and apolipoprotein in the Diltiazem Post-Infarction Trial	Marion Laboratories
1988-1989	Evaluation of XU-62-320 Study No. 12	Sandoz Pharmaceuticals
1990-1991	Comparison of Safety and Efficacy of XU 62-320 and Lovastatin	Sandoz Pharmaceuticals
1990-1991	Fluvastatin Study No. 26	Sandoz Pharmaceuticals
1992-1995	Coping Style Stress Responsiveness and Lipids	NIH

2. **Extramural Grant Reviewing (1985-1997)**

1985-1989	AHR for March of Dimes, U.S.- Israel BSF, VA
1985	NHLBV41: HV-85-2 Apoprotein and Antibody Standardization Program (AHR)
1985	RR: GCRC - Francis Scott Key Medical Center
1985	NHLBI: HL-25P - Nutrition and cardiovascular disease (AHR)
1986	NHLBI: HV-87-01 - Clinical Trails Review Committee (AHR - Chairman)
1987	NHLBI: Clinical Trails Review Committee (AHR)
1987	RR: GCRC - Washington University

1988	NHLBI: SRG - Demonstration and education and "Physicians role in lowering elevated lipids by diet" (AHR - Chairman)
1988	AHA: New England Regional Review
1988-1991	NIH: Nutrition Study Section
1989	NHLBI: SRC - Demonstration and education and "Physicians role in lowering elevated lipids by diet" (AHR - Chairman)
1990	NHLBI: 89-HL-I5P - Postprandial lipoproteins and atherosclerosis (AHR)
1990	NHLBI: SRG - Demonstration and Education Research (AHR - Chairman)
1993	NHLBI: Special Emphasis Panel (CARDIA) (AHR)
1996	NHLBI: Special Emphasis Panel (Dietary Effects on Lipoproteins and Thrombogenic Activity)
1997	NIH: Study of Women's Health Across the Nation - Advisory Panel

3. **Research Consultation**

1986-1988	NHLBI: DECA, Ad-Hoc Committee Member
1985-1988	NHLBI: Apoprotein and Antibody Standardization Planning Committee Member
1987-1990	AHA (RI): Research Committee (Chairman 1987-1989)
1986-1989	Rhode Island Partnership for Science and Technology (Institutional Representative)
1989	NHLBI: Workshop on Biochemical Markers of Compliance to Modified Fat Diets - Chairman

SERVICE:

1. **University and Medical School**
   Clinical Faculty Promotion Committee (Chairman)
   Academic Standing Committee
   Brown Biology Forum
   Section of Medicine Research Committee (Chairman)
   General Clinical Research Center - Scientific Advisory Council (1983- 1990)
   Department of Medicine Senior Faculty Promotions Committee (1984-1989)
   Brown University M.D. - Ph.D. Committee
   Medical Faculty Council
   Yale University School of Medicine Alumni Council (1994-present; Secretary 1997-1999)
   APT Foundation Central Medical Unit (1993-present)
   Yale University School of Medicine - Medical School Council (1997)
   Yale University School of Medicine - Board of Permanent Officers (1992-)

2. **Search Committees**

Chief of Neurology (1), Chief of Cardiology (1), Chief of Medicine (1), GCRC Program Director (1), Cardiologists (4), Endocrinologists (3), Hematology (1), Nephrology (1), Infectious Disease (3), General Internal Medicine (6), Emergency Medicine (1)

3. **Hospital Committees**

Miriam Hospital
Clinical Research Review Board (IRB)
Research Building (Chair)
Pharmacy
Nutrition
Medical Staff Selection
Internship Selection
Biomedical Research Support Grant (Chair and Principal Investigator)
Division Directors
University Physicians Foundation, Inc. (Department of Medicine Practice Plan - Vice President)
University Physicians Foundation, Inc. (Finance Committee - Chairman)
University Physicians Foundation, Inc. (Board of Directors)
Attending
Continuing Medical Education
Medical Advisory
Department of Medicine Research Committee (Chairman)
Academic Medicine Task Force
Capital Campaign (1989-1990)

Hospital of Saint Raphael
Executive
Medical Board
Administrative Council
Human Investigation
Ethics
Pharmacy and Therapeutics
Risk Management
Credentials
Quality Assurance - A
Quality Assurance - B
Clinical Chairmen
Graduate Medicine Education
Attending
Continuing Medical Education
Chair, Emergency Department Search Committee
Residency Recruitment and Review
Chair, Cardiology Fellowship Research Committee
Senior Staff
Computer Systems
Clinical Operations Group
Hospital Quality Improvement
Information Systems Task Force
Nuclear Medical Record Task Force Chair

Yale-New Haven Hospital
Board of Trustees

4. **Community**

American College of Physicians, Connecticut Chapter

1995 -	Scientific Program Judge
1993 - 1995	Scientific Program Committee (Chair, 1993)
1993 - present	Governor's Council

5. Yale-New Haven Hospital/Yale University School of Medicine

Search Committees:
Chair/Chief, Department of Surgery
Chair/Chief, Department of Obstetrics and Gynecology
Chair/Chief, Department of Radiology
Chair/Chief, Department of Internal Medicine
Chair, Section of Cardiology
Chair/Chief, Department of Child Psychiatry and Child Study Center
Chief, Department of Dentistry
Chair/Chief, Department of Laboratory Medicine
Chair/Chief, Department of Ophthalmology
Chair/Chief, Department of Pediatrics
Chief Medical Information Officer

Committee Memberships:
Chair, General Clinical Research Center Advisory Committee (GAC), 1993-1995
Board of Governors, Yale Medical Group
Comprehensive Cancer Center Dean's Committee
New Clinical Program Development Fund – Development Committee
Yale University School of Medicine Strategic Planning Committee
Yale Alumni in Medicine, Executive Committee and Secretary
Yale-New Haven Health System Quality Council
Yale-New Haven Hospital Performance Leadership Group
Yale-New Haven Hospital Patient Safety Steering Committee
Yale-New Haven Health System, Executive Committee
Yale-New Haven Hospital Senior Operations Group
Clinical Performance Improvement Steering Committee
Chair, Clinical Information Systems Steering Committee
Medical Center Insurance Corporation, Patient Safety Committee

Director, Ambulatory Services Corporation Board
President, Yale-New Haven Medical Services, PC
President, Yale-New Haven Nursing Home, PC

Community:
Columbus House, Capital Campaign Committee
CT State Quality in Health Care Advisory Committee

Updated: 7/27/05

CURRICULUM VITAE

PATRICIA SUE FITZSIMONS, R.N., Ph.D

Senior Vice President for Patient Services
Yale-New Haven Hospital
New Haven, Connecticut 06504
Telephone: (203) 688-2131
FAX: (203) 688-3360
e-mail: fitzsim@ynhh.org

29 Parker Place
Madison, Connecticut 06443
(203) 245-9217

EDUCATION

B.S.N. (Nursing) Cornell University New York, New York	1968
M.A. (Nursing) New York University New York, New York	1974
Ph.D. (Education) The Ohio State University Columbus, Ohio	1983

POSITIONS HELD

Staff Nurse (Cardiac Unit) Cornell University New York Hospital New York	1968- 1970
Staff Nurse (Medical-Surgical) Long Island Jewish Hospital New York	1970- 1971
Instructor of Nursing Queensboro Community College New York	1971- 1973
Assistant Professor of Nursing Adjunct Associate Professor Miami University Oxford, Ohio	1981- 1997

P.S. Fitzsimons, R.N., Ph.D.

POSITIONS HELD(continued)

Instructor of Nursing Assistant Professor of Nursing Graduate Faculty Director, Hospital Clinical Studies Wright State University Dayton, Ohio	1978- 1997
Senior Vice President Hospital Operations Miami Valley Hospital Dayton, Ohio	1982- 1997
Senior Vice President for Patient Services Yale-New Haven Hospital New Haven, Connecticut	1997- present

REARCH

- "Sensory Deprivation and Nightime Behavioral Disorders in the Aged, Immobilized Adult on an Orthopaedic Unit" — 1973
- Continuity of Care Study (curriculum) Wright State University — 1978
- "Attitudes Towards the Aged" following completion of a 3-credit hour gerontology course, curriculum study, Wright State University — 1978
- "Life Skills Needed at Different Life Stages by Professional Nurses," original dissertation research — 1982
- "An Ethnography-Closure of a Diploma School of Nursing," Dr. Betsy Frank, Wright State University, Dayton, Ohio — 1983
- A Triangulation Model for Evaluating an Educational Service in a Hospital Setting — 1984
- "An Oral History of the Alumni of the Miami Valley Hospital School of Nursing," — 1986
- "Patient Care Outcomes", Miami Valley Hospital — 1986

P.S. Fitzsimons, R.N., Ph.D.

AWARDS

- Graduated with Distinction, Cornell University College of Nursing, New York, New York — 1968
- "Excellence in Teaching Award," Wright State University School of Nursing — 1978
- "Role of the Administrator," Second Place, Midwest Alliance in Nursing, Oklahoma City, Oklahoma — 1982
- "Salute to Women in Education", Second Place, Shilito-Rikes Career Lifestyle Program, Dayton, Ohio — 1984
- "Who's Who in Nursing" — 1984
- "Top Ten Women of Dayton", Dayton Daily News — 1989
- "YWCA Salute to Career Women," Certificate of Merit — 1994
- "YWCA Tribute to Mentors" — 1995
- South Central Connecticut Chapter of Alzheimer's Association, Hall of Fame — 1999
- "20 Noteworthy Women in Connecticut for 2001" — 2001
- Ohio State University, College of Education Alumni Advisory Board "Career Achievement Award", October, 2001, Columbus, Ohio — 2001

PUBLICATIONS

- "Adult Development", videotape by Miami University — 1982
- "Nursing Research: It's for you," slide/tape — 1984
- "Pro-Active Decision-Making Model," Midwest Alliance in Nursing — 1984
- A Model for Collaboration, published by Wright State University-Miami Valley School of Nursing, (two chapters) — 1988
- A Time to Remember: A History of the Miami Valley hospital School of Nursing — 1986
- Setting the PACE: Managing Transition to Patient Centered Care, Health Administration Press — 1995

P.S. Fitzsimons, R.N., Ph.D.

PROFESSIONAL/COMMUNITY ORGANIZATIONS

- Wright State University College of Nursing Advisory Council
- Leadership Dayton Program
- Sinclair Community College Department of nursing Advisory
- City of Oakwood Board of Education Finance Committee
- Sigma Theta Tau
- Miami University Applied Sciences Advisory Council Board Member
- Dayton Area Nurse Administrators
- Midwest Alliance in Nursing
- Greater Dayton Area Hospital Association
- Buckeye Trails Girl Scout Council
- American organization of Nurse Executives
- VHA Central Nursing Task Force
- Ohio Organization of Nurse Executives Board Member
- Ohio Organization of Nurse Executives President
- Ohio Organization of Nurse Executives Legislative Committee Chair
- National League of Nursing Board Member
- Yale University, School of Nursing-Associate Clinical Professor
- VHA National Nursing Board
- East Shore Regional Day Care Center, Branford, CT.-Board Member
- United Health Care Corporation, Bridgeport, CT.-Board Member
- Southern Connecticut Pastoral Education Consortium Advisory Board
- UHC Chief Nursing Officers Steering Committee
- VHA National Nursing Leadership Council Education Committee Chair
- VHA National Nursing Leadership Council
- American College of Healthcare Executives
- American Organization of Nurse Executives
- Connecticut League for Nursing
- Connecticut Nurses Association
- Connecticut Colleagues in Caring
- The Advisory Board Company: Advisor on Hospital and Health System Workforce
- United Way of Greater New Haven–Board of Directors
- Connecticut Hospital Association: Future of Nursing in Connecticut Planning Project Planning Board

OTHER

- Thesis Advisement, Wright State University 1985-1997
- Manuscript Reviewer for The Journal of the Midwest Alliance:MAIN 1989-1997

P.S. Fitzsimons, R.N., Ph.D.

WRITTEN WORKS/PRESENTATIONS

- "Life Skills Needed for Development of Professional Nurses," Miami Valley Hospital Nursing Research Symposium — 1982
- "Nursing Research: An Integral Facet of Clinical Practice in New Knowledge for Nursing Practice," American Nurses Association — 1983
- "Qualitative Research," Miami Valley Hospital Research Symposium — 1983
- "Trends and Issues in Continuing Education," Ohio State University — 1983
- "A Pro Active Decision Making Model," co-authored with Donna Deane, Midwest Alliance in Nursing — 1984
- "Productivity: Nursing Administration in the 1980's, Wright State University Continuing Education — 1985
- "Service and Education: A Unified Collaboration Model," Midwest Alliance in Nursing — 1987
- The Use of Knowledge Deficit as a Nursing Diagnosis Made by RNs," Eighth Annual Research in Nursing Conference, Cincinnati, Ohio — 1988
- "Patterns in Care Outcomes for Clinical Nurse Specialists and Clinical Nurses, Clinical Nurse Specialist: Strategies for the 90's Workshop, Novi, Michigan — 1988
- Reengineering the Delivery of Care," American College of Healthcare Executives — 1994
- "Leadership for the Next Millennium: A Passion of Patients", keynote speaker, Sybil Palmer Bellos Lecture, Yale School of Nursing — 1998
- "Nursing in the Next Millennium", keynote speaker, Yale-New Haven Hospital, Nurse Day — 1998
- "The Future of Nursing" keynote speaker, Miami Valley Hospital, PACE Group, Dayton, Ohio — 1999
- "Medication Errors Improvement Initiatives, University Health System Consortium, Chicago — 2000
- Medication Error Competency Training, Connecticut Hospital Association, Wallingford, Connecticut — 2000
- "It's Up to You: Building Your Career and the Profession", keynote speaker, Connecticut League for Nursing, Student Day, Wallingford, Connecticut — 2000
- "The Nursing Shortage", Healthcare Policy Journal Club, Yale School of Medicine, Yale University — 2002

CHRISTOPHER M. O'CONNOR, FACHE

Office phone: (203) 789-3020 Office email: coconnor@srhs.org

HOSPITAL CEO / PRESIDENT

Successful hospital executive with 17 years of progressive hospital management experience across a broad range of healthcare systems. Track record of creating institutional success in complex urban teaching environments. Known for developing strong medical staff, high performing senior leadership teams and strong employee relationships – enabling operational, service and quality improvement.

- ***Strategic direction:*** Articulated the imperative for a new direction to preserve Saint Raphael's commitment to the community, created the vision for integration, and led the process to identify and pursue affiliation with a stronger partner.
- ***Leadership:*** Energetic and engaged leadership style built on high ethical standards and open, inclusive decision making. Ability to work effectively with multiple constituencies including Boards, medical staff, employees and the community to address difficult decisions and create positive change.
    - ***Communication:*** Strong communicator with the ability to convey strategic direction and gain active alignment with vision, strategy and goals. Implemented employee forums, weekly "Email from the CEO," Employee Advisory Council, monthly "Coffee with Chris" for managers, and on-line suggestion box, among other items, to personally communicate with employees.
    - ***Team Focused:*** Recognized for building high-performing teams that achieve exceptional results. Worked closely with both clinical and administrative teams to establish meaningful goals and the accountability for reaching them. Implemented balanced scorecard and comprehensive performance review systems.
- ***Medical Staff:*** Built extremely close and strong working relationships with the medical staff, including elected officers and clinical leadership. Encouraged inclusive decision-making processes that brought key medical staff constituents to the table when decisions were needed. Working closely with the patient care team, tackled tough issues including quality improvements and medical staff discipline.
- ***Financial Performance:*** Led Saint Raphael's continued turnaround, with two years of improving financial results including positive bottom-line in both years and for the first time since 2005, a profit from operations. Similarly, led St. Elizabeth's to three years of improving financial results that exceeded revenue targets, improved case mix and reduced controllable expenses, resulting in an improvement in operating margin from .5% to 2%.

PROFESSIONAL EXPERIENCE

SAINT RAPHAEL HEALTHCARE SYSTEM/HOSPITAL OF SAINT RAPHAEL, New Haven, CT 2009--Present

Healthcare system including a 511- bed tertiary teaching hospital affiliated with the Yale University School of Medicine, a 122-bed short-term rehabilitation and skilled nursing facility, two captive insurance companies, a philanthropic foundation, and joint ventures providing dialysis, cancer treatment and imaging services. Saint Raphael's has more than 3,500 employees with a broad range of clinical programs with almost $600 million in net patient revenue.

President *(2009 – Present)*

Responsible for the overall operation of the System and its entities, including mission fulfillment, effective performance, business development, strategic planning, and care and service quality.

- Championed Board-driven, meticulous process to evaluate options and identify a strategic partner, resulting in execution of a Letter of Intent with Yale-New Haven Hospital and ultimately an Asset Purchase Agreement. Negotiated contractual elements that preserve Catholic tradition on the Saint Raphael campus, and address outstanding debt and a Church Plan pension shortfall. Implemented multi-faceted communications strategy for internal and external stakeholders and interested parties, including proactive engagement of constituencies such as employees, physicians, donors and Catholic clergy. Leading Saint Raphael's participation in regulatory review process and integration planning.

- Led focused effort to turnaround four consecutive years of negative performance through stakeholder engagement, implementation of organization-wide Bridge Plans achieving more than $64 million in revenue enhancement/expense reduction in FYs 2010 and 2011, development of Clinical Business plans to grow services, and significant revenue cycle improvements. Resulted in positive bottom line for FYs 2010 and 2011, and a profit from operations in FY 2011--the first since 2005.
- Led physician alignment strategy, including first physician satisfaction survey in more than a decade, physician outreach, surgical services realignment and growth initiatives, and formation of a physician/medical foundation.
- Implemented strategic focus on clinical outcomes and patient satisfaction. Created chief quality officer role. Facilitated formation of multi-disciplinary teams, including CEO Patient Satisfaction Steering Committee, to implement best practices and drive improvements. Achieved 4 of 6 Board-approved service and quality goals for FY 2011.
- Oversaw process to strategically allocate scare capital dollars to support growth, patient satisfaction, quality and regulatory imperatives, including new family-focused birth center, renovation of a 23-bed medical telemetry unit, and creation of a 12-bed observation unit, as well as expansion of the Hospital's robotics program through acquisition of latest da Vinci surgical robot.

CARITAS ST. ELIZABETH'S MEDICAL CENTER, Boston, MA 2006 – 2009

Flagship tertiary teaching hospital of a six-hospital system affiliated with Tufts School of Medicine, located in eastern Massachusetts with 340 licensed beds and 2,500 employees and nearly $400 million in net revenue.

President *(2006 – 2009)*

Chief Operating Officer *(2006)*

Responsible for medical center operations including strategic plan, operational performance and community engagement for this urban tertiary teaching hospital.

- Exceeded budgeted performance, earning progressively larger bottom-lines of 1.1%, 1.5% and 2% during the three fiscal years under leadership.
- Successfully recruited more than 40 new physicians, including key leadership as well as clinical staff to facilitate clinical activity turnaround.
- Improved patient satisfaction from the 70th percentile to the 90th percentile by linking service, quality and access to leadership performance.
- Through a team approach, worked to improve quality goals in many areas including surgical care infection, cardiac outcomes, infection control and ventilator associated pneumonia. Facilitated the implementation of a transparent patient safety program with non-punitive reporting as well as a thorough root cause analysis process to ensure process improvements.
- Recognized as a Thomson Performance Improvement hospital in both 2007 and 2008 in the large teaching category.
- Improved quality outcomes, including benchmark performance in the surgical care infection program to over 95% compliance, and achieved distinction from the Institute of Healthcare Improvement.
- Facilitated programmatic expansion into hyperbaric wound care, neurosciences and robotic surgery. Oversaw milestone construction projects including: a new emergency department, operating suite renovations, a neuroscience and spine center and a multi-disciplinary wound center.
- Led the implementation of Leadership Development initiative across the system in conjunction with the "Achieving Exceptional Care" program – A Studer Group collaborative for over 600 system-wide leaders that focused on improving leadership tools.

OCHSNER HEALTH SYSTEM, New Orleans, LA 2003 – 2006

A non-profit, academic, multi-specialty healthcare delivery system dedicated to patient care, research and education. The system includes seven hospitals, more than 35 healthcare centers and 11,000 employees.

Vice President Clinical Operations

Responsible for specialty clinical services including cardiac, oncology, digestive diseases, musculoskeletal, transplant, surgical and perioperative services. Included within these service lines are both clinic operations and

hospital services for areas including infusion therapy, radiation therapy, endoscopy, cardiac cath labs and EP labs, 23 OR suites, 6 OR ASC, and 2 plastic surgical OR suites.

- Hurricane Katrina - Led the organization through its response to this national disaster. Ochsner was one of three hospitals to remain functional throughout the storm and flooding. Facilitated the emergency preparedness and response to this regional catastrophe including countless leadership and staff meetings and briefings for the 2,500 staff, patients and dependants sheltered at Ochsner. Assisted in communicating current operational status with media outlets. Assisted in coordination of assets and security needs with state and local emergency operations centers. Maintained a structured decision making process in the face of failing utilities, flooding, civil unrest and numerous operational and human resource issues.
- Assisted in the acquisition process that resulted in the purchase of three Tenet hospitals in the greater New Orleans region. Finalized planning for new cancer center and heart and vascular institute. Facilitated the operational opening of main campus ASC in January 2004.
- Worked with high end specialty groups such as orthopedics to develop appropriate performance criteria including working to balance implant expense management and outcome measures.
- Facilitated the focus on patient satisfaction, patient safety and quality, including implementing quality metrics as well as improving patient satisfaction within the operating room setting by 50% over a 12-month period.
- Upon arrival, addressed significant resource shortage within Anesthesia. Implemented recruitment and retention tactics to increase CRNA staff, recruited a new chair and increased staffed anesthesia locations 20% within a year of implementation.
- Improved endoscopy scheduling by both resource allocation and process improvement that increased procedures from 50 to 70 per day.

HOSPITAL OF SAINT RAPHAEL, New Haven, CT 1997 – 2003

Vice President, Clinical Operations *(2001 – 2003)*

Administrative Director, Departments of Surgery and Emergency Medicine *(1999 – 2001)*

Administrator, Saint Raphael Physician Organization *(1997 – 1999)*

Progressive responsibility focused on operational performance of major clinical departments including surgery, emergency medicine, radiology, pathology, gastroenterology, cardiac and oncology services. Responsible for more than 400 FTEs and $200+ million in net patient service revenue.

- Following 9/11, established the first regional emergency response agreement in Connecticut in collaboration with Yale New Haven Hospital and other local healthcare providers.
- Improved OR efficiency by both adding supply (from 19 OR suites to 23) and increasing production by $25 million in gross revenue. Improved cost per case by 5%, and increased OR utilization (saving approximately $3 million in both med/surg supplies and implant costs).
- Coordinated the evaluation, negotiation and transition of the emergency physicians to an outside national group saving $1 million in expenses and gaining more than $5 million in incremental professional revenue.
- Implemented OR information system (ORSOS) following a difficult period for both scheduling and preference cards.
- Working with surgical specialties, particularly orthopedics and neurosurgery maximized surgeon efficiency by adjusting block schedules while developing increasingly strong revenue performance for the hospital.
- Implemented a capitated defibrillator agreement with Medtronic that enabled savings of more than $1.2 million in pacemaker and defibrillator implants in one year.
- Coordinated the integration of additional subspecialties within the practice, increasing gross professional revenue to $1.5 million.

SINAI HOSPITAL OF BALTIMORE, Baltimore, MD 1995 – 1997

A large acute tertiary teaching hospital with nearly 500 beds and affiliated with the Johns Hopkins School of Medicine. It is the flagship for Lifebridge Health and two-hospital integrated healthcare delivery system.

Coordinator, Emergency Medicine Operations *(1996 – 1997)*

Administrative Resident *(1995 – 1996)*

Following post graduate residency, worked with then CEO Warren Green and the senior leadership team. Remained and managed this large emergency department, which at the time was seeing 65,000 patients annually with more than 20 physicians and PA FTEs.

SPEAKING ENGAGEMENTS

Numerous speaking engagements regarding Hurricane Katrina and Emergency Preparedness

Numerous clinical and hospital grand round presentations

AFFILIATIONS / BOARD MEMBERSHIPS / RECOGNITIONS

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES, **Fellow**

CONNECTICUT HOSPITAL ASSOCIATION, **Board member** (2010-Present)
Member of the Financial Oversight and Diversified Network Services committees

YANKEE ALLIANCE, **Board member** (2009-Present)

REGIONAL LEADERSHIP COUNCIL, **Board member** (2009-Present)

EDUCATION

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC 1996
Masters in Health Service Administration

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC 1993
Bachelor of Arts, Economics

Lawrence E. McManus, CPA
117 Winter Street
Hopkinton, MA 01784

(Cell) 602-639-0085 email: lmcmanus@srhs.org (Home) 508-435-9242

PROFILE

Senior healthcare executive with strong leadership, management and financial skills. Creative strategist and problem solver. Effective team leader who focuses groups on goal achievement and staff accountability. Reputation for high integrity and accomplishment among employees, board members and industry leaders.

PROFESSIONAL EXPERIENCE

SAINT RAPHAEL HEALTHCARE SYSTEM INC., New Haven, CT **2008 - Present**
A Catholic healthcare system in New Haven, Connecticut consisting of a 511 bed hospital, nursing home, VNA, and Surgery Center, among other entities. Sponsored by the Sisters of Charity of Saint Elizabeth, the mission of the system is to care for and improve the health of patients with compassion and with a special concern for the underserved, poor and elderly.

Senior Vice President - Chief Operating Officer and Chief Financial Officer (2009 - Present)
Report directly to the President and Chief Executive Officer. Accountable for overall system operations, financial and strategic initiatives. Advise the Board of Directors on matters of consequence to the future of the system.

Vice President, Chief Financial Officer (2008 - 2009)
Responsible for all hospital, ambulatory, joint venture and financial operations of the system.

- Designed and implemented a Hospital "Bridge Plan" strategy to improve financial and operational performance.
- Successfully re-negotiated contracts with Commercial Insurers during market downturn.
- Worked collaboratively with bond insurers and Auditors regarding covenant compliance issues.
- Improved system cash flow and profitability by implementing in excess of $20 million improvement with Bridge Plan initiatives.

ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER, Phoenix, AZ **2006 - 2008**
The flagship not-for-profit Catholic hospital of Catholic Healthcare West (CHW), with 690 beds and 32,000 admissions. Recognized for quality tertiary care, medical education, research and internationally known Barrow Neurological Institute.

Vice President, Chief Financial Officer

Reported directly to the Vice President, CHW and hospital President. Accountable for all financial operations and strategic input to Senior Management and Board to position medical center for the future.

- Hired as interim Chief Financial Officer.
- Responsible for all hospital ambulatory, joint venture and physician financial operations.
- Participant on Board committee evaluating institutional and academic strategic relationships.
- Designed and implemented "Bridge Plan" to improve hospital and physician operating results.

VANGUARD HEALTH SYSTEMS, INC., Southboro, MA **2005 - 2006**

A national for-profit healthcare system comprised of 19 hospitals, multiple physician group practices and related business entities across five geographic regions of the country; headquartered in Nashville, Tennessee. New England region is comprised of St. Vincent Hospital, Framingham Union Hospital and Leonard Morse Hospital.

Vice President, Business Development and Physician Services (New England Region)

- Reported directly to the Chief Executive Officer.
- Worked in collaboration with Vanguard Executive Management in Nashville to establish and manage regional activities in New England.
- Hired as senior leader in New England market to establish regional presence.
- Member of senior team determining strategy, budgets and monthly performance.
- Coordinated initiatives with tertiary partners - cardiology/oncology.
- Led in establishment and growth of Regional Physicians Organization.
- Participated in establishing research study - elective angioplasty for community hospitals.

CARITAS CHRISTI HEALTH CARE, Boston, MA **1991 - 2004**

An integrated $1.1 billion not-for-profit healthcare system comprised of 12,000 employees, six acute care hospitals, several specialty facilities, multiple physician group practices and related business entities.

Executive Vice President and Member of The Office of the President (1994 - 2004)

- Reported directly to the Chief Executive Officer. Responsible for all business operations and research matters at Caritas Christi including the development of corporate strategy and business plans for the system and for their implementation.
- Played leadership role in the creation of Caritas Christi and its growth to become the second largest healthcare system in Massachusetts. Working closely with the CEO, led the integration of several stand-alone hospitals into a single system, turned around their operating performance and helped create a single management team.
- Initiated analysis, led the due diligence and completed negotiations that resulted in the acquisition of the four hospitals acquired by Caritas Christi.
- Created and organized 26 "enterprise groups" of clinical and business leaders across the Caritas system. Established common processes and best practices that reduced costs and improved efficiency.
- Worked with the Massachusetts Legislature to develop a creative legislative approach to assist financially distressed hospitals. Result was an incremental reimbursement of millions of dollars to Caritas Christi system members and the continued viability of Caritas Carney Hospital.
- Led negotiations with third party payors (six hospitals and 1200 physicians) that involved hundreds of millions of dollars of payments to Caritas Christi member hospitals and physicians.
- Led the development of Caritas' research strategy and the integration of clinical operations. Resulted in millions of dollars of referral revenue and better-integrated hospital and physician services.
- Led in the formation and management of Caritas Medical Group (250 employed physicians) and functioned as COO of Caritas St. Elizabeth's Medical Center on two occasions to assist president.
- Hired and developed high performing individuals who were promoted to leadership roles in Caritas member hospitals.

Senior Vice President and Chief Financial Officer (1991 - 1997)

Reporting to the Chief Executive Officer, responsible for all financial matters throughout the corporation.

- Developed and led a high performing team of Chief Financial Officers in member hospitals. Result was creation of a strong financial infrastructure and consistent culture throughout the Caritas system.

CARITAS CHRISTI Continued:

- Assisted in developing a financial infrastructure and decision support system.
- Key participant in resolving legislative and regulatory issues critical to closure and consolidation of member hospitals.

DELOITTE & TOUCHE, Boston, MA **1984 - 1991**
Diversified international public accounting and consulting firm.

Audit Partner (1987 - 1991)
Responsible for audit and consulting services to a variety of firm's clients. Designed firm specialist in healthcare industry in the Boston office.

- Primary participant in developing the healthcare practice in Boston office that substantially improved the firm's market position. Growth of practice resulted in audit partnership after three years with the firm.
- Provided audit, reimbursement and consultancy services for hospitals related to major third party insurers, hospital charge sensitivity and various bond offering issues.
- Clients included Brigham and Women's Hospital, New England Deaconess Hospital, New England Baptist Hospital, South Shore Hospital and Joslin Diabetes Center.
- Oversaw audit services for hospitals and other corporations including Lowell General Hospital, Cardinal Cushing General Hospital and BASF Corporation.

Audit Senior Manager (1984-1987)

- Participated in practice development and assisted in market growth of firm's healthcare practice.
- Participated in leading the training and development of staff at the local and national level.

MASSACHUSETTS EYE AND EAR INFIRMARY, Boston, MA **1983 - 1984**

Manager of Reimbursement and Budgeting

Reported to the Vice President of Finance, responsible for administering contracts and working with third party payors as well as all budget preparation and maintenance throughout each department.

- Key participant in developing a successful multi-million dollar appeal with Blue Cross Blue Shield related to medical implants.
- Participated in developing and implementing cost accounting standards for clinical services.

GRANT THORNTON INTERNATIONAL, Boston, MA **1978 - 1983**
Diversified national public accounting and consulting firm (formerly Alexander Grant & Company).

Audit Supervisor (1982-1983); **Audit Senior** (1980-1982); **Audit Assistant** (1978-1980)

- Worked with a variety of clients in healthcare, retail, banking, manufacturing and utilities industries including Massachusetts General Hospital, Crane & Company, Inc., Rich's Department Stores and Medford Savings Bank.

EDUCATION

MS, University of Massachusetts, Amherst, MA, Health Administration, 1980

BS, University of Massachusetts, Amherst, MA , Zoology, 1975

BOARD DIRECTORSHIPS

Director, National Board of Healthcare Financial Management Association, Westchester, IL, 2004-Present

President, Massachusetts Chapter HFMA, 1996-1997

Member, Advisory Board, University of Massachusetts School of Public Health and Health Sciences, 2004-Present

Founding Director, Vascular Genetics, Inc. (startup gene therapy company, public in 2001), 1998-2000

Director, Saints Memorial Medical Center, Lowell, MA, 1992-1994

Director, Consorta, Inc. (group purchasing organization), Rolling Meadows, IL, 2003-2004

PROFESSIONAL ACTIVITIES AND AFFILIATIONS

Certified Public Accountant, 1980-Present

Fellow, Healthcare Financial Management Association, 2002-Present

Adjunct Assistant Professor, Boston University, 1996-1997

Member, Massachusetts Society of Certified Public Accountants, 1980-Present and

Chairman of MSCPA's Hospital Committee, 1989-1990

Member, American Institute of Certified Public Accountants, 1980-Present

Member, The University of Massachusetts Club, Boston, MA, 2006

Member, Weston Golf Club, Weston, MA, 1987-Present

CURRICULUM VITAE

Alan S. Kliger, M.D.

Born: April 21, 1946, New York, N.Y.

Education Public Schools of New York, High School of Music and Art, N.Y., 1962

City College of New York, B.S. 1966

SUNY Upstate Medical Center, Syracuse N.Y., M.D. 1970

Post-Graduate Training

Medical Internship and Residency State University Hospital, Upstate Medical Center, Syracuse N.Y. 1970 – 1973

Fellow in Nephrology Georgetown University, Washington D.C. 1973 – 1975

Research Fellow Washington and American Heart Association 1974 – 1975

Certification

National Board of Medical Examiners 1971

American Board of Internal Medicine 1973

American Board of Internal Medicine
Nephrology Subspecialty 1976

Academic Positions

Instructor in Medicine, Yale University School of Medicine 1975 – 1976

Assistant Professor of Medicine, Yale University School of Medicine 1976 – 1980

Associate Professor of Medicine, Yale University School of Medicine 1980 – 1983

Associate Professor Clinical Medicine, Yale University School of Medicine 1983 – 1993

Clinical Professor of Medicine, Yale University School of Medicine 1993 -

Professional Positions

Senior Vice President, Chief Medical Officer, Chief Quality Officer, Hospital of Saint Raphael, New Haven, CT

Past Chairman, Department of Medicine, Hospital of Saint Raphael, New Haven, CT

Steering Committee for Renal Quality Measures, National Quality Forum

Chairman, Steering Committee for NIH/NIDDK Frequent Hemodialysis Trial

Past President, ESRD Network of New England

Past President, Forum of ESRD Networks - The Forum of ESRD Networks is the national level organization coordinating the activities of the 18 ESRD Networks from around the country.

Past President, Current Board of Directors, Renal Physicians Association - The Renal Physicians Association is a national organization of academic and practice nephrologists, whose purpose is to serve the needs of the nephrology community and to improve the care of patients with renal disease.

Editorial Experience

Associate Editor of the Transactions of the American Society of Artificial Internal Organs, 1975

Editorial Board, Clinical Journal of American Society of Nephrology, 2011

Reviewer for several journals, including Journal of the American Medical Association, Kidney International, American Journal of Kidney Diseases, Journal of American Society of Nephrology, Clinical Journal of American Society of Nephrology, Hemodialysis International

Awards

Student's Award for Best Teaching Resident, SUNY Upstate Medical Center, 1973

Department of Medicine Housestaff Teacher of the Year Award, Yale University, 1979

Department of Medicine Housestaff Teaching Award, Yale University 1988, 1992

National Kidney Foundation of Connecticut James P. Colangelo, M.D. Achievement Award, January 28, 2000

American Association of Kidney Patients, Mauren Lundin aakpRENALLIFE Award, 2004 for his valuable contributions to kidney patients through numerous patient education articles in Renal Life.

Membership

Member, American Society of Nephrology

Member, International Society of Nephrology

Fellow, American College of Physicians

Book Chapters

Kliger, AS and Hayslett, JP: Disorders of potassium balance. In Brenner, BM, Stein, JH (Eds.): Contemporary Issues in Nephrology: Acid-Base and Potassium Homeostasis, New York, 1978, pp.168-204 (Ch. 6).

Kliger, AS: The role of the kidney in Fluid, Electrolyte, and Acid-Base Disorders. In Priebe, HJ (Ed.): International Anesthesiology Clinics: The Kidney in Anesthesia, Boston, MA, 1984, Vol. 22 (1), pp. 65-82.

Kliger, AS: Management of Center Hemodialysis Programs. In Horl, WH, Ronco, C, Winchester, JF, Koch, KM, Lindsay, RM (Eds.) Replacement of Renal Function by Dialysis, 5th edition, Kluwer Academic Publishers, Dordrecht. September 2003.

Suri, RS and Kliger, AS: Frequent hemodialysis: physiological, epidemiological, and practical aspects. Chronic Kidney Disease, Dialysis, and Transplantation, A companion to Brenner & Rector's The Kidney, 3rd edition, Elsevier Saunders Publishers, 2010, pp 370-384.

Publications

1. Kliger AS, Finkelstein FO, McGuire E, Schiff, M: The Antecubital Fossa Fistula. Clinical Nephrology 5:229-231, 1976.

2. Kliger AS, Scheer RL: Familial Disease of the Renal Medulla: A Study of Progegy in a Family with Medullary Cystic Disease. Ann Int Med 85: 190-194, 1976

3. Finkelstein FO, Kliger AS, Bastl C, Yap P, Goffinet J: Chronic Peritoneal Dialysis in Diabetic Patients with End Stage Renal Failure. Proc Dialysis Transplant Forum 5:142-145, 1975.

4. Finkelstein FO, Kliger AS, Bastl C, Yap P: Sequential Clearances and Dialysance Measurements in Chronic Peritoneal Dialysis Patients. Nephron 18, 342-347, 1977.

5. Finkelstein FO, Kliger AS: Role of Medullary Structures in Calcium Reabsorption in Rats with Renal Insufficiency. Am J Phys 233:F197-F200, 1977.

6. Mandell I, Ahern MJ, Kliger AS, Andriole VT: Candida Peritonitis Complicating Peritoneal Dialysis: Successful Treatment with Low Dose Amphotericin B Therapy. Clinical Nephrology 6,:492-496, 1976.

7. Kliger AS, Eastman ST, Zachek M, Kullick M, Preuss HG: Effect of Renal Fuels on p-aminohippurate Transport in Rat Renal Corical Fragments. Metabolism 26:979-988, 1977.

8. Kliger AS, Resing J, Eastman ST, Preuss H: Effects of Medium pH on p-aminohippurate Transport in Rat Kidney Slices. Nephron 20:32-39, 1978.

9. Kliger AS, Yap P, Jensen P, Finkelstein FO: Dihydrotachysterol (DHT) and Supplemental Calcium Therapy in Dialysis Patients. Proc Dialysis and Transplant Forum 6, 184-189, 1976.

10. Jensen PS, Kliger AS: Early Radiographic Manifestations of Secondary Hyperparathyroidism Associated with Chronic Renal Disease. Radiology 125:645-652, 1977.

11. Bastl C, Kliger AS, Binder HJ, Hayslett JP: Characteristics of Potassium Secretion in the Mammalian Colon. Am J Physiol 234 (1):F48-F53, 1978.

12. Brown EA, Kliger AS, Goffinet J, Finkelstein FO: The Effect of Hypertonic Dialysate and Vasodilators on Peritoneal Dialysis Clearances in the Rat. Kidney International 13:271-277, 1978.

13. Brown EA, Kliger AS, Finkelstein FO: Peritoneal Dialysis Clearances. A Practical Approach to the Measurement of Small and Middle Molecule Clearances. Nephron 21:310-316, 1978.

14. Lynn RI, Honig CL, Jatlow PI, Kliger AS: Resin Hemoperfusion for Treatment of Ethchlorvynol Overdose. Ann Int Med 91:549-553, 1979.

15. Finkelstein FO, Kliger AS: Enhanced Efficiency of Peritoneal Dialysis Using Rapid Small Volume Exchanges. ASAIO 2:103-106, 1979.

16. Preuss H, Geoly K, Johnson M, Chester A, Kliger A, Schreiner G: Tubular Function in Adult Polycystic Kidney Disease. Nephron 24:198-204, 1979.

17. Steidl JH, Finkelstein FO, Wexler JP, Feigenbaum H, Kitsen J, Kliger AS, Quinlan DM: Interactions Between Medical Condition Adherence and Family Functioning in Chronic Dialysis Patients. Arch G Psychiatry 37:1025-1027, 1980.

18. Bagley DH, Kliger A, Weiss R: Anaerobic Urinary Infections: Bacteroides Fragilis Bacteremia From the Urinary Tract. J Urology 124:160-161, 1980.

19. Finkelstein FO, Yap P, Kliger AS: Effect of Nitroprusside on Peritoneal Dialysis Clearances. Yale J Biol Med 53:127-132, 1980.

20. Brown EA, Kliger AS, Hayslett JP, Finkelstein FO: Renal Function in Rats with Acute Medullary Injury. Nephron 26:64-68, 1980.

21. Bia MJ, Baggish D, Katz L, Gonzalez R, Kliger AS, Rosenfeld AT: Computed Tomography in the Diagnosis of Pelvic Abscesses in Renal Transplant Patients. J Amer Med Assn 245:1435-1437, 1981.

22. Kliger AS, Binder HJ, Bastl C, Haslett JP: Demonstration of Active Potassium Transport in the Mammalian Colon. J Clin Invest 67:1189-1196, 1981.

23. Broadus AE, Lang R, Kliger AS: The influence of calcium intake and the status of intestinal calcium absorption on the diagnostic utility of measurement of 24 hour cyclic AMP excretion. J Clin Endocrinol Metab 52:1085-1089, 1981.

24. Sigal SL, Kliger A, Walker-Smith GJ: Adult Respiratory distress syndrome in a previously healthy young male. Yale J Biol Med 55:463-475, 1982.

25. Broadus AE, Insogna KL, Lang R, Mallette LE, Oren DA, Gertner JM, Kliger AS, Ellison AF: A consideration of the hormonal basis and phosphate leak hypothesis of absorptive hypercalciuria. J Clin Endocrinol Metab 58:161-169, 1984.

26. Carey, HB, Finkelstein S, Santacroce S, Brennan N, Raffone D, Rifkin J, Kliger AS, Cooper K, Finkelstein FO. The Impact of Psychosocial Factors and Age on CAPD Dropout. Advances in Peritoneal Dialysis 6:26-29, 1990.

27. Lewis M, Gorban-Brennan NL, Kliger AS, Cooper K, Finkelstein FO. Incidence and Spectrum of Organisms Causing Peritonitis in HIV Positive Patients on CAPD. Advances in Perit Dial 6:136-138, 1990

28. Kazmi H, Kliger A, Raffone D, Finkelstein F. Pseudomonas Exit Site Infections in Continuous Ambulatory Peritoneal Dialysis Patients. J Amer Soc Neph 2:1498-1501, 1992.

29. Tebben JA, Rigsby MO, Selwyn PA, Brennan N, Kliger AS, Finkelstein FO: Outcome of HIV Infected Patients on Continuous Ambulatory Peritoneal Dialysis. Kidney Int 44:191-198, 1993.

30. Gorban-Brennan N, Kliger AS, Finkelstein FO: CAPD Therapy for Patients Over 80 Years of Age. Perit Dial Int 13:140-141, 1993.

31. Mooraki A, Kliger AS, Gorban Brennan N, Juergensen P, Brown E, Finkelstein FO: Weekly KT/V Urea and Selected Outcome Criteria in 56 Randomly Selected CAPD Patients. Advances in Peritoneal Dialysis 10:81-84, 1994.

32. Juergensen PH, Finkelstein FO, Cooper K, Santacroce S, Kliger AS: Hyperparathyroidism in CAPD Patients: Therapy with Pulse Oral Calcitriol. Advances in Peritoneal Dialysis 10:259-261, 1994.

33. Boroujerdi-Rad H, Juergensen P, Mansourian V, Kliger AS, Finkelstein FO: Abdominal Abscesses Complicting Peritonitis in CAPD Patients. American J Kidney Disease 23:717-721, 1994.

34. Kiernan L, Kliger A, Gorban-Brennan N, Juergensen P, Tesin D, Vonesh E, Finkelstein FO: Comparison of CAPD-Related Infections using different Y-Tubing exchange systems. J Amer Soc Nephrol 5:1835-1837, 1995.

35. Morrissey PE, Lorber KM, Marcarelli M, Bia MJ, Kliger AS, Lorber MI: Immunologic monitoring after organ transplantation: Relationship between Epstein-Barr virus infection and CD19+ B cells measured by flow cytometry. Transplantation Proceedings 27:1428-1430, 1995.

36. Morrisey PE, Lorber KM, Marcarelli M, Bia MJ, Kliger AS, Lorber MI: Post transplant Epstein-Barr virus infection associated with elevated levels of CD19+ B lymphocytes. Transplantation 59:637-640, 1995.

37. Ghahramani N, Gorban-Brennan N, Kliger A, Finkelstein FO. Infection rates in end stage renal disease patients treated with CCPD and CAPD using the ultra twin bag system. Advances in Peritoneal Dialysis 11:164-167, 1995.

38. Rodriguez A, Stewart D, Hotchkiss M, Farrell P, Kliger A, Finkelstein F. Sleep Apnea in CAPD. Advances in Peritoneal Dialysis 11:123-126, 1995.

39. Perazella M, McPhedran P, Kliger A, Lorber M, Levy E, Bia MJ. Enalapril treatmeny of post-transplant erythrocytosis—efficacy independent of circulation erythropoietin levels. Am J Kid Dis 26:495-500, 1995.

40. Kiernan L, Finkelstein FO, Kliger AS, Gorban-Brennan N, Juergensen P, Mooraki A, Brown E. Outcome of polymicrobial peritonitis in continuous ambulatory peritoneal dialysis patients. Am J Kid Dis 3:461-464, 1995.

41. Steele T, Baltimore D, Finkelstein S, Juergensen P, Kliger A, Finkelstein F. Quality of Life in Peritoneal Dialysis Patients. J Nerv Mental Dis 184:368-374, 1996

42. Goldie SJ, Kiernan-Troidle L, Torres MD, Gorban-Brennan N, Dunne D, Kliger AS, Finkelstein FO. Fungal Peritonitis in a Large Chronic Peritoneal Dialysis Population: A Report of 55 Episodes. Amer J Kid Dis 28:86-91, 1996.

43. Steele TE, Wuerth D, Finkelstein S, Juergensen D, Juergensen P, Kliger AS, Finkelstein FO. Sexual Experience of the Chronic Peritoneal Dialysis Patient. J Am Soc Neph 7:1165-1168, 1996.

44. Troidle L, Kliger AS, Goldie S, Gorban-Brennan N, Brown E, Fikrig M, Finkelstein FO. CPD Associated Peritonitis of Nosocomial Origin. Peritoneal Dialysis International 16:505-510, 1996.

45. Juergensen PH, Juergensen DM, Wuerth DB, Finkelstein SH, Steele TE, Kliger AS, Finkelstein FO. Psychosocial Factors and Incidence of Peritonitis. Advances in Peritoneal Dialysis 12:196-198, 1996.

46. Troidle L, Kliger AS, Gorban-Brennan N, Fikrig M, Golden M, Finkelstein FO. Nine Episodes of CPD-associated peritonitis with Vancomycin Resistant Enterococci. Kidney International 50:1368-1372, 1996.

47. Friedman AL, Goker O, Dennis MJ, Basadonna GP, Wiklund RA, Kliger AS, Bia M, Lorber MI. Must living renal donors be hospitalized overnight prior to surgery? Clin Transplant 5:444-6, 1996.

48. Gotch FA, Gentile DE, Keen ML, Amerling R, Folkert VW, Kliger AS, Shapiro WB. The incident patient cohort study design with uncontrolled dose. Substantial over-estimation of mortality as a function of peritoneal dialysis dose? ASAIO J 42:M514-517, 1996.

49. Darenkov IA, Marcarelli MA, Basadonna GP, Friedman AL, Lorber KM, How JG, Crouch J, Bia MJ, Kliger AS, Lorber MI. Reduced Incidence of Epstein-Barr Virus-Associated Post Transplant Lymphoproliferative Disorder Using Preemptive Antiviral Therapy. Transplantation 64:848-852, 1997.

50. Wuerth DB, Finkelstein SH, Juergensen DM, Juergensen PH, Steele TE, Kliger AS, Finkelstein FO. Quality of life assessment in chronic peritoneal dialysis patients. Adv Perit Dial 13:125-127, 1997.

51. Juergensen PH, Wuerth DB, Juergensen DM, Finkelstein SH, Steele TE, Kliger AS, Finkelstein FO. Psychosocial factors and clinical outcome on CAPD. Adv Perit Dial 13:121-124, 1997.

52. Troidle LK, Gorban-Brennan N, Kliger AS, Finkelstein FO. Differing Outcomes of Gram-positive and Gram-negative Peritonitis. Amer J Kidney Disease 32:623-628. 1998.

53. Juergensen PH, Allen JR, Kliger AS, Finkelstein FO. Adequacy of CPD: Comparing Kt/V and Creatinine Clearance. Advances in Peritoneal Dialysis 14:72-74, 1998.

54. Troidle LK, Gorban-Brennan N, Kliger AS, Finkelstein FO. Peritonitis in the Extended Care Facility. Advances in Peritoneal Dialysis 14:127-130, 1998.

55. Troidle LK, Gorban-Brennan N, Kliger AS, Finkelstein FO. Continuous Cycler Therapy, Manual Peritoneal Dialysis Therapy and Peritonitis. Advances in Peritoneal Dialysis 14:137-141, 1998.

56. Juergensen PH, Cooper K, Kliger AS, Finkelstein FO. Hyperparathyroidism: A Seven-year Follow-up. Advances in Peritoneal Dialysis 14:188-190, 1998.

57. Kliger AS. Clinical Practice Guidelines and Performance Measures in ESRD. Amer J Kidney Disease 32:5173-5176, 1998.

58. Juergensen PH, Rizvi H, Caride VJ, Kliger AS, Finkelstein FO. Value of Peritoneal Scintigraphy in CPD Patients. Kidney International 55:1111-1119, 1999.

59. Kliger AS, Haley WE. Clinical Practice Guidelines in End Stage Renal Disease: A Strategy for Implementation. J Amer Soc Neph 10:872-877, 1999.

60. Troidle L, Gorban-Brennan N, Kliger AS, Finkelstein FO. The Effect of Duration of Chronic PD Therapy on the Development of Peritonitis. Perit Dial International 19:376-379, 1999.

61. Troidle L, Kliger AS, Finkelstein FO. Challenges of Managing CPD-Peritonitis. Peritoneal Dialysis International 19:315-318, 1999.

62. Troidle L, Gorban-Brennan N, Kliger AS, Finkelstein FO. Once Daily Intraperitoneal Cefazolin and Oral Ciprofloxacin as Empiric Therapy for the Treatment of Peritonitis. Advances in Peritoneal Dialysis 15:213-216, 1999.

63. Kliger AS, Cary HB, Finkelstein FO. Peritoneal Dialysis: Improving Patients' Lives and Learning What They Want. Seminars in Dialysis 12:363-364, 1999.

64. Cary HB, Troidle L, Kliger AS, Finkelstein FO. VRE Peritonitis: A Case Report and Review of the Literature. Seminars in Dialysis 12:333-335, 1999.

65. Troidle L, Kliger AS, Finkelstein FO. Challenges of managing peritonitis. Perit Dial Int 19:315-318, 1999

66. Brand DA, Kliger AS. Planning for a kidney transplant. Is my doctor listening? J Amer Med Assn 282(7): 691-694, 1999

67. Juergensen PH, Murphy AL, Pherson KA, Chorney WS, Kliger AS, Finkelstein FO. Tidal peritoneal dialysis to achieve comfort in chronic peritoneal dialysis patients. Adv Perit Dial 15:125-126, 1999

68. Wuerth DB, Finkelstein SH, Kliger AS, Finkelstein FO. Patient assessment of quality of care in a chronic peritoneal dialysis facility. Amer J Kidney Diseases 35:638-643, 2000

69. Juergensen PH, Murphy AL, Pherson KA, Kliger AS, Finkelstein FO. Tidal peritoneal dialysis: comparison of different tidal regiments and automated peritoneal dialysis. Kidney Int 57:2603-2607, 2000

70. Allen JR, Troidle LK, Juergensen PH, Kliger AS, Finkelstein FO. Incidence of peritonitis in chronic peritoneal dialysis patients infused with intravenous iron dextran. Perit Dial Int 20:674-678, 2000

71. Ronco C, Kliger AS, Amici G, Virga G. Automated peritoneal dialysis; clinical prescription and technology. Perit Dial Int Suppl 2:S70-S76, 2000

72. Bolton WK, Kliger AS. Chronic renal insufficiency: current understandings and their implications. Am J Kidney Dis. 36(suppl 3): S4-S12, 2000

73. Shemin D, Bostom AG, Lambert C, Hill C, Kitsen J, Kliger AS. Residual renal function in a large cohort of peritoneal dialysis patients: change over time, impact on mortality and nutrition. Perit Dial Int. 20(4): 439-444, 2000.

74. Kliger AS. Improving the quality of care in dialysis facilities: a model for accountability. Dialysis & Transplantation 2:5, 2000.

75. Cayco AV, Wysolmerski J, Simpson C, Mitnick MA, Gundberg C, Kliger A, Lorber M, Silver D, Basadonna G, Friedman A, Insogna K, Cruz D, Bia, M. Posttransplant bone disease: Evidence for a high bone resorption state. Transplantation 70:1722-1728, 2000.

76. Carey HB, Chorney W, Pherson K, Finkelstein FO, Kliger AS. Continuous peritoneal dialysis and the extended care facility. Am J Kidney Dis. 37:580-587, 2001.

77. Kliger AS, Haley WE. Dialysis Compare: how good is your dialysis unit? aakp Renal Life, September 2001, pp 9,26-27.

78. DeOreo PB, Kliger AS. Serratia liquefaciens infections at a hemodialysis center. N Engl J Med. 2001 Sep 20;345(12):91; author reply 922-3.

79. Wuerth D, Finkelstein SH, Ciarcia J, Peterson R, Kliger AS, Finkelstein FO. Identification and treatment of depression in a cohort of patients maintained on chronic peritoneal dialysis. Am J Kidney Dis. 37:1011-1017, 2001

80. Khaled GH, Finkelstein FO, Carey HB, Wardlaw SC, Kliger AS, Edberg SC. Method for studying development of colonization and infection of dialysis catheters. Adv Perit Dial. 2001;17:163-71.

81. Kliger AS, Diamond LH. Patient safety in end-stage renal disease: How do we create a safe environment? Adv Ren Replace Ther 8:131-137, 2001.

82. Cruz DN, Wysolmerski JJ, Brickel HM, Gundberg CG, Simpson CA, Mitnick ME, Kliger AS, Lorber MI, Basadonna GP, Friedman AL, Insogna KL, Bia MJ. Parameters of high bone-turnover predict bone loss in renal transplant patients: a longitudinal study. Transplantation 2001 Jul 15; 72(1):83-88, 2001.

83. Cruz DN, Brickel HM, Wysolmerski JJ, Gundberg CG, Simpson CA, Kliger AS, Lorber MI, Basadonna GP, Friedman AL, Insogna KL, Bia MJ. Treatment of osteoporosis and osteopenia in long-term renal transplant patients with alendronate. Am J Transplant. 2002 Jan;2(1)62-7.

84. Wuerth DB, Finkelstein SH, Schwetz O, Carey H, Kliger AS, Finkelstein FO. Patients' descriptions of specific factors leading to modality selection of chronic peritoneal dialysis or hemodialysis. Perit Dial Int 2002 Mar-Apr; 22(2): 184-90.

85. Kliger AS. Serum Albumin Measurement in Dialysis Patients: Should It Be A Measure of Clinical Performance? Journal of Renal Nutrition 12(3):July, 2002.

86. Kadambi PV, Troidle L, Gorban-Brennan N, Kliger AS, Finkelstein FO. Chronic Peritoneal Dialysis in the Elderly. Semin Dial.2002 Nov-Dec;15(6):430-3.

87. Juergensen PH, Murphy AL, Kliger AS, Finkelstein FO. Increasing the dialysis volume and frequency in a fixed period of time in CPD patients: the effect on Kpt/V and creatinine clearance. Perit Dial Int. 2002 Nov-Dec;22(6):693-7.

88. Goldstein A, Kliger AS, Finkelstein FO. Recovery of Renal Function and the Discontinuation of Dialysis in Patients Treated with Continuous Peritoneal Dialysis (CPD). Peritoneal Dialysis International. March 2003, Vol. 23(2):151-156.

89. Kliger AS, Padilla N. Anemia in Chronic Kidney Disease: Clinical Implications of Early Management. Dialysis & Transplantation 2003 April 32(4):179-87.

90. Kliger AS, Finkelstein FO. Which patients choose to stop dialysis? Nephrology Dialysis Transplantation. 2003 May; 18(5):870-871.

91. Kliger AS. Serum albumin measurement in dialysis patients with clinical depression: results of pharmacologic therapy. Adv Ren Replace Ther. 2003 Jul; 10(3):225-7.

92. Parker, TF, Kliger, AS. CKD Initiative Now in the Hands of Renal Societies. Nephrology News and Issues. August 2003 17(9):34-35, 51.

93. Troidle L, Watnik S, Wuerth DB, Gorban-Brennan N, Kliger AS, Finkelstein FO. Depression and Its Association with Peritonitis in Long-Term Peritoneal Dialysis Patients. American Journal of Kidney Diseases. August 2003 42(2):350-354.

94. Wuerth D, Finkelstein SH, Kliger AS, Finkelstein FO. Chronic Peritoneal Dialysis Patients Diagnosed with Clinical Depression: Results of Pharmacologic Therapy. Seminars in Dialysis November-December2003 16(6):424-427.

95. Troidel, L, Gorbann-Brennan N, Kliger AS, Finkelstein FO. Continuous Peritoneal Dialysis Associated Peritonitis: A Review and Current Concepts. Seminars in Dialysis November-December 2003 16(6):428-437.

96. Diamond, LH, Kliger AS, Goldman RS, Palevsky PM. Quality Improvement Projects: How Do We Protect Patients Rights? American Journal of Medical Quality. Jan-Feb. 2004, 19(1):25-27.

97. Rubin HR, Fink NE, Plantinga LC, Sadler JH, Kliger AS, Power NR. Patient Ratings of Dialysis Care with Peritoneal vs. Hemodialysis. JAMA. 2004 Feb 11; 291(6):697-703.

98. Parker TF, Blantz R, Hostetter T, Himmelfarb J, Kliger A, Lazarus M, Nissenson AR, Pereira B, Weiss J. The chronic kidney disease initiative. J Am Soc Nephrol. 2004 Mar;15(3):708-16.

99. Reynolds JT, Homel P, Cantey L, Evans E, Harding P, Gotch F, Wuerth D, Finkelstein S, Levin N, Kliger AS, Simon DB, Finkelstein, FO. A one-year trial of in-center daily hemodialysis with an emphasis on quality of life. Blood Purification. 2004; 22(3):320-328.

100. Kliger AS, Finkelstein FO. Payment of USA Physicians for Dialysis Care. Peritoneal Dialysis International 2004 Nov-Dec; 24(6):518-20.

101. Nissenson AR, Agarwal R, Allon M, Cheung AK, Clark W, Depner T, Diaz-Buxo JA, Kjellstrand C, Kliger A, Martin KJ, Norris K, Ward R, Wish J. Improving outcomes in CKD and ESRD patients: carrying the torch from training to practice. Semin Dial. 17(5):380-97, 2004.

102. Friedman AL, Goker O, Kalish MA, Basadonna GP, Kliger AS, Bia MJ, Lorber MI. Renal transplant recipients over aged 60 have diminished immune activity and a low risk of rejection. International Urology and Nephrology 36:451-456, 2004.

103. Jaar BG, Coresh J, Plantinga LC, Fink NE, Klag MJ, Levey AS, Levin NW, Sadler JH, Kliger AS, Powe NR. The Risk of Death with Peritoneal Dialysis versus Hemodialysis in a National Cohort of Incident End-Stage Renal Disease Patients. Ann Intern Med 2005;143:174-183.

104. Troidle L, Kliger A, Gorban-Brennan N, Finkelstein F. Course of C-reactive protein during continuous peritoneal dialysis-associated peritonitis. Nephrology. 2005 Oct;10(5):442-5.

105. Juergensen P, Eras J, McClure B, Kliger AS, Finkelstein FO. The impact of various cycling regimens on phosphorous removal in chronic peritoneal dialysis patients. Int J Artif Organs. 2005 Dec; 28(12):1219-23

106. Kliger AS. Patient safety in the dialysis facility. Blood Purif. 2006; 24 (1):19-21.

107. Kliger AS. How should chronic kidney disease be defined and classified? Nature Clinical Practice Nephrology Jan 2006 Vol 2 (1): 12-13.

108. Troidle L, Kliger A, Finkelstein F. Barriers to utilization of chronic peritoneal dialysis in network # 1, New England. Perit Dial Int. 2006 Jul-Aug;26(4):452-7.

109. Himmelfarb J, Kliger AS. End-Stage Renal Disease Measures of Quality. Annual Review of Medicine, 58:387-399, February 2007.

110. Kliger, AS. High-Frequency Hemodialysis: Rationale for Randomized Clinical Trials. Clin. J. Am. Soc. Nephrol., 2: 390-392, Mar 2007.

111. Suri RS, Garg AX, Chertow GM, Levin NW, Rocco MV, Greene T, Beck GJ, Gassman JJ, Eggers PW, Star RA, Ornt DB and Kliger AS. Frequent Hemodialysis Network (FHN) randomized trials: Study design. Kidney International (2007) 71, 349-359.

112. Kliger AS: The Dialysis Medical Director's Role in Quality and Safety. Seminars in Dialysis 2007 May-Jun;20 (3), 261-4.

113. Kliger AS, Gellens M. Will innovations in dialysis improve dialysis care? Adv Chronic Kidney Dis. 2007 Jul;14(3):229-30.

114. Kliger AS, Nissenson AR. Epoetin dosing and dialysis facility ownership (letter). JAMA 298:861-862, 2007.

115. Kliger AS. Frequent Nocturnal Hemodialysis- A Step Forward? JAMA 298:1331-1333, Sep 2007.

116. Kliger AS, Gutman RA. The Role of the Medical Directors in Dialysis Facilities. SDI 375:B, July 2007.

117. Blaser RE, Kliger AS. Congressional Oversight of Medicare Program Intensifies: A Look at the Factors Surrounding the Scrutiny and Nephrology's Response. Adv Chronic Kidney Dis. Vol 15 (1): 10-14, Jan 2008.

118. Jaar BG, Plantinga LC, Crews DC, Fink NE, Hebah N, Coresh J, Kliger AS, Powe NR. Timing, causes, predictors and prognosis of switching from peritoneal dialysis to hemodialysis: a prospective study. BMC Nephrology 10:3, 2009.

119. Kliger AS. New options to improve hemodialysis patient outcomes. Clin. J. Am. Soc. Nephrol., 4:694-695, 2009.

120. Kliger AS, Schmidt RJ. Economic Factors in Nephrology: Core Curriculum in Nephrology. Am J Kidney Dis 2009 54:572-581.

121. Kliger AS, Finkelstein, FO. Can We Improve the Quality of Life for Dialysis Patients? American Journal of Kidney Diseases, VOl 54, No 6 (December), 2009: pp 993-995.

122. Kliger, AS. More Intensive Hemodialysis. Clin J Am Soc Nephrol 4: S121-S124, 2009.

123. Chertow GM, Levin NW, Beck GJ, Depner TA, Eggers PW, Gassman JJ, Gorodetskaya I, Greene T, James S, Larive B, Lindsay RM, Mehta RL, Miller B, Omt DB, Rajagopalan S, Rastogi A, Rocco MV, Schiller B, Sergeyeva O, Schulman B, Ting GO, Unruh ML, Star RA, Kliger AS. In-center Hemodialysis six times per week versus three times per week. N Engl J Med 2010 Dec 9; 363(24):2287-300.

124. Rocco MV, Larive B, Eggers PW, Beck GJ, Chertow GM, Levin NW, Kliger AS. Baseline Characteristics of Participants in the Frequent Hemodialysis Network (FHN) Daily and Nocturnal Trials. American Journal of Kidney Disease, 2011 Jan:57(1):90-100.

125. Suri RS, Larive B, Garg AX, Hall YN, Pierratos A, Chertow GM, Gorodetskeya I, Kliger AS; for the FHN Study Group. Burden on caregivers as perceived by Hemodialysis patients in the Frequent Hemodialysis Network (FHN) trials. Nephrol Dial Transplant. 2011 Mar 18.

126. Unruh M, Tamura MK, Larive B, Rastogi A, James S, Schiller B, Gassman J, Chan C, Lockridge R, Kliger A. Impact of Sleep Quality on Cardiovascular Outcomes in Hemodialysis Patients: Results from the Frequent Hemodialysis Network Study. Am J Nephrol. 2011 Apr 8;33(5):398-406.

127. Rocco MV, Lockridge RS, Beck GJ, Eggers PW, Gassman JJ, Greene T, Larive B, Chan CT, Chertow GM, Copland M, Hoy CD, Lindsay RM, Levin NW, Ornt DB, Pierratos A, Pipkin MF, Rajagopalan S, Stokes JB, Unruh ML, Star RA, Kliger AK, and the Frequent Hemodialysis Network (FHN) Trial Group. The effects of frequent nocturnal home Hemodialysis: the Frequent Hemodialysis Network Nocturnal Trial. Kidney International advance online publication , 20 July 2011; doi:10.1038/ki.2011.213

JOSEPH B. BISSON

39 Gilbert Hill Road
Chester, Connecticut 06412

(860) 526-3606 (Residence)
(203) 789-3975 (Business)
Jbisson@srhs.org (Email)

EXPERIENCE

9/10 to pres. **HOSPITAL OF SAINT RAPHAEL**
New Haven, Connecticut (A major teaching hospital with revenues of $519 million and the fourth largest healthcare system in the state of Connecticut)

Vice President, Business Development (9/10 to present)

Responsibilities: Oversee strategic planning and business development functions for the health system, with a primary focus in FY2011 on the successful conclusion of negotiations and execution of an Asset Purchase Agreement for the acquisition of the Hospital of Saint Raphael by Yale-New Haven Hospital.

Accomplishments:

- Directed negotiations in conjunction with Yale-New Haven counterpart leading to the completion of a $160M Definitive Agreement for the purchase of the Hospital of Saint Raphael by Yale-New Haven Hospital. Agreement is currently under regulatory review.
- Managed due diligence process and associated work plans for ten executive sponsored subcommittees. Content areas for select subcommittees included medical staff analysis, financial analysis, employee integration, subsidiaries/joint ventures, operating/infrastructure and capital efficiencies, regulatory review and communications.
- Provided multiple presentations to health system Board of Trustees and Strategic and Finance Board Sub-Committee throughout the affiliation process.
- Maintained internal focus on strategic referral development through establishment of the system's first Physician Outreach program, resulting in growth of 6 surgical service lines after several years of steady declines.
- Implemented a structured clinical business planning process in collaboration with system's Chief Financial Officer.

4/98 to 8/10 **SAINT FRANCIS HOSPITAL AND MEDICAL CENTER**
Hartford, Connecticut (A major teaching hospital with revenues of $696 million and the third largest healthcare system in the state of Connecticut)

Vice President, Business Development (1/04 to 8/10)

Responsibilities: Oversaw business development, physician recruitment, physician contracting, joint ventures, and ambulatory facilities planning and construction for the health system. Managed eighteen community based medical office buildings (access centers) and Saint Francis *Care* Medical Group, the hospital-sponsored primary care group.

Accomplishments:

- Directed recruitment efforts leading to the addition of 220 physicians to the active medical staff over a five-year period, and a 7% net increase in active staff.
- Led development and construction of 150,000 square feet of outpatient medical office space in strategic suburban markets over a five-year period.
- Increased total net revenue to the institution from access center markets by 29% over a four-year period.
- Increased total volume to the institution from access center markets by 12% over a four-year period.
- Established first physician liaison service at the institution.
- Directed development of the 2010-2014 Physician Resource Plan.
- Chaired Physician Contracting and Physician Recruitment Committees
- Chaired Ambulatory Strategies Committee

Director, Access Centers (12/00 to 1/04)

Responsibilities: Administrative management of medical office network and Saint Francis *Care* Medical Group, P.C.

Accomplishments:

- Increased total net revenue to the institution from access center markets by 39% over a three-year period.
- Increased total volume to the institution from access center markets by 43% over a three-year period.
- Directed privatization and sale of select Saint Francis *Care* Medical Group practices as a component of system's primary care network development strategy.
- Improved Saint Francis *Care* Medical Group operating performance by 33% over a three-year period.
- Participated in the creation of comprehensive five-year medical staff development plan.

Director, Contracting and External Relations, Saint Francis Care Behavioral Health (1/99 to 12/00)

Responsibilities: Administrative management of seven departments within behavioral health subsidiary. Departments included contracting, marketing, network development, crisis services, clinical assessment center, consultation/liaison service and case management service.

Accomplishments:

- Consolidated contracting and business development functions for newly formed regional behavioral health network.
- Integrated clinical assessment services for efficient and effective triage across all levels of care.
- Managed provider relations activities for all payers.

Administrator for Behavioral Health (4/98 – 1/99)

Responsibilities: Administrative management of behavioral health services on the Mount Sinai campus of Saint Francis Hospital and Medical Center. Clinical programs included inpatient psychiatry, partial hospitalization, outpatient services, crisis services, clinical assessment services and the consultation liaison service.

Accomplishments:

- Chosen as first member of for-profit network management team to oversee hospital based departments during transition period following company purchase.
- Directed departmental and service-line reorganization.
- Led integration of policies and procedures utilizing best practice methodologies.
- Implemented daily treatment team meetings and improved program assessment tools.

10/90 to 4/98 **ELMCREST BEHAVIORAL HEALTH NETWORK**
Portland, Connecticut (A for-profit behavioral health system which included a 100 bed inpatient psychiatric hospital)

Program Director, Adult and Trauma Service (6/94-4/98)

Responsibilities: Managed all administrative and clinical operations of wide ranging behavioral health service, including a 50 bed adult inpatient service and a partial hospital/intensive outpatient treatment program for trauma survivors.

Program Director, Dual Diagnosis Service (12/93-6/94)

Responsibilities: Managed all activities of 30-bed adult inpatient dual diagnosis psychiatric unit.

Primary Therapist, Child and Adolescent Service (12/91-12/93)

Responsibilities: Provided individual, group and family therapy services to child and adolescent patient population within an acute care inpatient setting.

Creative Therapist, Child and Adolescent Service (10/90-12/91)

Responsibilities: Provided creative therapy services to child and adolescent patient population in an acute care inpatient setting using expressive and adventure oriented group modalities.

10/89 to 10/90 **COMMUNITY ASSOCIATES OF CONNECTICUT**
New Britain, Connecticut (A rehabilitation network serving developmentally disabled adults)

Rehabilitation Specialist

Responsibilities: Provided vocational rehabilitation services to developmentally disabled adults in a day treatment setting.

9/88 to 9/89 **CLUB DIJON**
Dijon, France (French National Hockey League)

Professional Hockey Player – Played professional ice hockey in French National League prior to attending rookie camp with the NHL Minnesota North Stars.

EDUCATION

1999 MBA – Healthcare Administration, University of Hartford, Hartford, Connecticut
1993 MSW – Social Work, University of Connecticut, West Hartford, Connecticut
1988 BA – Psychology/English, Colby College, Waterville, Maine

PROFESSIONAL AND COMMUNITY BOARD MEMBERSHIPS

Vice Chair, Dean's Advisory Board, UConn School of Social Work, 2009-Present
Saint Francis G.I. Endoscopy, L.L.C., Board of Directors, Treasurer, 2007-2010
Saint Francis Care Medical Group, Board of Directors, 2007-2010
First Cathedral Church Community Wellness Center, Board of Directors, Secretary, 2007-2009
Woodland Physician Associates, Inc., Board of Directors, Secretary, 2007-2009
Glastonbury Chamber of Commerce, Board of Directors, 2002-2008

PROFESSIONAL AFFILIATIONS

American College of Healthcare Executives, member since 2000
Connecticut Association of Healthcare Executives, member since 2005

REFERENCES

Available upon request

Mary Kuncas, RN
102 Litchfield Road
Watertown, Connecticut
Home Telephone 860 274-8491

Summary of Qualifications

Highly skilled senior hospital administrator with over thirty years experience in all aspects of acute care operations; including nursing, pharmacy, physical therapy and rehabilitative services, support services and information systems.

Known as a strong team player with the ability to motivate groups towards achievement of goals.

Experience

Hospital of Saint Raphael
1450 Chapel Street
New Haven ,Connecticut

1992-present **Vice President, Patient Services**

Responsible for the strategic development and overall operations of the nursing division as well as other hospital services such as pharmacy, dietary, housekeeping, materials management, parking, security, social services and patient transport.

- Currently manage an operating budget of 110 million dollars and 1100 FTEs.
- Reduced the use and cost for patient sitters by 54% with no negative impact on quality.
- Developed and implemented RN recruitment and retention campaign, reducing the RN vacancy rate by 50%.
- Instituted a shared governance structure within the department of nursing.
- Implemented a clinical ladder for Registered Nurses.
- Transitioned the NBICU from a Level 2A to Level 2B unit, allowing for care of newborns from 32 weeks gestation.
- Outsourced pharmacy management, reducing costs while improving service and quality.
- Responsible for regulatory standards, led multiple JCAHO accreditation process and state licensure surveys.
- Led hospital wide customer service initiative, achieving improvement in patient satisfaction and inter departmental collaboration.
- Expanded inpatient capacity for the medical and child psychiatric services-adding a total of 28 beds.
- Redesigned nursing documentation system which improved compliance with patient care planning and the quality of nursing evaluative notes.

- Instituted a Nurse Residency Program for new graduates and nurses returning to acute care.
- Implemented patient placement algorithm and nurse staffing model resulting in reduced census variation and increased predictability in nurse-patient ratio.
- Implemented centralized automated staffing and scheduling system.
- Implemented web based shift bidding program, allowing staff to request additional work shifts on line, resulting in improved staffing, reduced cost and increased staff satisfaction.
- Provided clinical oversight to several facility renovation projects.
- Provided leadership to patient safety and quality initiatives; reduced number and severity of patient falls, reduced pressure ulcer prevalence to below national average, developed new process for the management of titrated medications.
- Served as administrative liaison to the outpatient cancer center.

1990-1992 **Director, Patient Care Systems**

Responsible for the implementation of the hospital wide integrated clinical information system.

- Recruited project team.
- Conducted work flow analysis for initial go live departments
- Implemented first two modules of an integrated clinical information system.

1980-1990 **Director , Medical Nursing**

Responsible for the daily operations of the medical nursing division.

- Developed and implemented emergency department contingency plan
- Developed and implemented intensive rehabilitation, angioplasty and geriatric transition inpatient services.
- Coordinated the activities of the nursing department during the absence of the vice president.
- Coordinated the development of a criteria based performance evaluation for the department of nursing.
- Developed and implemented the clinical practice advancement program for nursing staff (clinical ladder)

Saint Mary's Hospital

Franklin Street
Waterbury, Connecticut

1977-1980 **Nursing Supervisor**

Responsible for the clinical and administrative activities of four nursing units on the 7-3 and 3-11 shifts.

West Haven Veterans Administrative Hospital
Campbell Avenue
West Haven, Connecticut

1975-1977 **Staff Nurse**

Provided nursing care to intensive cardiac and post operative cardiothoracic patients.

Education

1985 Master of Science
Rensselar at Hartford
Hartford, Connecticut

1975 Bachelor of Science Nursing
University of Connecticut
Storrs, Connecticut

Professional Affiliations

Connecticut Organization of Nurse Executives.
American Organization of Nurse Executives

Attachment V

Documentation of Non-Profit Status

Internal Revenue Service

District Director

Department of the Treasury
P.O. Box 9107
JFK Federal Bldg., Boston, Mass. 02203

Yale-New Haven Hospital Inc.
789 Howard Avenue
New Haven, Ct. 06504

Person to Contact: Daniel T. Valenzano

Telephone Number: (617) 223-1442

Refer Reply to: EO:Processing Unit

Date: JUL 10 1979

Name of Organization: Same

Gentlemen:

This is in reply to your recent letter requesting a copy of an exemption letter for the above-named organization.

Due to our records retention program, a copy of the original letter is not available.

[x] However, records in this office show that a determination letter was issued in November 1966 ruling that the organization was exempt from Federal Income Tax under Section (now) 501(C)(3) of the Internal Revenue Code of 1954.

[ ] However, records in this office show that the organization is exempt under Section (now) _____ of the Internal Revenue Code as part of a group ruling issued to _____

[x] Further, the organization is not a private foundation because it is an organization described under Section 170(b)(1)(a)(vi) and 509(a)(1).

This ruling remains in effect as long as there are no changes in the character, purposes, or method of operation of the organization.

I trust the foregoing information will serve your purpose.

If you have any questions, you may contact the person whose name ar telephone number are shown in the heading of this letter.

Sincerely yours,

H. Michael

District Director

STATE OF CONNECTICUT

TAX EXEMPTION PERMIT ISSUED UNDER SALES AND USE TAX ACT

State Tax Department — Collections and Accounting Division
92 Farmington Ave., Hartford, Conn. 06115

In accordance with the provisions of the Sales and Use Tax Act, effective July 1, 1953 and the Regulations thereunder, it is hereby certified that the charitable or religious organization named below is exempt from all sales and use taxes on purchases of tangible personal property made by it for the sole and exclusive purposes of the organization.

Permit No. E-00305

Date Issued
10/17/78
(duplicate)

ST. RAPHAEL HOSPITAL
1450 CHAPEL ST.
NEW HAVEN, CONN. 06511

Gerald J. Heffernan
Tax Commissioner

This permit is NOT assignable or transferable.

C&A-S185E (5/74)

Attachment VI

State of Connecticut, Department of Public Licence(s)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Division of Health Systems Regulation

DEBORAH Z. WOODWORTH

JAN 30 2012

ASST. TO THE PRESIDENT

TO: Administrator
Yale-New Haven Hospital, Inc.
20 York Street
New Haven, CT 06504

FROM: Colleen Judge
Processing Technician

DATE: January 25, 2012

We are enclosing a corrected license showing a change for your facility:

( ) Change of Administrator

( ) Change of Medical Director

( ) Change of Director of Nurses

(X) Increase of bed capacity from 874 General Hospital Beds to 896 General Hospital Beds Eff: 1/11/12.

(X) Increase of bed capacity from 92 Bassinets to 112 Bassinets, effective 1/11/12.

( ) Decrease of bed capacity from _____ to _____ Eff: _____.

(X) Other change, describe below:
Added (1) Satellite – P.T. Barnum Pediatric Center located at 226 Mill Hill Avenue, Bridgeport CT 06610 effective 1/11/12.

Please note that this license is in effect only for the operation of the facility as it is now organized. This division should be notified immediately if you:

1. Change your Administrator
2. Change your Director of Nurses
3. Change your Medical Director
4. Plan to relocate
5. Plan to sell your facility
6. Plan to discontinue operation.

Any of these changes or proposed changes also require written notification to this division.

If we can be of any assistance, please do not hesitate to call the licensure office.

Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0044

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Yale-New Haven Hospital, Inc. of New Haven, CT d/b/a Yale-New Haven Hospital, Inc. is hereby licensed to maintain and operate a General Hospital.

Yale-New Haven Hospital, Inc. is located at 20 York Street, New Haven, CT 06504.

The maximum number of beds shall not exceed at any time:

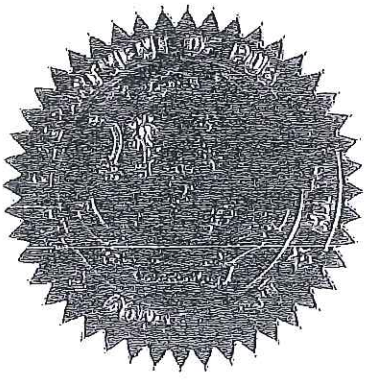
112 Bassinets
896 General Hospital Beds

This license expires **September 30, 2013** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, October 1, 2011.

Satellites:

Hill Regional Career High School, 140 Legion Avenue, New Haven, CT
Branford High School Based Health Center, 185 East Main Street, Branford, CT
Walsh Middle School, 185 Damascus Road, Branford, CT
James Hillhouse High School Based Health Center, 480 Sherman Parkway, New Haven, CT
Weller Building, 425 George Street, New Haven, CT
Yale-New Haven Psychiatric Hospital, 184 Liberty Street, New Haven, CT
Yale-New Haven Shoreline Medical Center, 111 Goose Lane, Guilford, CT
Pediatric Dentistry Center, 860 Howard Avenue, New Haven, CT
YNHASC Temple Surgical Center, 60 Temple Street, New Haven, CT
YNHASC Women's Surgical Center, 40 Temple Street, New Haven, CT
Mauro-Sheridan School Based Health Center, 191 Fountain Street, New Haven, CT
Yale-New Haven Hospital Dental Center, 2560 Dixwell Avenue, Hamden, CT
Murphy School Based Health Center, 14 Brushy Plain Road, Branford, CT
*P.T. Barnum Pediatric Center, 226 Mill Hill Avenue, Bridgeport, CT

License Revised to Reflect:
*Increased Bassinets by 20 Beds and Increased General Beds by 22 effective 1/11/12
*Added (1) Satellite effective 1/11/12



Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TO: Administrator
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

FROM: Rose McLellan
License and Application Supervisor
Facility Licensing and Investigations Section

DATE: October 26, 2011

Enclosed is your license to operate a **General Hospital**. The license must be posted in a conspicuous place as required by the General Statutes of Connecticut Section 19a-493.

The license is in effect **only** for the operation of the facility as it is now organized. It is not transferable to any other person, facility or address.

As a reminder, any changes in key personnel (Administrator, Director of Nursing and President) must be submitted in writing, along with any license number, resume, effective date and affidavit. Any changes in your Medical Director must be submitted in writing with the effective date and license number.

If we can be of any assistance, please do not hesitate to call the licensure office, Facility Licensing and Investigations Section.

Enclosure: License
RM/cbj

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

Department of Public Health

LICENSE NO. 0056

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Hospital of Saint Raphael of New Haven, CT d/b/a Hospital of Saint Raphael is hereby licensed to maintain and operate a General Hospital.
Hospital of Saint Raphael is located at 1450 Chapel Street, New Haven, CT, 06511.

The maximum number of beds shall not exceed at any time:

22 Bassinets
511 General Hospital Beds

This license expires **September 30, 2013** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 2011. RENEWAL.

SATELLITES

Adolescent Day Hospital, 646 George Street, New Haven, CT
Psychiatric Day Hospital, 1294 Chapel Street, New Haven, CT
Children's Psychiatric Day Hospital, 1450 Chapel Street, New Haven, CT
Elder Care Clinic, Atwater Clinic, 26 Atwater Street, New Haven, CT
Elder Care Clinic/Tower One, Tower Lane, New Haven, CT
Elder Care Clinic/Casa Otonal, 135 Sylvan Avenue, New Haven, CT
Elder Care Clinic/Edith Johnson Tower, 114 Bristol Street, New Haven, CT
Evening Chemical Dependency Program, 1294 Chapel Street, New Haven, CT
Elder Care Clinic/Surfside, 200 Oak Street, West Haven, CT
Troup School Base Health Center, 259 Edgewood Avenue, New Haven, CT
Adult PHP, 1110 Sherman Avenue, Hamden, CT
Wheat, 674 Washington Avenue, West Haven, CT
Barnard Environmental Studies Magnet School, 170 Derby Avenue, New Haven, CT
Hospital of Saint Raphael, 84 North Main Street, Branford, CT
Center for Women's Health/Midwifery & Chapel Pediatrics, 2 Ivy Brook Road, Suite 111, Shelton, CT
"Smiles 2 Go" Dental Mobile Van, 60 Commerce Street, East Haven, CT
Project Eldercare, 2080 Whitney Avenue, Suite 150, Hamden, CT
Chapel Pediatrics, 2080 Whitney Avenue, Suite 150, Hamden, CT
The Fair Haven Community Health Center, 374 Grand Avenue, New Haven, CT
Shoreline Child and Adolescent Mental Health Services, 21 Business Park Drive, Branford, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

Attachment VII

OHCA Financial Attachments I for YNHH and HSR for OHCA

12. C (i). Please provide one year of actual results and three years of projections of Total Facility revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: YNHH Description	FY 2011 Actual Results	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE													
Non-Government	$ 831,993	$ 898,809	$ 126,839	$ 1,025,648	$ 998,647	$ 281,169	$ 1,279,816	$ 1,067,473	$ 299,023	$ 1,366,496	$ 1,128,068	$ 317,558	$ 1,445,626
Medicare	415,678	449,060	109,156	558,216	500,516	217,629	718,145	525,812	220,863	746,675	548,562	223,427	771,990
Medicaid and Other Medical Assistance	187,979	203,075	22,542	225,618	209,935	47,616	257,551	219,917	47,655	267,572	233,278	47,694	280,972
Other Government	6,407	6,922	110	7,032	6,929	2,299	9,228	6,936	3,027	9,962	6,943	3,054	9,997
Total Net Patient Patient Revenue	$ 1,442,057	$ 1,557,866	$ 258,648	$ 1,816,514	$ 1,716,027	$ 548,713	$ 2,264,741	$ 1,820,139	$ 570,567	$ 2,390,706	$ 1,916,850	$ 591,734	$ 2,508,584
Other Operating Revenue	$ 46,640	$ 37,000	$ 11,271	$ 48,271	$ 35,000	$ 22,779	$ 57,779	$ 35,000	$ 23,024	$ 58,024	$ 35,000	$ 23,275	$ 58,275
Revenue from Operations	$ 1,488,697	$ 1,594,866	$ 269,919	$ 1,864,785	$ 1,751,027	$ 571,493	$ 2,322,520	$ 1,855,139	$ 593,591	$ 2,448,730	$ 1,951,850	$ 615,009	$ 2,566,859
OPERATING EXPENSES													
Salaries and Fringe Benefits	$ 690,314	$ 676,833	$ 151,324	$ 828,157	$ 721,990	$ 308,686	$ 1,030,676	$ 782,010	$ 324,980	$ 1,106,990	$ 814,882	$ 339,192	$ 1,154,074
Professional / Contracted Services	285,100	329,135	20,172	349,307	356,700	24,196	380,896	376,440	21,305	397,745	402,802	21,417	424,219
Supplies and Drugs	322,526	372,342	71,049	443,391	436,037	157,736	593,773	449,228	159,463	608,691	476,151	153,198	629,349
Bad Debts	26,390	26,962	13,157	40,119	27,771	27,870	55,642	28,604	29,520	58,125	29,462	31,270	60,732
Other Operating Expense	15,721	18,149	7,788	25,938	19,422	16,075	35,498	20,782	16,622	37,403	22,236	17,191	39,427
Subtotal	$ 1,340,051	$ 1,423,421	$ 263,491	$ 1,686,913	$ 1,561,920	$ 534,564	$ 2,096,484	$ 1,657,064	$ 551,890	$ 2,208,954	$ 1,745,534	$ 562,267	$ 2,307,801
Depreciation/Amortization	$ 67,948	$ 74,169	$ 7,088	$ 81,257	$ 87,337	$ 16,349	$ 103,686	$ 93,393	$ 18,021	$ 111,415	$ 98,980	$ 18,836	$ 117,815
Interest Expense	16,867	35,202	4,188	39,390	34,478	8,289	42,767	33,772	8,167	41,939	33,027	10,610	43,637
Lease Expense	10,941	12,631	2	12,633	13,010	-	13,010	13,400	-	13,400	13,802	-	13,802
Total Operating Expense	$ 1,435,807	$ 1,545,423	$ 274,770	$ 1,820,193	$ 1,696,745	$ 559,201	$ 2,255,947	$ 1,797,629	$ 578,078	$ 2,375,707	$ 1,891,343	$ 591,712	$ 2,483,055
Gain/(Loss) from Operations	$ 52,890	$ 49,443	$ (4,850)	$ 44,592	$ 54,282	$ 12,291	$ 66,573	$ 57,509	$ 15,513	$ 73,023	$ 60,507	$ 23,297	$ 83,804
Plus: Non-Operating Revenue	14,272	33,435	(7,000)	26,435	37,100	-	37,100	39,236	1,000	40,236	41,409	1,200	42,609
Revenue Over/(Under) Expense	$ 67,162	$ 82,878	$ (11,850)	$ 71,027	$ 91,382	$ 12,291	$ 103,674	$ 96,745	$ 16,513	$ 113,258	$ 101,916	$ 24,497	$ 126,413
FTEs	7,864	7,653	3,303	10,955	7,727	3,303	11,030	7,804	3,303	11,107	7,883	3,303	11,186
Inpatient Cases	57,451	59,242	23,232	82,474	60,930	23,232	84,162	62,667	23,232	85,899	64,453	23,232	87,685
Outpatient Visits	634,795	657,649	-	657,649	689,217	-	689,217	722,299	-	722,299	756,969	-	756,969
Outpatient Equivalent Visits	-	-	5,407	5,407	-	10,814	10,814	-	10,814	10,814	-	10,814	10,814

*Volume Statistics:
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.

SRHS/HSR FINANCIAL PROJECTIONS

Due to the inherent unpredictability of the economy in the country and local region during the projection period, and the inherent inability to accurately estimate patient volumes and rates of payment from governmental and non-governmental payers during the projection period, the attached projections are susceptible to a wide range of variability.

The attached projections are based upon known facts as of January 2012 that impact and define assumptions for FY2012-2015. The attached projections reflect an assumed continued trend in reduced levels of inpatient discharges into the projection period. Direct expenses are assumed to flex in accordance with volume reductions. The projected volume decline may vary from this projection, and management actions to reduce other expenses or increase revenues to improve results if such volume reductions are realized, have not been reflected since the action steps in the future are unknown at this time. SRHS' Board and management remain committed to taking necessary management actions to work towards remaining financially viable during challenging economic times.

12. C (i). **Please provide one year of actual results and three years of projections of Total Facility revenue, expense and volume statistics** without, incremental to and with the CON proposal in the following reporting format:

Projected as of: 2/7/12

[The attached assumptions are an integral component of the projected results of operations, and actual results will differ from projected results.]

Total Facility: SRHS w/o Affiliation *dollars in thousands* Description	FY 2011 Actual Results	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE													
Non-Government	$ 191,888	$ 204,883			$ 209,737			$ 217,603			$ 225,768		
Medicare	222,318	208,460			211,019			210,577			215,130		
Medicaid and Other Medical Assistance	61,953	60,090			61,342			63,354			65,442		
Medical Group	16,178	17,760			18,293			18,842			19,407		
Total Net Patient Revenue	492,337	491,193	-		500,391	-		510,376	-		525,747	-	
Other Operating Revenue	26,665	26,487			27,284			28,104			28,960		
Revenue from Operations	519,002	517,680	-		527,675	-		538,480	-		554,707	-	
OPERATING EXPENSES													
Salaries and Fringe Benefits	346,926	301,150			310,508			323,531			337,284		
Professional / Contracted Services		47,715			48,624			50,069			51,557		
Supplies and Drugs	131,821	133,117			135,987			140,179			144,353		
Bad Debts	23,430	23,961			24,454			24,957			25,715		
Other Operating Expense													
Subtotal	502,177	505,943	-		519,573	-		538,736	-		558,909	-	
Depreciation/Amortization	14,006	14,734			15,499			14,699			13,599		
Interest Expense	2,704	3,655			3,655			3,655			3,655		
Lease Expense													
Total Operating Expense	518,887	524,332	-		538,727	-		557,090	-		576,163	-	
Gain/(Loss) from Operations	115	(6,652)	-		(11,052)	-		(18,610)	-		(21,456)	-	
Plus: Non-Operating Revenue	654	573			545			514			483		
Revenue Over/(Under) Expense	$ 769	$ (6,079)	$ -		$ (10,507)	$ -		$ (18,096)	$ -		$ (20,973)	$ -	
SRHS Total FTEs	3,288	3,170			3,137			3,136			3,135		
Hospital Inpatient Discharges	23,120	21,793			21,226			21,226			21,226		
Hospital Outpatient Equivalents	11,672	12,308			12,308			12,308			12,308		

12. C (i). **Please provide one year of actual results and three years of projections of Total Facility revenue, expense and volume statistics** without, incremental to and with the CON proposal in the following reporting format:

Projected as of: 2/7/12

[The attached assumptions are an integral component of the projected results of operations, and actual results will differ from projected results.]

Total Facility: HSR w/o Affiliation *dollars in thousands* Description	FY 2011 Actual Results	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
NET PATIENT REVENUE													
Non-Government	$ 190,048	$ 203,050			$ 207,897			$ 215,759			$ 223,917		
Medicare	217,843	204,004			206,549			206,093			210,633		
Medicaid and Other Medical Assistance	56,239	54,399			55,635			57,629			59,699		
Medical Group	13,827	17,760			18,293			18,842			19,407		
Total Net Patient Revenue	477,957	479,213	-		488,374	-		498,323	-		513,656	-	
Other Operating Revenue	23,534	23,102			23,805			24,529			25,277		
Revenue from Operations	501,491	502,315	-		512,179	-		522,852	-		538,933	-	
OPERATING EXPENSES													
Salaries and Fringe Benefits	334,441	291,305			300,235			312,811			326,088		
Professional / Contracted Services		47,284			48,181			49,612			51,086		
Supplies and Drugs	125,050	127,127			129,822			133,833			137,817		
Bad Debts	22,840	23,511			23,981			24,461			25,195		
Other Operating Expense													
Subtotal	482,331	489,227	-		502,219	-		520,717	-		540,186	-	
Depreciation/Amortization	13,478	14,135			14,900			14,100			13,000		
Interest Expense	2,513	3,329			3,329			3,329			3,329		
Lease Expense													
Total Operating Expense	498,322	506,691	-		520,448	-		538,146	-		556,515	-	
Gain/(Loss) from Operations	3,169	(4,376)	-		(8,269)	-		(15,294)	-		(17,582)	-	
Plus: Non-Operating Revenue	305	225			232			238			246		
Revenue Over/(Under) Expense	$ 3,474	$ (4,151)	$ -		$ (8,037)	$ -		$ (15,056)	$ -		$ (17,336)	$ -	
Hospital FTEs	3,124	3,004			2,971			2,970			2,969		
Hospital Inpatient Discharges	23,120	21,793			21,226			21,226			21,226		
Hospital Outpatient Equivalents	11,672	12,308			12,308			12,308			12,308		

Attachment VIII

Assumptions for OHCA Financial Attachment I

Yale-New Haven Hospital's Acquisition of Saint Raphael Healthcare System Inc.
CON ASSUMPTIONS

		FY 2012	FY 2013	FY 2014	FY 2015
A.	Net Revenue Rate Increases				
	1) Government	0.0 - 2.8%	0.0 - 2.8%	0.0 - 2.8%	0.0 - 2.8%
	2) Non-Government	5.0 - 6.0%	5.0 - 6.0%	5.0 - 6.0%	5.0 - 6.0%

		FY 2012	FY 2013	FY 2014	FY 2015
	EXPENSES				
B.	Salaries and Fringe Benefits	5.0%	5.0%	5.0%	5.0%
C.	Non-Salary				
	1) Medical and Surgical Supplies	3.5%	3.5%	3.5%	3.5%
	2) Pharmacy and Solutions	15.0%	15.0%	15.0%	15.0%
	3) Malpractice Insurance	7.0%	7.0%	7.0%	7.0%
	4) Professional and Contracted Services	2.5%	2.5%	2.5%	2.5%
	5) All Other Expenses	3 - 7%	3 - 7%	3 - 7%	3 - 7%
D.	Start Date:	April - 1 - 2012			
E.	Purchase Price:	$160(m)			
F.	HSR Foundation:	Excluded from the CON analysis			
F.	HSR Utilization Increase:	No Increase was assumed			
G.	Incremental FTE's	3,303	3,303	3,303	3,303

Yale-New Haven Hospital's Acquisition of Saint Raphael Healthcare System Inc.
Depreciation Schedule

Description	Capital Amounts	2012	2013	2014	2015
Routine Capital Requirements	**25,000**	2,500	7,500	5,000	5,000
Facility Upgrade Capital Requirements	**85,000**	9,760	29,281	24,401	10,798
Capital Requirements EPIC	**14,427**		8,847	5,580	
IT Collapse Expenditure	**5,100**	1,783	1,783	1,534	
	129,527	14,043	47,411	36,515	15,798
Average Asset Life		**16**	**16**	**16**	**16**
Depreciation on Capital Expenditure		219	2,359	4,982	6,617
Depreciation / Amortization on SRHS existing Depreciable Assets		6,869	13,990	13,039	12,219
		7,088	16,349	18,021	18,836

Saint Raphael's Recurring Operations without Affiliation Transaction

dollars in thousands

Projected as of
2/7/12

Key Assumptions:

[The assumptions are an integral component of the projected results of operations, and actual results will differ from projected results.]

		FY2012	FY2013	FY2014	FY2015
	Hospital Volume Assumptions:				
A. 1)	Inpatient discharges	21,793	21,226	21,226	21,226
2)	Outpatient equivalents	12,308	12,308	12,308	12,308
3)	Payer mix unchanged during projection period				
	Hospital I/P & O/P Net Revenue Rate Increases:				
B. 1)	Government	-1% to 2%	1% to 3%	1% to 3%	1% to 3%
2)	Net negative impact of Health care reform	$ -	$ (800)	$ (9,100)	$ (12,700)
3)	Non-government	5% to 8%	4% to 6%	4% to 6%	4% to 6%
4)	Projected "Financial Bridge Plan" revenue items	$ -	$ -	$ -	$ -
	Expense Inflation:				
C. 1)	Salaries	3%	3%	3%	3%
2)	Fringe benefits	8%	9%	9%	9%
3)	Incremental DC pension costs	$ -	$ -	$ -	$ -
D. 1)	Non-salary costs	3%	3%	3%	3%
2)	Malpractice costs	Actuarial estimates	Actuarial estimates	Actuarial estimates	Actuarial estimates
3)	Professional & contracted services	3%	3%	3%	3%
4)	Variable inpatient costs	60%	60%	60%	60%
	Variable outpatient costs	80%	80%	80%	80%
5)	Other operating revenues	3%	3%	3%	3%
6)	Projected "Financial Bridge Plan" expense items	$ -	$ -	$ -	$ -

Other Key Assumptions:

E. 1) Assumes no affiliation transaction occurs during the projection period.

2) Assumes Defined Contribution pension plan is not re-instituted during the projection period.

3) Due to the inherent unpredictability of the economy in the country and local region during the projection period, and the inherent inability to accurately estimate patient volumes and rates of payment from governmental and non-governmental payers during the projection period, the attached projections are susceptible to a wide range of variability.

The attached projections are based upon known facts as of January 2012 that impact and define assumptions for FY2012-2015. The attached projections reflect an assumed continued trend in reduced levels of inpatient discharges into the projection period. Direct expenses are assumed to flex in accordance with volume reductions. The projected volume decline may vary from this projection, and management actions to reduce other expenses or increase revenues to improve results if such volume reductions are realized, have not been reflected since the action steps in the future are unknown at this time. SRHS' Board and management remain committed to taking necessary management actions to work towards remaining financially viable during challenging economic times.

MRI Appendix

MRI Appendix

MRI CON Questions and Responses – Appendix I

1. **Project Description: Acquisition of Equipment**

   a. Please provide a narrative detailing the proposal.

   As part of the YNHH's proposed acquisition of certain assets of the SRHS, YNHH would assume DePaul Health Services Corporation's 50% ownership share in an existing MRI joint venture, the Saint Raphael Magnetic Resonance Center ("SRMRC"). This joint venture has been in existence since 1988 and is partnership between DePaul Health Services Corporation, a wholly-owned subsidiary of the Saint Raphael Healthcare System and Medical Imaging Associates, a subsidiary of New Haven Radiology Associates, P.C.

   SRMRC operates two MRI scanners approved through Certificate of Need applications (DN: 99-1000, 02-562, 05-22933MDF). Please note that the Applicants are still trying to locate original MRI Docket Number which dates back to 1988. The scanners are located on the Hospital of Saint Raphael's New Haven campus in the lower level of the Orchard Medical Building at 330 Orchard Street, New Haven, CT.

   The scanners provide MRI services to HSR's inpatients, outpatients in the service area and a small number of HSR emergency department patients.

   b. Provide letters that have been received in support of the proposal.

   Not applicable. YNHH's ownership share in SRMRC is part of the entire acquisition of the SRHS.

   c. Provide the Manufacturer, Model, Number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

   Scanner 1: Siemens 3 Tesla Trio
   Scanner 2: Siemens 1.5 Tesla Symphony

   d. List each of the Applicant's sites and the imaging modalities and other services currently offered by location.

   SRHS and HSR offer the following imaging modalities by locations:

SRHS and HSR	Location	Modalities
SRMRC	330 Orchard Street New Haven, CT 06511	MRI
HSR	1450 Chapel Street New Haven, CT 06511	Full service radiology services including:

SRHS and HSR	Location	Modalities
		Bone Densitometry **CT** **Interventional Radiology** **Mammography** **Nuclear Medicine** **PET-CT** **X-Ray** **Ultrasound**
HSR	**2800 Whitney Avenue Hamden, CT**	**Radiation Therapy and CT Simulation**

2. **Clear Public Need**

a. Explain why there is a clear public need for the proposed equipment. Provide evidence that demonstrates this need.

Not applicable. YNHH's acquisition of DePaul Health Service's ownership interest is a component of a larger SRHS and HSR acquisition by YNHH.

SRMRC is a long-standing MRI provider, operating two scanners and performing more than 9,000 MRI scans annually. These scanners will continue to serve patients that seek care at the Saint Raphael campus and the greater New Haven community.

b. Provide the utilization of existing health care facilities and health care services in the Applicant's service area.

Utilization data for other MRI providers is not publicly available information. The following MRI providers have been identified in the service area of SRMRC.

Town	MRI Provider	Address
Branford	**Radiology Associates**	**1208 Main Street**
Cheshire	**MidState Radiology Associates**	**680 S. Main Street**
Derby	**Griffin Hospital**	**130 Division Street**
Guilford	**RAM Radiology**	**1591 Boston Post Road**
	Madison Radiology Imaging	**705 Boston Post Road**
	YNHH – Temple Radiology	**111 Goose Lane**

Town	MRI Provider	Address
Hamden	**Southern CT Imaging Center d/b/a Whitney Imaging Center**	**2200 Whitney Avenue**
Meriden	**MidState Medical Center**	**435 Lewis Avenue**
Milford	**Diagnostic Imaging of Milford**	**30 Commerce Park**
	Milford Hospital	**300 Seaside Avenue**
New Haven	**University Standing Open MRI of New Haven**	**216 Crown Street**
	Yale University Health Services	**150 Sargent Drive**
	YNHH Temple Radiology	**60 Temple Street**
	YNHH – Main campus	**20 York Street**
Orange	**Advanced Radiology Consultants**	**320 Boston Post Road**
Shelton	**Robert Russo, MD & Associates**	**25 Constitution Blvd.**

Note: OHCA indicated by telephone that MRI volumes for YNHH were not required in this CON application as they are available to OHCA via the recent Imaging survey.

c. Complete **Table 1** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

Table 1: Existing Equipment Operated by the Applicant

Provider Name Street Address Town, Zip Code	Description of Service *	Hours/Days of Operation **	Utilization ***
SRMRC 330 Orchard Street New Haven, CT	MRI Scanning 1 - 3T Scanner 1 – 1.5T Scanner	Monday through Friday: 6:30am – 10:30 pm Saturday: 7am – 3pm	9,127 scans (FY 2011)

* Include equipment strength (e.g. slices, tesla strength), whether the unit is open or closed (for MRI)
** Days of the week unit is operational, and start and end time for each day; and
*** Number of scans/exams performed on each unit for the most recent 12-month period (identify period).

d. Provide the following regarding the proposal's location:

i. The rationale for locating the proposed equipment at the proposed site;

The two MRI scanners are currently located at 330 Orchard Street in New Haven, CT and will continue operation in the same location. It is planned that they will continue to serve the patient population that seeks care at the Saint Raphael campus and the greater New Haven community.

ii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

The population to be served includes residents of the service area that require MRI imaging either as inpatients, outpatients or emergency department patients.

iii. How and where the proposed patient population is currently being served;

The proposed patient population is currently being served by SRMRC and that is expected to continue.

iv. All existing providers (name, address) of the proposed service in the towns listed above and in nearby towns;

See response to question 3 b.

v. The effect of the proposal on existing providers; and

There is no effect anticipated on existing providers in the service area as this proposal represents only a change of one of two partners in an existing MRI service and has an established patient base.

vi. If the proposal involves a new site of service, identify the service area towns and the basis for their selection.

Not applicable. No new site of service is proposed.

e. Explain why the proposal will not result in an unnecessary duplication of existing or approved health care services.

Not applicable. This proposal represents only a change of one of two partners in an existing MRI service. No additional equipment is proposed.

3. Actual and Projected Volume

a. Complete the following tables 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 proposed pieces of equipment (of the type proposed, at the proposed location only). In Table 2a, report the units of service by piece of

equipment, and in Table 2b, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

Table 2a: Historical, Current, and Projected Volume, by Equipment Unit

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
MRI Scans (1)							
Inpatient	2,112	2,133	2,114	2,124	2,354	2,473	2,623
Outpatient	7,853	7,257	7,008	7,089	7,160	7,303	7,522
Total	9,965	9,390	9,122	9,213	9,514	9,776	10,145

'(1) Scan volume is not tracked by scanner. Volumes include both scanners.

***FY 2012 volume annualized based on first quarter actual.**

* 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.

** 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.

*** Identify each scanner separately and add lines as necessary. Also break out inpatient/outpatient/ED volumes if applicable. **Inpatient and Outpatient volume has been provided. ED volume is not tracked specifically.**

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

Table 2b: Historical, Current, and Projected Volume, by Type of Scan/Exam

	Actual Volume (Last 3 Completed FYs)			CFY Volume*	Projected Volume (First 3 Full Operational FYs)**		
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Service type***							
Body	2,747	2,583	2,489	2,487	2,569	2,640	2,739
Neuro	7,218	6,807	6,633	6,725	6,945	7,137	7,406
Total	9,965	9,390	9,122	9,212	9,514	9,776	10,145

* 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.

** 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.

*** Identify each type of scan/exam (e.g. orthopedic, neurosurgery or if there are scans/exams that can be performed on the proposed piece of equipment that the Applicant is unable to perform on its existing equipment) and add lines as necessary.

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

b. Provide a breakdown, by town, of the volumes provided in Table 2a for the most recently completed full FY.

Included as Attachment A is a listing of MRI scans by patient town of origin for FY 2011.

c. Describe existing referral patterns in the area to be served by the proposal.

As previously stated, SRMRC is an established MRI provider in Greater New Haven and has an existing referring physician base representing the majority of medical specialties.

d. Explain how the existing referral patterns will be affected by the proposal.

Existing referral patterns are expected to continue following any acquisition by YNHH of DePaul Health Services ownership interest in SRMRC.

e. Explain any increases and/or decreases in volume seen in the tables above.

Historical volumes between FY 2009 and FY 2011 have declined slightly. This decline is assumed to be related to the challenges faced by the Hospital of Saint Raphael as described more fully in the main CON application. Despite the small decline during the past couple of years, each scanner is performing more than 4,500 scans and remains highly utilized. A breast radiologist and a full time marketing staff person have recently been added and their roles are expected to increase outpatient volumes.

i. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Projected volumes were developed based on the following assumptions:

- **Outpatient scan volume is projected to increase slightly due to the addition of a marketing staff role and a breast radiologist. Projected increases are listed below:**
  - **FY 2012: Annualized first quarter actual**
  - **FY 2013: 1% growth**
  - **FY 2014: 2% growth**
  - **FY 2015: 3% growth**
- **Inpatient scan volume is projected to increase in proportion to an expected increase in the average daily inpatient census (ADC) at the Saint Raphael campus following the acquisition by YNHH. Projected FY 2012 inpatient scan volume is based on first quarter actual annualized. The ADC is projected to increase by 40 in FY 2013, 60 in FY 2014 and 85 in FY 2015. The ratio of inpatient MRI to ADC was determined for FY 2011 and applied to the**

projected increase in ADC to project incremental inpatient MRI scans.

f. Provide a copy of any articles, studies, or reports that support the need to acquire the proposed scanner, along with a brief explanation regarding the relevance of the selected articles.

Not applicable. This proposal is not related to the addition or introduction of any new technology.

4. Quality Measures

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

Key professional, administrative and clinical personnel related to SRMRC include:

Copies of CV's have been included in Attachment B.

b. Explain how the proposal contributes to the quality of health care delivery in the region.

SRMRC has been a high quality provider of MRI services in the region. The MRI scanners are accredited by the American College of Radiology. Copies of SRMRC's ACR certificates have been included in Attachment C.

5. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

SRMRC is a partnership.

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☒ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

Not applicable. DPH does not license MRI providers.

d. Financial Statements

i. If the Applicant is a Connecticut hospital: Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. If the Applicant is not a Connecticut hospital (other health care facilities): Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

SRMRC does not have audited financial statements. A copy of SRMRC's most recent internal financial statements is included as Attachment D.

e. Submit a final version of all capital expenditures/costs as follows:

Table 3: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure (TCE)	
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost (TCC)	$
Total Project Cost (TCE + TCC)	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* 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.

f. 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.

Financing for the proposed MRI acquisition is part of an overall financing plan for the acquisition of SRHS and HSR and is planned to include tax exempt finance where appropriate with the difference being financed with taxable financing.

g. Demonstrate how this proposal will affect the financial strength of the state's health care system.

The proposed acquisition by YNHH of DePaul Health Services' ownership interest in SRMRC is part of an overall acquisition of the SRHS and HSR by YNHH. This proposal will preserve access to critically needed MRI services in the greater New Haven community and will strengthen the financial health of SRMRC which in turn strengthens the financial health of the State's health care system.

6. Patient Population Mix: Current and Projected

a. Provide the current and projected patient population mix (based on the number of patients, not based on revenue) with the CON proposal for the proposed program.

Table 4: Patient Population Mix

	Current** FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	26%	26%	26%	26%
Medicaid*	9%	9%	9%	9%
CHAMPUS & TriCare	1%	1%	1%	1%
Total Government	**36%**	**36%**	**36%**	**36%**
Commercial Insurers*	58%	58%	58%	58%
Uninsured	1%	1%	1%	1%
Workers Compensation	5%	5%	5%	5%
Total Non-Government	64%	64%	64%	64%
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

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

b. Provide the basis for/assumptions used to project the patient population mix.

Payer mix is based on the number of scans by patient's type of payer. No changes in payer mix are projected.

7. Financial Attachments I & II

a. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

Financial Attachment I has been provided in Attachment E.

b. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

YNHH and SRHS/HSR cannot share managed care rate information and therefore Financial Attachment II has not been provided.

c. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

Assumptions utilized in Financial Attachment I are also included in Attachment E.

d. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

A copy of SRMRC's charges has been included in Attachment F.

e. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

Not applicable. There are no incremental losses from the proposal.

f. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

Not applicable. There are no incremental losses from the proposal.

g. Describe how this proposal is cost effective.

As previously noted, this proposal is a part of a larger acquisition of SRHS/HSR by YNHH. Please refer to the response to this question in the main CON application.

Attachment A

MRI Scans by Patient Town of Origin

SRMRC
FY 2011
Outpatients by Town of Origin

TOWN	ZIP CODES	Volume	% Total
NEW HAVEN	06511	2383	34%
WEST HAVEN	06516	640	9%
EAST HAVEN	06512	395	6%
NEW HAVEN	06513	290	4%
HAMDEN	06514	269	4%
NORTH HAVEN	06473	223	3%
BRANFORD	06405	214	3%
WALLINGFORD	06492	210	3%
NEW HAVEN	06515	176	3%
MILFORD	06460	168	2%
ORANGE	06477	164	2%
HAMDEN	06518	144	2%
HAMDEN	06517	129	2%
CHESHIRE	06410	100	1%
NEW HAVEN	06519	96	1%
GUILFORD	06437	95	1%
WOODBRIDGE	06525	93	1%
NORTH BRANFORD	06471	77	1%
MADISON	06443	70	1%
NORTHFORD	06472	64	1%
MERIDEN	06450	56	1%
HUNTINGTON	06484	50	1%
BETHANY	06524	44	1%
SEYMOUR	06483	38	1%
ANSONIA	06401	36	1%
DERBY	06418	31	0%
MILFORD	06461	30	0%
OXFORD	06478	30	0%
MERIDEN	06451	29	0%
SOUTHINGTON	06489	28	0%
MIDDLETOWN	06457	26	0%
NAUGATUCK	06770	26	0%
CLINTON	06413	24	0%
PROSPECT	06712	22	0%
STRATFORD	06614	18	0%
DURHAM	06422	15	0%
TRUMBULL	06611	15	0%
WESTBROOK	06498	13	0%
BRIDGEPORT	06606	13	0%
WATERBURY	06475	12	0%
		0	
< 17 PER ZIP CODE		454	6%
TOTAL		7008	100%

SRMRC
FY 2011
Inpatients by Town of Origin

TOWN	ZIP CODES	Volume	% Total
NEW HAVEN	06511	480	23%
WEST HAVEN	06516	197	9%
EAST HAVEN	06512	128	6%
NORTH HAVEN	06473	98	5%
HAMDEN	06514	90	4%
NEW HAVEN	06513	88	4%
BRANFORD	06405	84	4%
WALLINGFORD	06492	79	4%
MILFORD	06460	64	3%
ORANGE	06477	59	3%
NEW HAVEN	06515	53	3%
HAMDEN	06518	49	2%
HAMDEN	06517	45	2%
GUILFORD	06437	40	2%
CHESHIRE	06410	39	2%
WOODBRIDGE	06525	35	2%
NORTH BRANFORD	06471	29	1%
NEW HAVEN	06519	28	1%
MADISON	06443	26	1%
MERIDEN	06450	22	1%
NORTHFORD	06472	22	1%
HUNTINGTON	06484	17	1%
BETHANY	06524	15	1%
SEYMOUR	06483	15	1%
DERBY	06418	15	1%
ANSONIA	06401	13	1%
MERIDEN	06451	12	1%
CLINTON	06413	11	1%
OXFORD	06478	10	0%
MIDDLETOWN	06457	9	0%
MILFORD	06461	8	0%
NAUGATUCK	06770	8	0%
SOUTHINGTON	06489	7	0%
STRATFORD	06614	7	0%
KILLINGWORTH	06419	7	0%
TRUMBULL	06611	6	0%
WESTBROOK	06498	6	0%
OLD SAYBROOK	06475	5	0%
PROSPECT	06712	5	0%
DURHAM	06422	5	0%
< 5 PER ZIP CODE		176	8%
TOTAL		2114	100%

Attachment B

CVs

Name: Zenon Protopapas, M.D. Date: January 30, 2012

Born: August 26, 1959. Nicosia Cyprus.

Education:

Medical Degree	1980-86	Albert-Ludwigs University, Freiburg, Germany (Magna Cum Laude) German Academic Exchange Service Scholarship

Career:

1986-87	Research Associate, Department of Biochemistry, Tufts University School of Medicine, Boston, MA
1987-90	Internal Medicine, Waterbury Hospital, Waterbury, CT
1990-94	Radiology Residency, Hospital of St. Raphael, New Haven, CT
1993-94	Chief Resident
1/95 - 1997	Assistant Professor, Department of Diagnostic Radiology, University of Maryland School of Medicine, Baltimore, MD
1997 – present	Attending, Department of Radiology, Hospital of St Raphael, New Haven, CT.
2008 – present	Medical Director, Saint Raphael Magnetic Resonance Center
2008 – present	President Medical Imaging Associates
2003	Assistant Clinical Professor of Radiology, Yale School of Medicine.

Board Certification:

1990	American Board of Internal Medicine
1994	American Board of Radiology

Professional Honors:

2006 American Roentgen Ray Society Scientific Exhibit Award: Bronze Medal.
MR Imaging of Cardiomyopathies; Can we tell them apart?

2005 American Roentgen Ray Society Scientific Exhibit Award: Certificate of Merit.
Standard Cardiac MR Imaging Planes and Normal Cardiac Anatomy:
All you wanted to know and were afraid to ask.

1996 Radiological Society of North America Scientific Award: Certificate of Merit.

Cross sectional anatomy of the pericardial recesses.

Bibliography:

Original Papers:

1. Reiner B. Siegel E. Protopapas Z. Hooper F. Ghebrekidan H. Scanlon M. Impact of filmless radiology on frequency of clinician consultations with radiologists. American Journal of Roentgenology. 173(5):1169-72, 1999.

2. Reiner BI. Siegel EL. Hooper F. Protopapas Z. Impact of filmless imaging on the frequency of clinician review of radiology images. Journal of Digital Imaging. 11(3 Suppl 1):149-50, 1998.

3. Rozenshtein A. White CS. Austin JH. Romney BM. Protopapas Z. Krasna MJ. Incidental lung carcinoma detected at CT in patients selected for lung volume reduction surgery to treat severe pulmonary emphysema. Radiology. 207(2):487-90, 1998

4. Reiner B. Siegel E. Hooper F. Ghebrekidan H. Warner J. Briscoe B. Protopapas Z. Pomerantz S. Variation of monitor luminance on radiologist productivity in the interpretation of skeletal radiographs using a picture archiving and communication system. Journal of Digital Imaging. 10(3 Suppl 1):176, 1997

5. Reiner B. Siegel E. Hooper F. Ghebrekidan H. Warner J. Briscoe B. Protopapas Z. Pomerantz S. Effect of screen monitor number on radiologist productivity in the interpretation of portable chest radiographs using a picture archiving and communication system. Journal of Digital Imaging. 10(3 Suppl 1):175, 1997.

6. Protopapas Z. Siegel EL. Scanlon M. Mazan W. Reiner BI. Ghabrekidan H. Warner J. Pomerantz SM. Gitlin JN. Experience with comparative picture archiving and communication system baseline data collection at four Veterans Affairs Medical Centers: methodology, lessons learned, and suggestions for improvement. Journal of Digital Imaging. 10(3 Suppl 1):161-4, 1997.

7. Siegel EL. Protopapas Z. Reiner BI. Pomerantz SM. Patterns of utilization of computer workstations in a filmless environment and implications for current and future picture archiving and communication systems. Journal of Digital Imaging. 10(3 Suppl 1):41-3, 1997.

8. Latief KH. White CS. Protopapas Z. Attar S. Krasna MJ. Search for a primary lung neoplasm in patients with brain metastasis: is the chest radiograph sufficient? American Journal of Roentgenology. 168(5):1339-44, 1997.

9. Reiner BI. Siegel EL. Hooper F. Pomerantz SM. Protopapas Z. Pickar E. Killewich L. Picture archiving and communication systems and vascular surgery:

clinical impressions and suggestions for improvement. Journal of Digital Imaging. 9(4):167-71, 1996.

10. Protopapas Z. Siegel EL. Reiner BI. Pomerantz SM. Pickar ER. Wilson M. Hooper FJ. Picture archiving and communication system training for physicians: lessons learned at the Baltimore VA Medical Center. Journal of Digital Imaging. 9(3):131-6, 1996.

11. Pomerantz SM. Siegel EL. Protopapas Z. Reiner BI. Pickar ER. Experience and design recommendations for picture archiving and communication systems in the surgical setting. Journal of Digital Imaging. 9(3):123-30, 1996.

12. Reiner B. Siegel E. McLaurin T. Pomerantz S. Allman R. Hebel JR. Fritz S. Protopapas Z. Evaluation of soft-tissue foreign bodies: comparing conventional plain film radiography, computed radiography printed on film, and computed radiography displayed on a computer workstation. American Journal of Roentgenology. 167(1):141-4, 1996.

13. Protopapas Z. Westcott JL. Transthoracic needle biopsy of mediastinal lymph nodes for staging lung and other cancers. Radiology. 199(2):489-96, 1996.

14. White CS. Romney BM. Mason AC. Austin JH. Miller BH. Protopapas Z. Primary carcinoma of the lung overlooked at CT: analysis of findings in 14 patients. Radiology. 199(1):109-15, 1996.

15. Protopapas Z. Westcott JL. Left pulmonic recess of the pericardium: findings at CT and MR imaging. Radiology. 196(1):85-8, 1995.

16. Meyer DK. Protopapas Z. Studies on cholecystokinin-containing neuronal pathways in rat cerebral cortex and striatum. Annals of the New York Academy of Sciences. 448:133-43, 1985.

17. Charina Gayomali, Usama Hussein, Scott Cameron. Zenon Protopapas, Fredric O. Finkelstein Encapsulating Peritoneal Sclerosis: A Single-Center Experience. Peritoneal Dialysis International. Accepted 3/9/2011

18. Ciampi, Marc A.; Sadigh, Majid J; Sherwood, A.; Protopapas, Zenon; Thornton, George F.; Andriole, Vincent T. Temperate Pyomyositis at Two Community Hospitals. Infectious Diseases in Clinical Practice. 7:265-273, 1998.

Case Reports:

19. Rao SK, Protopapas Z, Vikram HR. Unusual presentation of purulent pericarditis: diagnostic contribution of MRI. Emergency Radiology. 10 (3): 152 – 154, 2003.

20. Chrissoheris M, Ali R, Vivas Y, Marieb M, Protopapas Z. Isolated noncompaction of the ventricular myocardium: contemporary diagnosis and management. Clin Cardiol. 2007 Apr;30(4):156-60.

21. Cardiac assessment of patients with Becker's Muscular Dystrophy; Costin N. Ionescu MD PhD, Ajoy Kapoor MD, Zenon Protopapas MD Constatin B. Marcu MD: Connecticut Medicine. 73(7):395-7, 2009 Aug.

Reviews, Chapters, Books:

22. Protopapas Z. Westcott JL. Transthoracic hilar and mediastinal biopsy. Radiologic Clinics of North America. 38(2):281-91, 2000.

23. Protopapas Z. Westcott JL. Transthoracic hilar and mediastinal biopsy. Journal of Thoracic Imaging. 12(4):250-8, 1997.

FRANK MICHAEL MELE, MD
President, New Haven Radiology Associates, PC
200 Burr Street, Fairfield, CT
Home: 203.254.9573
Mobile: 203.218.4610
fmele@nhrad.com

Education:

1984-1988
Albright College
Reading, PA
Bachelor of Science

1988-1992
The Chicago Medical School
Chicago, IL
Doctor of Medicine

Training:

1992-1993
Medical Internship
Norwalk Hospital
Norwalk, CT

1993-1997
Radiology Residency
Hospital of Saint Raphael
New Haven, CT

1997-1998
Thoracic Imaging Fellowship/Winchester Fellow
Yale New Haven Hospital
New Haven, CT

Board Certification:

The American Board of Radiology- June, 1997

Experience:

1998-present
Attending Radiologist, Thoracic Imaging Section Chief and Chief of Diagnostics
New Haven Radiology Associates

Professional Honors/Recognition:

1998
Yale New Haven Hospital Radiology Fellow of the Year

1997
Robert Shapiro Radiology Resident of the Year

1996-1997
Chief Resident, Department of Radiology

1996
Medical Staff President's Award

1990
Alpha Omega Alpha

Memberships:

American College of Radiology
American Medical Association
American Roentgen Ray Society
Connecticut Radiology Society
New England Radiology Society
New Haven County Medical Association
Society of Thoracic Radiology

Licensure:

Connecticut since 1997

Publications:

Mele FM, Forman B, Caride VJ. Thymic Uptake of Gallium in a Patient with Unsuspected Hyperthyroidism. American Journal of Roentgenology 1996; 166:450.

Mele FM,Caride VJ. Pleural Effusion. Patterns on Ventilation Perfusion Lung Scanning. Clinical Nuclear Medicine, 1998;23:571-575.

Mele FM, Friedman M, Reznik A. MRI of the Knee: Findings in Cat Scratch Disease. American Journal of Roentgenology 1996; 166:1232.

Mele FM, Ileal-Loop Bypass: A Historical Encounter. American Journal of Roentgenology 1996; 167:281.

Chapters:

Reinhold R, Mele FM, Jajoo D. Chapter 25: "Selected Technologies and General Surgery." The Physiologic Basis of Surgery. J Patrick O'Leary, Editor, Williams and Wilkins. 1996.

Sostman HD, Mele FM, Matthay RA. Chapter 6: "Chest Imaging" Chest Medicine. Ronald B. George, Editor. Lippincott Williams & Wilkins. 2000.

Sostman HD, Mele FM, Matthay RA. Chapter 6: "Chest Imaging" Chest Medicine. Ronald B. George, Editor. Lippincott Williams & Wilkins. 2005.

CURRICULUM VITAE

1. **Date:** **December 2011**

I. PERSONAL

2. **Name:** **DIEGO B. NUÑEZ, JR., M.D., MPH**
3. **Home Phone:** (203)-795-3210
4. **Office Phone:** (203)-789-3627
5. **Home Address:** 25 Hedgefield CT, Orange CT 06477
6. **Current Academic Rank:** **Clinical Professor of Radiology**
   Yale University School of Medicine.
   New Haven CT
7. **Primary Department:** **Chairman**
   Department of Radiology
   Hospital of Saint Raphael.
   New Haven CT
8. **Citizenship:** US Citizen
9. **Social Security** 023-48-3024

II. HIGHER EDUCATION

11. **Institutional:**

Fatima High School
Fort Lee, New Jersey, 1960

Santiago de Leon de Caracas College
Caracas, Venezuela
Degree: B.S., 1965

Universidad Central de Venezuela
Caracas, Venezuela

Degree: M.D., 1972

Internal Medicine Internship
Carney Hospital
Boston University School of Medicine
Boston, MA
July 1972 - June 1973

Diagnostic Radiology Residency
Hospital of St. Raphael
Yale University School of Medicine
New Haven, CT
July 1973 - June 1976

Cardiovascular Radiology/Special
Procedures Fellowship
Jackson Memorial Hospital
University of Miami School of Medicine
Miami, FL
July 1976 - June 1977

Master of Public Health in
Health Care Management and Policy
Harvard School of Public Health
Sept 1999 – June 2001

12. Non-Institutional: None

13. Certification, Licensure: National Board of Medical Examiners, 1974

Diplomate, American Board of Radiology, 1976

Diplomate, American Board of Radiology with added qualifications in Vascular and Interventional Radiology, 1995.

Diplomate, American Board of Radiology with Added qualifications in Neuroradiology, 1997

Washington DC- 1975-1981 (not active)

State of Florida - #0039362, issued in 1981

State of Massachusetts- #160251, issued in 1999.

State of Connecticut- # 039728, issued in 2001

III. EXPERIENCE

14. Academic:

Clinical Instructor
Department of Radiology
University of Miami School of Medicine
Miami, FL
1978-1982

Assistant Professor of Radiology
University of Miami School of Medicine
Miami, FL
January 1983-June 1986

Clinical Associate Professor of Radiology
University of Miami School of Medicine
Miami, FL
July 1986-July 1991

Associate Professor of Clinical Radiology
University of Miami School of Medicine
August 1991-June 1996

Professor of Clinical Radiology & Surgery
University of Miami School of Medicine
July 1996-June 1998

Professor of Radiology & Surgery with tenure
University of Miami School of Medicine
July 1998-June 2001.

Visiting Professor of Radiology
Harvard Medical School
September 1999 to August 2001

Clinical Professor of Radiology
Yale University School of Medicine
Sept 2001 to present

15. Non-Academic:

Attending Radiologist
Centro Medico de Caracas

Caracas, Venezuela
1978-1982

Attending Radiologist
Jackson Memorial Medical Center
VA Medical Center
Miami, FL
1983-1986

Chairman, Department of Radiology
Centro Medico de Caracas
Caracas, Venezuela
1986-1991

Visiting Fellow, Neuroradiology and MRI
University of Miami/MR Center
Miami,FL.
1988- 1989

Chief, Emergency and Trauma Radiology
University of Miami/Jackson Memorial
Medical Center
Miami, FL
1991- 1999

Chief, University of Miami Radiology
Services Cedars Medical Center
Miami, FL
1995- 1998

Coordinator, Neuroangiography Services
Jackson Memorial Medical Center
Miami, FL
1994-1995

Attending Radiologist, Emergency Radiology
Department of Radiology-Brigham and Women's
Hospital-Harvard Medical School
1999- 2000

Director, Emergency Radiology Section
Department of Radiology-Brigham and Women's
Hospital-Harvard Medical School
2000- 2001

Director, Post Graduate Education
Department of Radiology
Brigham and Women's Hospital
Harvard Medical School
March 2001 to August 2001

Chairman, Department of Radiology
Hospital of St. Raphael
Yale University School of Medicine
Sept 2001 to present

Residency Program Director
Hospital of St Raphael
Yale University School of Medicne
2005-2007

16. Military: None

IV. PUBLICATIONS

17. Books, Chapters and Monographs Published:

Nunez Jr D El diagnostico de la lesion traumatica cervical: Una decada de cambios basados en la evidencia: Radiologia, 2006; 48(4):185-7

Nunez Jr D Facial and suprahyoid neck infections. In Franquet and Berrocal. Imagenes diagnosticas en la infeccion. Panamericana Editorial, Madrid, Spain, 2006

Nuñez Jr D Imaging the multitrauma victim . In Del Cura and Oleaga. La Radiologia de Urgencias. Panamericana Editorial, Madrid, Spain 2005

Ledbetter MS, **Nunez Jr D** Abdominal trauma in patients with pre-existing lesions. In Dondelinger RF editor. Imaging in abdominal trauma, Berlin-Heilderberg: Springer Verlag; 2004

Rogers L, **Nuñez Jr D** Cervical Spine Injuries. In Rogers L, Radiology of Skeletal Trauma., Phila Lippincott Co. 2002

Nuñez Jr D, Zuluaga A. Cervical Spine Trauma. In Taveras J ed. Texbook of Radiology. Phila: Lippincott Co. 2001

Nuñez Jr D. Chest Trauma: Vascular Injuries. In Taveras J ed. Textbook of Radiology. Phila: Lippincott Co. 2000

Munera F, Zuluaga A, **Nuñez Jr D.** Abdominal Trauma. In Taveras J ed. Textbook of Radiology. Phila: Lippincott Co. 1999

Nuñez Jr D, Lentz K. Interventional Radiology in the critically ill patient. In Civetta J ed. *Critical Care* Phila: JB Lippincott Co. 1997

Nuñez Jr. D. Imaging of acute cervical spine trauma.
In: Practical Reviews in Radiology. Vol. 21- Number 11, May 1996

Nuñez Jr. D. Imaging of the hepatobiliary system. In Beker S ed. *Hepatology for the clinician.* New York: Allan R. Liss. 7-17. 1988

Nuñez Jr. D: Liver diseases. Radiological studies: ultrasound evaluation (Gray Scale). In Beker S ed. *Diagnostic procedures in the evaluation of hepatic disease.* New York: Allan R. Liss. 289. 1983

Nuñez Jr. D. *Caliber Changes of the Celiac Branches*. In Radiolog, Biomedia, Inc., Princeton, NJ., 1(8), 1979

18. **Juried or Refereed Journal Articles or Exhibitions:**

Gonzalez Beicos A, Nunez Jr D. Imaging of Acute Head and Neck Infections. *Rad Cl of N Am 50:73-83, 2012*

Gonzalez-Beicos A, **Nunez Jr D.** Role of multidetector CT in the assessment of cervical spine trauma. *Seminars in US, CT and MRI 30;159-167, 2009*

Brandman S, **Nunez Jr D**. Emergent Infections of the head and neck. In: *State of the Art Emergency Radiology 1-9. ARRS 2008 syllabus, Nunez D, Ledbetter S, Soto J, Yu J, Eds.*

Gonzalez-Beicos A, **Nuñez Jr D**. et al: Trauma to the ankylotic spine: Imaging spectrum of vertebral and soft tissue injuries.
Emergency Radiology 14:371. 2007

Nuñez Jr, D, Berkmen T: Blunt cerebrovascular injuries. *European Journal of Radiology,* 59:317-326, 2006.

Staller B, Munera F, Sanchez A, **Nuñez Jr, D**: Helical and multislice CTA following penetrating trauma to the subclavian and axillary arteries. *Emergency Radiology* 11:336-41, 2005

Rao S, Wasyliw C, **Nunez Jr D:** Hyperextension injuries of the neck: Spectrum of imaging findings . *Radiographics,* 2;:1239-1254, 2005

Munera F, Soto JA, **Nunez Jr D** : Penetrating Injuries of the neck and the increasing role of CTA. *Emergency Radiology,* 10: 303-309, 2004

Nunez Jr D, Torres-Leon M, Munera F: Vascular injuries of the neck and thoracic inlet:
Helical CT/ Angiographic Correlation. *Radiographics*, 24:1087-1098, 2004

Rao S, **Nunez Jr D**, Gahbauer H: MRI evaluation of an open globe injury *Emergency Radiology* 10:144-146, 2003

Nunez Jr D: Cervical Spine trauma Imaging: Are we finally agreeing? *Emergency Radiology*, Editorial 10:126-127, 2003

Kang P, **Nunez Jr D**: Arteriovenous fistula following pacemaker lead removal: CT diagnosis. *Emergency Radiology,* 10:40, 2003

Nunez Jr D, Ledbetter ML, Farrell L: Dedicated CT scanner in an Emergency Department: Quantification of factors contributing to lack of use.
AJR, 179:859-862, 2002

Rybicky F, Nawfel R, Ledbetter ML, **Nunez Jr. D**: Thyroid Dose estimates in routine screening for suspected cervical spine injury: A comparison between helical CT of the entire cervical spine and a radiographic trauma series.
AJR 179:933-937, 2002

Nunez Jr D: Helical CT of cervical spine in trauma patients. AJR, 178: 1566, 2002

Rybicky F, Knoll B, McKenney K, **Nuñez Jr. D**: Are cervical spine radiographs necessary in the initial trauma assessment when helical CT is routine?
Emergency Radiology, 7: 352-355, 2000

Blackmore C, Mann F, **Nuñez Jr. D**.: Variability in the practice of Emergency Radiology: A Survey among Members of the American Society of Emergency Radiology. *Emergency Radiology,* 7: 142-148, 2000

Nuñez Jr. D, Baptista K, McKenney KA: Trauma to abnormal organs: CT Diagnosis. *Emergency Radiology,* 7: 120-125, 2000

Nuñez Jr. DB. Value of complete cervical helical computed tomography in identifying cervical spine injuries. *Journal of Trauma*, 48:988-989, 2000.

LeBlang SD, **Nuñez Jr.** D: Non invasive imaging of cervical vascular injuries *AJR,* 174:1269-1278, 2000

Pihneiro LW, McKenney KL, Rivas LE, **Nuñez Jr. D**: Incidental findings on trauma sonography- Is there more than just free fluid? *Emergency Radiology,* 7:19-24, 2000.

Leblang SD, **Nuñez Jr. D**: Helical CT of Cervical Spine and Soft Tissue Injuries of the Neck. *Radiol Clin North Am,* 37: 515-532,1999.

Fishman JE, **Nuñez Jr. D** Kane A, Rivas LA, Jacobs WE: Direct versus Indirect Signs of Traumatic Aortic Injury Revealed by Helical CT: Performance characteristics and interobserver agreement. *AJR,* 172:1027-1031, 1999.

Nuñez Jr. D , Quencer R: The Role of helical CT in the assessment of cervical spine injuries. *AJR*, 171:951-957,1998.

Fernandez L, McKenney MG, McKenney KL, **Nuñez D**: Ultrasound in blunt abdominal trauma. A review. *Journal of Trauma,* 45:841-848, 1998.

McKenney KL, **Nuñez DB**, McKenney MG, Cohn S: Ultrasound for blunt abdominal trauma: Is it free fluid? *Emergency Radiology,* 5:203-209, 1998.

Nuñez Jr. D, Rivas L, McKenney K, LeBlang S, Zuluaga A: Helical CT of Traumatic Arterial Injuries. *AJR*, 170:1621-1626,1998

Nuñez Jr. D: Helical CT for the Evaluation of Cervical Vertebral Injuries. *Seminars in Musculoskeletal Radiology*, 2:19-26, 1998

McKenney KL, **Nuñez Jr. D,** McKenney MG, Aser J, Zelnick K, Shipshak D: Sonography as the Primary Screening Technique for Blunt Abdominal Trauma: Experience with 899 Patients. *AJR*, 170:979-985, 1998

Quencer RM, **Nuñez Jr. D**, and Green BA: Controversies in Imaging Acute Cervical Spine Trauma. *AJNR* 18:1866-1868, 1997

LeBlang S, **Nuñez Jr. D**, et al: CT in gunshot wounds to the neck: Can we predict vascular injuries?. *Emergency Radiology*, 4:191-199, 1997

LeBlang S, **Nuñez Jr. D**, et al: Helical CT Angiography in penetrating neck trauma. *Emergency Radiology*, 4:200-206, 1997

McKenney K, McKenney M, **Nuñez Jr. D,** Martin L: Cost reduction using Ultrasound in Blunt Abdominal Trauma. *Emergency Radiology*; 4:3-6, 1997

Nuñez Jr. D, Zuluaga A, Fuentes-Bernardo D, Rivas L: Cervical Spine Trauma: How Much More do We Learn by Routinely Using Helical CT? *RadioGraphics*; 16:1307-1318, 1996

Nuñez Jr. D, Becerra JL, Fuentes D, Pagson S: Traumatic Occlusion of the Renal Artery: Helical CT Diagnosis. *AJR*; 167:777-780, 1996

Ginzburg E, Montalvo BM , LeBlang SD, **Nuñez Jr. D**, Martin L: The use of duplex ultrasonography in penetrating neck trauma. *Arch Surgery*; 131:691-693, 1996

Montalvo BM, LeBlang SD, **Nuñez Jr. D**, Ginsburg EK. Color Doppler Sonography in Penetrating Injuries of the Neck. *AJNR*; 17: 943-951, 1996

Lentz KA. McKenney MG, **Nuñez Jr. D,** McDowell L: Interpreting the trauma ultrasound: Observations in 62 positive cases. *Emergency Radiology*; 3: 113-117, 1996

Lentz KA, McKenney MG, **Nuñez Jr. D,** Martin L: Evaluating blunt abdominal trauma: Role for ultrasonography. *Journal of Ultrasound in Medicine*; 15: 447-451, 1996

McKenney MG, Martin L, Lentz KA , Kirton O, **Nuñez Jr. D**: 1,000 consecutive ultrasounds for blunt abdominal trauma. *J of Trauma*; 40: 607-612, 1996

Nuñez Jr. D, Wester JD, Lentz KA, Amendola M : Helical CT of liver injuries: a trial of dual phase imaging. *Emergency Radiology*; 3:20-24, 1996

Nuñez Jr. D, Ahmad A, Coin CG, LeBlang S, Becerra JL, Henry R, Lentz K, Quencer R: Clearing the cervical spine in multiple trauma victims: A time-effective protocol using Helical Computed Tomography. *Emergency Radiology*; 1: 273-278, 1994

McKenney M, Lentz KA, **Nuñez Jr. D**, Sosa JL, Sleeman D, et. al.: Can ultrasound replace diagnostic peritoneal lavage in blunt trauma. *J of Trauma*; 37:439-441, 1994

Nuñez Jr. D, Becerra JL, Martin L: Subhepatic collections complicating laparoscopic cholecystectomy: percutaneous management. *Abdominal Imaging*; 19:248-250, 1994

Nuñez Jr. D, Yrizarry JM, Casillas VJ, et al. Percutaneous management of appendiceal abscesses. *Seminars in Ultrasound, Computed Tomography and Magnetic Resonance*; 10:348-351, 1989

Beerman R, **Nuñez Jr. D,** Metli CV: Radiographic evaluation of the cocaine smuggler. *Gastrointestinal Radiology*; 11:351-354, 1986

Castillo M, **Nuñez Jr. D**, Morillo G. Review of computed tomographic findings in thrombosis of the major abdominal venous pathways. *J Comput Tomogr*; 10:205-214, 1986

Nuñez Jr. D, Huber JS, Yrizarry JM, Mendez G, Russell E: Nonsurgical drainage of appendiceal abscesses. *AJR*; 146:587-589, 1986

Russell E, Yrizarry JM, Huber JS, **Nuñez Jr. D,** Hutson DG, Schiff E, Reddy RK, Jeffers L, Williams A. Percutaneous transjejunal biliary dilatation: alternative management in benign biliary strictures. *Radiology*; 159:209-214, 1986

Nuñez Jr. D, Guerra Jr. J, Al-Sheikh W, Russell E, Mendez G. Percutaneous Biliary drainage in acute suppurative cholangitis. *Gastrointestinal Radiology*; 11:85-89, 1986

Nuñez Jr. D, Hansen D. Current trends in endourology: ureteral interventions. *Rev Interam Radiol*;10:47-52, 1985

Nuñez Jr. D, Yrizarry J, Russell E, et al. Transgastric drainage of pancreatic fluid collections. *AJR*; 145:815-818, 1985

Russell E, Hutson D, Guerra Jr J, **Nuñez Jr. D**. Dilatation of biliary strictures through a stomatized jejunal limb. *ACTA Radiologica*; 26:283-286, 1985

Nuñez Jr. D, Guerra Jr J, Russell E. CT demonstration of contrast extravasation complicating translumbar aortography. *J Comput Tomogr*; 9:69-70, 1985

Mendez G, **Nuñez Jr. D,** Yrizarry J, Russell E, Guerra Jr J. Uses and abuses of biliary endoprosthesis. *Seminars in Interventional Radiology*; 2:60-68, 1985

Mendez G, **Nuñez Jr. D**. Intra-arterial digital angiography in the evaluation of transient ischemic attacks. *Rev Interam Radiol*; 9:201-205, 1984

Nuñez Jr. D, Marti A, Lynne CB, Russell E, Guerra Jr. JJ: Percutaneous management of staghorn and large pelvic stones. *Rev Interam Radiol*; 9:187-192, 1984

Nuñez Jr. D, Russell E, Yrizarry J, Pereiras R, Viamonte Jr. M. Portosystemic communications studied by transhepatic portography. *Radiology*; 127:75-79, 1978

Russell E, **Nuñez Jr. D,** Yrizarry J. The 23-gauge sheathed needle: an alternative to transhepatic cholangiography. *Radiology*; 128:822-823, 1978

Nuñez Jr. D, Russell E, Morillo G. Unusual complications of renal cyst puncture. *Rev Interam Radiol*; 3:1-4, 1978

Fishbone G, **Nuñez Jr. D,** et al. Massive splenic infarction in sickle cell hemoglobin C disease. *AJR*; 129:927-928, 1977

Nuñez Jr. D, Avella J. Intramural hematomas of the GI tract complicating anticoagulant therapy. *GEN*; 32:185-187, 1977

Nuñez Jr. D., Angiodiagnosis and angiotherapy of GI bleeding. *GEN*; 32:125-129, 1977

Nuñez Jr. D, Gonzalez-Serva L, Galloway S. Pulmonary lymphangitic carcinomatosis in renal adenocarcinoma. *Br J Radiol*; 50:142-146, 1977

Nuñez Jr. D, Bjarnason, Schwartz S. Barium findings in retrograde intussusception. *AJR*; 125:717-722,1975

19. Other Works, Publications and Abstracts:

Rybicki FJ, Nawfel RD, Ledbetter SL, **Nunez DB Jr.** *Thyroid dose estimates in routine screening for suspected Cervical Spine Injury*
Radiology, 217 (P): 322, 2000

Nuñez Jr. DB. *Imaging of lower cervical spine injuries. In Categorical Course Syllabus, American Roentgen Ray Society: Emergency and Trauma Radiology*-2000, 47-53

Montalvo BM, LeBlang SD, **Nuñez DB.** *Color Doppler Sonography in Penetrating Injuries of the Neck.* The Year Book of Emergency Medicine, Mosby, 27, 1998

Nuñez DB, Jr., Becerra JL, Fuentes D and Pagson S. *Traumatic Occlusion of the Renal Artery: Helical CT Diagnosis*. Journal of Urology, 158:1629, 1997

Coin CG, Zych GA, Fuentes D, **Nuñez Jr. D**. *Helical CT Holography of Pelvic Fractures: comparison with radiography and helical CT in the trauma setting.* Radiology, 201(B): 200, 1996

McKenney KL, McKenney MG, **Nuñez Jr. D.** *Ultrasound As A Primary Screening Modality In Blunt Abdominal Trauma: Experience With More Than 700 Patients.* Radiology, 201(B): 433, 1996

Amendola MA, Lebeille R, **Nuñez Jr. D.** *Spiral CT of uretero pelvic junction obstruction.* Radiology, 201(B): 289, 1996

Broder JD, **Nuñez Jr. D.** *Spiral CT in Trauma, Indications and Contributions to Case Management.* Radiology, 201(B):513, 1996

Zuluaga A., **Nuñez Jr. D. B.**, Fuentes-Bernardo D. A., Rivas L., Ahmad A. A., *Cervical Spine Trauma Series: How Much More Do We Learn by Routinely using Helical CT?* Radiology, 197(P):471, 1995

Shill S. D., Kiszonas R. A., **Nuñez Jr. D. B.**, *Significance of a Dense, Wide Mediastinum* Radiology, 197(P):524, 1995

Wester Jr. D. J., **Nuñez Jr. D. B.**, Lentz K. A., Martin L. C., Taubenfeld A. K., Franca E. R., *Nonopertive Management of Liver Lacerations: CT Observations* Radiology, 193(P):435, 1994

Serafini A., LeBlang S. D., **Nuñez Jr. D. B.**, Montalvo B. M., Donovan Post M. J., Becerra J. L., *Contribution of CT in Penetrating Neck Injuries* Radiology, 193(P):456, 1994

Nuñez Jr. D. B., Gomez-Jorge J. T., Mendez K. R., Lentz K. A., Becerra J. L., Yrizzary J. M., et al., *Posttraumatic Angiography: Spectrum of Lesions Treated with Transcatheter Interventions* Radiology, 193(P):382, 1994

Gomez-Jorge J. T., **Nuñez Jr. D. B.**, Lentz K. A., Becerra J. L., Henry Jr. R. P., Rivas L., *Trauma-related Abscesses and Fluid Collections: Value of imaging guided Percutaneous Interventions* Radiology, 193(P):385, 1994

Jacobs W. E., Ahmad A. A., Rivas L., **Nuñez Jr. D. B.**, *The Role of Helical CT in the Evaluation of Traumatic Vascular Injury* Radiology, 193(P):385, 1994

LeBlang S. D., **Nuñez Jr. D. B.**, Donovan Post M.J., Serafini A., Montalvo B. M., Becerra J. L., *CT of the Neck In Penetrating Trauma: Predictive Value for Vascular Injury* Radiology, 193(P):241, 1994

LeBlang S. D., Montalvo B. M., **Nuñez Jr. D.**, Becerra J.L., Kochan J., Ginsburg E., *Color Doppler Imaging in Traumatic Neck Injuries* Radiology, 189(P):394, 1993

Ahmad A. A., Coin C. G., Soto R. F., Echenique A. M., **Nuñez Jr. D.**, Becerra J. L., *Evaluation of Cervical Spine Injuries in Trauma Patients: Usefulness and*

Limitations of Plain Films and Conventional and Spiral CT Radiology, 189(P):398, 1993

LeBlang S. D., **Nuñez Jr. D.**, Montalvo B.M., Lentz K., Becerra J. L., Schmaltz R., *Trauma Center US: Newer Applications Impacting on Case Management* Radiology, 189(P):421, 1993

Ahmad A. A., **Nuñez Jr. D.**, Soto R., Echenique A. M., Montalvo B. M., *Spiral CT in the Evaluation of Blunt Abdominal Trauma* Radiology, 189(P):422, 1993

Nuñez D. J, Ahmad A.A., Coin C. G., Becerra J.L., Quencer R., *Spiral CT of the Cervical Spine Primary Role in Multiple-Trauma Patients* Radiology, 189(P):259, 1993

Coin C. G., LeBlang S., **Nuñez D. Jr**., Becerra J.L., Henry R., Lerner H., *Digital Radiology of Pelvic Fractures* Radiology, 189(P):309, 1993

Lentz K. A, McKenney M., **Nuñez Jr. D.**, Axelrod A., Kirton M. O., Martin L., Et al., *Can US Replace Diagnostic Peritoneal Lavage in Blunt Abdominal Trauma?* Radiology,189(P):311, 1993

Olazabal R., Huson II H., Fishman J. E., **Nuñez Jr. D.**, Amendola M. A., *Is It Clot or Is It Not? CT Evaluation of Inferior Vena Cava Thrombosis*, Radiology 189(P):361, 1993

Mendez K, Casillas J, Montalvo BM, Yrizarry J, **Nuñez D,** *Imaging-Guided Drainage of Abdominal Post Traumatic hematomas* Radiology, 185(P):167, 1992

Nuñez Jr. D, Malave S, Leon E. CT of the psoas muscle. *J Computed Assist Tomogr*;4(5):708, 1980

Nuñez Jr. D, Barnason T, Schwartz S. Barium findings in retrograde intussusception. *Year Book of Diagnostic Radiology*; 271, 1977

20. Other works accepted for publication:

V. PROFESSIONAL

22. Editorial Responsibilities:

Associate Editor: *Radiology* – Jan 2007 to present

Associate Editor: *Emergency Radiology*- June 2001 to 2005

Reviewer: Radiology (RSNA)
American Journal of Neuroradiology (ASNR)
Emergency Radiology (ASER)
Radiographics
American Journal of Roentgenology (AJR)

Member of the Editorial Board: Emergency Radiology. Feb 2000 to present

Associate Editor of *Revista Interamericana Radiologia (Journal of the Interamerican College of Radiology)*. 1984-1989.

Editorial Advisory Board: Diagnostic Imaging 1995-1999.

International Editorial Board: Revista Mexicana de Radiologia. 1996 to present

International Advisory Board: Radiologia- Revista Espanola de Radiologia. 1996 to present.

Editorial Advisory Board of Radiolog - Continuing Professional Education Center, Inc. Princeton, NJ 1978-1983.

23. Professional and Honorary Organizations:

Member Scientific Program.Committee ARRS 2007 to present

Chairman RSNA Scientific Program Subcommittee in Emergency Radiology 2007-2010

Chairman Education Committee American Society Emergency Radiology 2006

Coordinator of Instructional Courses, Emergency Radiology Track. American Roentgen Ray Society – 2004-2009.

Writer Task Force in Neuroradiology (Emergency Radiology). American Board of Radiology. 2004-2006

Oral Boards Examiner in Neuroradiology. American Board of Radiology 2005, 2008

Member of Scientific Program Committee. Radiological Society of North America 2004-2007.

Chairman By-Laws Committee American Society Emergency Radiology 2003

Member Nominating Committee American Society Emergency Radiology 2003

Vice-President New England Roentgen Ray Society 2002-2003

President American Society Emergency Radiology 1999-2000

President-Elect American Society Emergency Radiology 1998-1999

Refresher Course Faculty- Radiological Society of North America, 1997, 1998, 1999, 2000, 2002, 2003, 2004, 2006, 2007, 2008.

Member of Committee on Standards and Accreditation of the American College of Radiology -Member of the Sub-committee on Cervical Spine Radiography, 1998-2004

Director-at-large American Society of Emergency Radiology 1997-1998

President Interamerican College of Radiology 1996-1998

President-Elect Interamerican College of Radiology 1994-1996

Program Committee Chairman American Society of Emergency Radiology, 1996-1997

Member of the Program Committee of the American Society of Emergency Radiology. 1995-1996

Member of the Site Committee of the American Society of Emergency Radiology. 1994-1995

Member of the Educational Committee of the American Society of Emergency Radiology. 1993-1994

Memberships:
Radiological Society of North America, American Roentgen Ray Society, American Society of NeuroRadiology, American Society of Emergency Radiology, Interamerican College of Radiology, American College of Radiology, New England Roentgen Ray Society, American Society Spine Radiology, Society of Chairman of Academic Radiology Departments (SCARD).

24. Honors and Awards: **Gold Medal**- American Society of Emergency Radiology, September 2004

Gold Medal- InterAmerican College of Radiology, June 2004

Certificate of Merit
Rao S, Wasyliw C, **Nunez Jr D** Spectrum of imaging findings in hyperextension injuries of the neck
Exhibited at RSNA,Chicago, IL 2003

Certificate of Merit
Nuñez Jr. D, Zuluaga A, Fuentes D, Rivas L, Becerra JL. "Cervical spine trauma series: how much more do we learn by routinely using helical CT?"
Exhibited at RSNA, Chicago, IL 1996

Magna Cum Laude
Nuñez Jr. D, LeBlang S, Montalvo B, et al: "Color Doppler Imaging in Penetrating Neck Trauma. Exhibited at the ASNR, Nashville, TN 1994

Certificate of Merit
LeBlang S, **Nuñez Jr. D**, Becerra J, Kochan J, et al. "Color Doppler Imaging in Traumatic Neck Injuries". Exhibited at the RSNA, Chicago, Il 1993.

Chief Resident, Diagnostic Radiology
Hospital of St. Raphael
Yale University School of Medicine
New Haven, CT
July 1975 - June 1976

Honorary Member- Sociedad Española de Radiologia, 1995

25. Post-Doctoral Fellowships:

Cardiovascular Radiology/Special Procedures Fellowship
Department of Radiology
University of Miami School of Medicine
Jackson Memorial Hospital
Miami, FL 33136
July 1976 - June 1977

Visiting Fellow in Neuroradiology and MRI
University of Miami MR Center
Dec 1988 - May 1989

26. Other Professional Activities:
Course and Congress Directorships:

Course Director: Categorical Course of ARRS in Emergency Radiology 2008

RSNA International Visiting Professor. Peruvian Society of Radiology at Lima and Arequipa, Peru. Nov. 2-11, 2002

Course Director: Emergency Radiology: Pearls and Perils, Harvard Medical School, Department of Continuing Education. North Carolina May 10-12 and New York Dec 14-15, 2001.

President XIX Interamerican Congress of Radiology, Miami, Florida, October 10-14 October, 1998.

Chairman: Program Committee American Society of Emergency Radiology. 1996-1997

President: XV Interamerican Congress of Radiology, Caracas, Venezuela, February 11-16, 1990

Course Director: Radiology of Hepatobiliary and Pancreatic Diseases. Sponsored by the Department of Radiology, University of Miami School of Medicine, Miami Hyatt Regency Hotel, April 2-5, 1986

Invited Lectures:

Imaging head and neck emergencies: I can't see, I can't swallow. American Society of Emergency Radiology. Miami Fl. Sept 2011

Head and Neck Emergencies: Keynote lecture New England Roentgen Ray Society Boston MA. Feb 2011

Frequent Errors in Emergent Neuroimaging, University of Miami CME Course, Palm Beach FL Feb 2011

Head and neck infections: University of Miami CME Course, Palm Beach Fl Feb 2011

Easily missed findings in Emergency Radiology: Skull base and neck, RSNA Chicago 2010

Imaging of spine trauma. San Marino Italy, Sept 2010

Imaging acute myelopathies. ASER, Seattle WA, Aug 2010

MDCT of Spine Injures: ASNR, Boston MA, May 2010

Managing your Emergency Radiology practice. Special series moderation and Presiding Officer. RSNA Chicago IL Nov 2009

Common mistakes in emergent neuroimaging, Head and neck emergent infections and MDCT of cervical spine trauma. Musculoskeletal, Neuro and Body Imaging in the ER. Miami,Fl Nov 2009

Cervical spine trauma imaging: Implications for management and Imaging head and neck infections ARRS, Boston May 2009

Emergent cervicofacial imaging: Radiology Grand Rounds. University of Maryland. April 2009

Easily missed findings in emergency radiology: Brain. Chicago, RSNA 2008

Controversies in Emergency Radiology: Screening cervical vascular injuries. Chicago 2008 RSNA

Founders lecture ASER- Reflections on the practice of emergency neuroimaging. Houston, Tx Oct 2008

Pitfalls in Trauma Radiology and Imaging assessment of the multitrauma victim at the National Congress of Radiology Seville, Spain May 2008

Emergent Infections of the Head and Neck. ARRS, Washington DC April 2008

Easily missed findings in emergency radiology: Brain, RSNA, Chicago Il, Nov 2007

Pitfalls in Emergent Neuroimaging: ASER, San Diego Ca, Oct 2007
Nontraumatic emergencies of the Head and Neck, ARRS, Orlando Fl, May 2007

Moderator Scientific session in emergency care, ARRS Orlando Fl May 2007

Neuroimaging of Emergencies (4 lectures) Head and neck infections, What we frequently miss in the ED, Cervical Spine Trauma,
Imaging Cerebrovascular injuries. RSNA sponsored symposium in Mexico City, Feb 2007

Frequently missed findings in emergent brain imaging RSNA, Chicago, Dec 2006

Presiding Officer/Moderator Scientific session in Trauma imaging and emergency care, RSNA Chicago Dec 2006

Neuroimaging of the Emergency Department patient. ARRS, Vancouver C, May 2006

Visiting Professor at Medical University of South Carolina, Charleston SC.
Lectures: Imaging Head and Neck Emergencies and Contemporary imaging of suspected spine trauma March 2006

Presiding officer/Moderator. Scientific Session A24 Emergency Radiology: CT in trauma.
RSNA Chicago IL, Dec 2005

Postgraduate course in Emergency and Trauma Radiology (6 Lectures)
Annual Symposium Hospital 12 de Octubre Madrid, Spain

MDCT in Emergency Neuroradiology: A case-based presentation
Annual meeting ARRS, New Orleans LA, May 2005

Traumatic emergencies of the brain, head and neck:
SERAM Annual Symposium- Madrid Spain, Feb 2005

Applications of MDCT: Spine trauma
Annual Assembly of RSNA, Chicago, IL Dec 2004

Visitng Professor- Neuroradiology Case presentation
Winthrob University Hospital, Mineola NY
Grand Rounds lecture: Imaging Spine Trauma, Oct. 2004

Moderator Emergency Radiology Case Panel, New England ray society, Boston MA, Oct 2004

Thoracic Vascular Injuries
International Congress of Radiology, Montreal Canada, June 2004

MDCT of Spine Trauma: Post processing and 3D rendering
American Society of NeuroRadiology, Seattle WA. May 2004

MDCT of Craniocervical Trauma. Hospital Cardarelli, University of Naples, Italy, May 2004

MDCT/Post Processing and benefits of 3D rendering for Spine Trauma
American Society of Spine Radiology, Miami Beach, Fl February 2004

Essentials of Trauma CT: Spine
Anuual Assembly of the RSNA, Chicago IL, December 2003

Overview of Trauma Imaging: A look into the future
Annual assembly of the RSNA, Chicago IL, December 2003

Cervical Spine Trauma: Imaging the unevaluable patient
American Society of Emergency Radiology, Las Vegas NV Sept. 2003

Cervical Spine Trauma: Imaging the neurologically impaired
American Society of Emergency Radiology, Las Vegas NV Sept. 2003

Visiting Professor-
Grand Rounds: Vascular and soft tissue injuries of the neck
Neuroradiology Board Review
Department of Radiology. University of Connecticut
Farmington CT, April 2003

Visiting Professor- Neuroradiology Board review
Radiology Grand Rounds lecturer: How to image the spine in the high risk trauma patient.
Department of Radiology McGill University
Montreal Canada, March 2003

Imaging the patient with suspected spine trauma,
Abdominal trauma. University of Miami Winter Symposium, Coral Gables March 2003

Brain Trauma, Cervical Spine Injuries and Facial Fractures: Lectures at Harvard University Radiology Course. Hyannis MA, Feb 2003

Imaging suspected spine trauma.
Radiology Grand Rounds. Yale University School of Medicine, Dec 2002

Essentials of Trauma CT: Spine
Annual Assembly of the RSNA, Chicago IL, December 2002

Thoracic vascular trauma, US and CT of abdominal trauma, and Cervical Spine Injuries at Peruvian Congress of Radiology, Nov. 2002

Initial imaging assessment of the traumatized abdomen. Surgical Grand Rounds at Hospital of St. Raphael New Haven CT, Sept. 2002

Brain Trauma, Cervical Spine Injuries, Facial Fractures: Harvard University Radiology Course. Hyannis MA, August 2002

Cervical Spine Trauma: Mechanistic approach and
Head and Neck Vascular Injuries:
Visiting Professor University of Washington Emergency Radiology Course. Seattle WA, August 2002

Trauma Imaging Course (Brian injuries, Facial fractures, Spine Trauma, Abdominal trauma, Vascular Injuries) in Salvador, Brasil, August 2002

Ultrasound in Abdominal Trauma, Aortic injuries, Spine trauma.
International Congress of Radiology. Cancun Mexico, July 2002

Multidetector CT of vascular injuries.
American Roentgen Ray Society, Atlanta Ga., April 2002

Multidetector CT in spine trauma: American Society Emergency Radiology, Orlando Fl, March 2002

Lecturer in annual Radiology Course: RSNA and Mexican Federation of Radiology (4 lectures), Mexico City Mexico, February 2002

Moderator: Panel of unknown cases, New England Roentgen Ray Society
Boston, MA. Nov. 2001

J.Hodak lecturer and Visiting Professor in Neuroradiology, the Barrow Neurological Institute and St. Joseph Medical Center. Phoenix, AZ. Oct. 2001

Instructional Course:
ARRS- Helical and Multidetector CT in Neuro Emergencies
Seattle, Washington May 2001

Head and Neck emergencies- 12th annual meeting, American Society of Emergency Radiology, San Francisco, California March 2001.

Refresher Course: RSNA- Helical CT of Abdominal Trauma, Nov 2000

Guest Speaker: Venezuelan Congress of Radiology- Cervical spine injuries, vascular thoracic injuries and abdominal trauma. Caracas, Venezuela. October 2000

Imaging of Lower Cervical Spine Injuries- in Emergency and Trauma Radiology Categorical Course, American Roentgen Ray Society, Washington DC. May 2000

New trends in the diagnosis and management of stroke in the Emergency Room Focus Session moderator, 11th annual meeting, American Society of Emergency Radiology, Orlando Florida. March 2000

Radiology Grand Rounds- Imaging of cervical spine injuries, Boston Medical Center, Boston University School of Medicine, February 2000.

Guess Faculty Johns Hopkins Medical School CT Symposium: The cutting edge.February 2000.

Guest speaker at the Interamerican Congress of Trauma Surgery. Aortic Injuries, Spine Trauma, Abdominal Trauma. Venezuela, Nov 1999 .

Emergency NeuroRadiology: Strategies for successful implementation.
American Society of NeuroRadiology. San Diego May 1999

Spine Trauma
American Society of NeuroRadiology. San Diego May 1999

Helical CT in Spine Trauma: Applications, protocols and pitfalls
Annual Meeting American Society Emergency Radiology. Las Vegas- March, 1999.

"Ultrasound and Helical CT of Abdominal Trauma: initial assessment" and
"Abdominal trauma: beyond the liver and the spleen"
Annual Meeting- Department of Radiology, University of Chicago- March, 1999.

Helical CT of Abdominal Trauma: Refresher Course RSNA- November 1998.

Guest speaker for Radiology Grand Rounds at Harvard Medical School/Massachusetts General Hospital. The Role Helical CT in the Evaluation of Cervical Spine Trauma, September 1998.

Guest speaker at the Sociedad de Radiologia del Peru, Lima, July, 1998.

Visiting Professor to the Hospital Naval, Lima, Peru, July, 1998.

Visiting Professor University of Cordoba/Argentina. Conferences on Abdominal Trauma, Initial Assessment and new Observations. May 1998.

Categorical course in Trauma Radiology in the Venezuelan Congress of Radiology. May 1998.

Visiting Professor/Universidad Veracruzana. Conference on Cranial Cerebral Trauma and Spine Trauma, Veracruz, Mexico. April 1998.

Coordinator and Speaker in the Interactive Workshop on Vascular Injuries/Annual Meeting of the American Society of Emergency Radiology, St. Petersburg, Florida. April 1998.

"Ultrasound and Helical Screening of the Traumatized Abdomen", "Cervical Spine: Initial Assessment", "Diagnosis and Treatment, Part I and II", "Facial Trauma", Common Intracraneal Injuries" – The international Institute for Continuing Medical Education, Inc. – Imaging in the Acute Care Setting. Cancun, Mexico, February 1998.

Emergent US and Helical CT: Options in trauma imaging. Refresher Course – RSNA, Chicago December 1997.

"Traumatismo Torácico", "Traumatismo Vascular", "Traumatismo Cerebral", "Traumatismo del cuello"- "IX Symposium Internacional de Actualización en Diágnostico por la Imagen", Zaragoza, Spain, November, 1997.

"Interventional Radiology in the Traumatized Patient", "Blunt and Penetrating Neck Trauma", 1997, presented in Central American Congress of Radiology, Guatemala, October 1997

"Helical CT Evaluation of Abdominal Trauma", "Course and Diagnostic Imaging", organized by the Asociacion Colombiana de Radiologia, Medellin, August 1997

"The Role of the Radiologist in the Emergency Room". Lecture to the Puerto Rican Association of Radiology in August, 1997

"The radiologist in the emergency room" - National Meeting of Residency in Radiology, Caracas, Venezuela, July 1997.

"Selected topics in trauma radiology" - International Course in Diagnostic Imaging, Tucumán, Argentina, June 1997.

"Imaging of blunt and penetrating neck injuries" - Curso de Imagenologia en Español, Miami, May 1997.

"Clearing the cervical spine with helical CT" - Trauma Symposium American Roentgen Ray Society Meeting, Boston, Massachusetts, May 1997.

"Cranio cerebral trauma, Abdominal trauma". - "Radiology Course in Trauma" in Malaga, Spain, February 1997.

"Helical CT and angiography for mediastinal trauma, initial evaluation of blunt abdominal trauma, abdominal trauma beyond the liver and the spleen, cervical spine trauma" - XXI Annual Course in Diagnostic Imaging, University of Florida, Mexico City, Mexico, February 1997.

"Abdominal trauma imaging" - Interamerican Congress of Radiology, Cancún, Mexico, October 1996.

"CT Helicoidal en urgencias" - Curso de Imagenologia en Español, University of Miami, Miami, Florida, July 1996.

"Blunt and penetrating cervical injuries" Radiological Congress- Radiological Association of Guatemala- November 1995.

"Imaging of neurologic emergencies" Radiological Congress- Radiological Association of Guatemala- November 1995.

Visiting Professor Univeristy of San Luis Potosi, Mexico,"Topics in emergency radiology": Head trauma, abdominal injuries, helical CT in trauma imaging, vascular interventions in the traumatized patient, October 1995.

"Monographic Course in Trauma Radiology": Brain trauma, Cervical spine injuries, Abdominal Trauma, Vascular injuries and Interventional Radiology in trauma, Imaging protocols in the trauma patient. Dictated at annual meeting of the Radiological Society of Spain, Sept. 1995.

"Vascular trauma - diagnosis and intervention". Radiological Society of Panama, Panama August 1995.

"Helical CT in trauma". Radiological Society of Panama, Panama August 1995.

"Penetrating neck injuries". Radiological Society of Panama, Panama , 1995

"Imagenología de emergencía neurologíca" and "Problemas diagnosticos en trauma abdominal". Curso de Imagenología en Español, University of Miami, Miami, July 1995.

"Peripheral vascular trauma". Venezuelen Congress of Surgery, Caracas, Venezuela, March 1995.

"Imaging of thoracic vascular injuries". Venezuelan Congress of Surgery, Caracas, Venezuela, March 1995.

"CT of acute inflammatory diseases of the abdomen". Venezuelan Congress of Surgery, Caracas, Venezuela, March 1995.

"Update in trauma radiology". The Robert Shapiro Memorial Lecture, Miami Beach, March 1995.

"The radiologist in the emergency room: The value of ultrasound, Helical CT and Interventional procedures. Interamerican Congress of Radiology, Buenos Aires, Argentina, September 1994.

"TAC Helicoidal: Aspectos Generales y Aplicaciones en Trauma". Curso de Imagenologia en Español: Miami 1994. Miami, Florida, June 1994

"Evaluacion Radiologica del Traumatismo Craneo-Encefalico y Facial". Curso de Imagenologia en Español: Miami 1994. Miami, Florida, June 1994

"Diagnostic dilemmas in emergency radiology". VI Jornadas Internacionales de Actualizacion en Diagnostico por Imagenes. Cordoba, Argentina, May 1994.

"Interventional radiology in the emergency room". VI Jornadas Internacionales de Actualizacion en Diagnostico por Imagenes. Cordoba, Argentina, May 1994.

"Craneo-facial trauma". VI Jornadas Internacionales de Actualizacion en Diagnostico por Imagenes. Cordoba, Argentina, May 1994.

"Imaging of cervical spine trauma". VI Jornadas Internacionales de Actualizacion en Diagnostico por Imagenes. Cordoba, Argentina, May 1994.

"Imaging protocols in trauma patients". VI Jornadas Internacionales de Actualizacion en Diagnostico por Imagenes. Cordoba, Argentina, May 1994.

"Brain and Facial Trauma". Congreso Centroamericano de Radiologia. Managua, Nicaragua, December 1993.

"Imaging of thoracic emergencies". Congreso Centroamericano de Radiologia. Managua, Nicaragua, December 1993.

"Radiologic anatomy of the face and paranasal sinuses ". Congreso Centroamericano de Radiologia. Managua, Nicaragua, December 1993.

"Inflammatory diseases of the CNS ". Congreso Centroamericano de Radiologia. Managua, Nicaragua, December 1993.

"Brain tumors". Congreso Centroamericano de Radiologia. Managua, Nicaragua, December 1993.

"Radiologia Intervencionista en Trauma: Aplicaciones Vasculares y No Vasculares. Curso de Imagenologia en Español: Miami 1993. Miami, FL, June 1993.

"Interventions in the Chest and Abdomen". Congress of Radiology, Sao Paulo, Brazil, April 1991.

"Interventional CT and US of the Abdomen". Review Course in Diagnostic Imaging, Cordoba, Argentina, May 1990.

"Pulmonary Nodule: Imaging Guided biopsies". Review Course in Diagnostic Imaging, Cordoba, Argentina, May 1990.

"The Thoracic Wall". Review Course in Diagnostic Imaging, Cordoba, Argentina, May 1990.

"The Pulmonary Nodule". Interamerican Congress of Radiology, Caracas, Venezuela, February 1990.

"Radiology of Urinary Infections". Radiology Seminar, San Juan, Puerto Rico, May 1989.

"Radiology of Hematuria". Radiology Seminar, San Juan, PR, May 1989

"Renal and Peripheral Angioplasty". Radiology Review Course, Quito, Ecuador, November 1988.

"Transcatheter Angioplasty". Radiology Review Course, Quito, Ecuador, November 1988.

"CT Guided Biopsies". Radiology Review Course, Quito, Ecuador, November 1988.

"Hepatobiliary Interventions". Radiology Review Course, Quito, Ecuador, November 1988.

"Transrenal Interventions". Radiology Review Course, Quito, Ecuador, November 1988.

"Thoracic Interventional Radiology". International Congress of Radiology of the Radiological Society of Peru, Lima, Peru, November 1988.

"Interventional Ultrasound". International Congress of Radiology of the Radiological Society of Peru, Lima, Peru, November 1988.

"Interventional Computed Tomography". International Congress of Radiology of the Radiological Society of Peru, Lima, Peru, November 1988.

"Interventional Techniques in Hepato-Biliary Diseases". International Congress of Radiology of the Radiological Society of Peru, Lima, Peru, November 1988.

"Interventional CT: Chest Lesions". Postgraduate Course of the Interamerican Congress of Radiology and Mt. Sinai Medical Center, Miami, FL, April 1988.

"Interventional US: Abscess Drainage". Postgraduate Course of the Interamerican Congress of Radiology and Mt. Sinai Medical Center, Miami, FL, April 1988.

"The Radiologist as a Consultant". I Venezuelan Congress of Radiology, Maracaibo, Venezuela, October 1987.

"Renal Interventions". I Venezuelan Congress of Radiology, Maracaibo, Venezuela, October 1987.

"CT of the GI Tract". I Venezuelan Congress of Radiology, Maracaibo, Venezuela, October 1987.

"Abscess Drainage". VIII Congress of Gastroenterology, Pto. Ordaz, Venezuela, October 1987.

"Linear and Computed Tomography in Pulmonary Diseases". Review Course in Diagnostic Imaging, Tucuman, Argentina, May 1987.

"Interventional G.I. Radiology". Review Course in Diagnostic Imaging, Tucuman, Argentina, May 1987.

"CT of the GI Tract". Review Course in Diagnostic Imaging, Tucuman, Argentina, May 1987.

"Mediastinal CT". Review Course in Diagnostic Imaging, Tucuman, Argentina, May 1987.

"Complications in Biliary Interventions". Refresher Course of the American Roentgen Ray Society 87th Annual Meeting ARRS, Miami, FL, May 1987.

"Complications in Interventional Radiology". Postgraduate Course of Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, Fl, April 1987.

"G.I. Interventions". Postgraduate Course of Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, Fl, April 1987.

"CT of the GI Tract". Postgraduate Course of Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, April 1987.

"Transthoracic Guided Biopsies". Pan-American Congress of Chest Diseases, Caracas, Venezuela, January 1987.

"Transthoracic Guided Biopsies". Pan-American Congress of Chest Diseases, Caracas, Venezuela, January 1987.

"The Work Up of Renal Masses". XI Congress of Urology, Barquisimeto, Venezuela, November 1986.

"Interventional Ultrasound". XIV Interamerican College of Radiology Congress, Buenos Aires, Argentina, October 1986.

"Selected Topics in G.I. Interventions". XIV Interamerican College of Radiology Congress, Buenos Aires, Argentina, October 1986.

"G.I. Bleeding: Diagnosis and Management". XIV Interamerican College of Radiology Congress, Buenos Aires, Argentina, October 1986.

"Transrenal Interventions". XIV Interamerican College of Radiology Congress Buenos Aires, Argentina, October 1986.

"Diagnosis and Management of Pancreatic Fluid Collections, Radiology of Hepatobiliary Diseases: Imaging and Intervention". University of Miami School of Medicine, Miami, FL April 1986.

"Interventional Ultrasound". III Congress of Ultrasonography, Caracas, Venezuela, March 1986.

"Gallbladder Imaging". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, March 1986.

"Refresher Course: Diagnosis and Management of Abdominal Fluid Collections". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, March 1986.

"Interventional Radiology of the G.U. Tract". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, March 1986.

"Imaging Guided Biopsies". Radiological Society of Dominican Republic, Dominican Republic, March 1986.

"Hepatic Imaging". Radiological Society of Dominican Republic, Dominican Republic, March 1986.

"CT of the Mediastinum". Radiological Society of Dominican Republic, Dominican Republic, March 1986.

"Interventional Radiology of the G.U. Tract". Radiology Update: 1986. Tulane University School of Medicine, New Orleans, LA February 1986.

"Radiological Management of Abscesses". Quito, Ecuador, September 1985.

"CT and US in Space Occupying Lesions of the Liver". Quito, Ecuador, September, 1985.

"Percutaneous Guided Biopsy International Course of Diagnostic Imaging". Quito, Ecuador, September 1985.

"Abdominal Biopsies Guided by CT and US Radiology". 1985 Postgraduate Course of the Colombian Radiological Society, Cartagena, Colombia, May 1985.

"G.U. Interventions". Postgraduate Course of the Colombian Radiological Society, Cartagena, Colombia, May 1985.

"Radiology of Hepatic Disease". Radiology Board Review Course of the University of Miami School of Medicine, Miami, FL, May 1985.

"Percutaneous Management of Abdominal Masses and Fluid Collections". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, April 1985.

"Radiology of Abdominal Trauma". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami, FL, April 1985.

"The Radiologist's Role in Endourologic Procedures". Adult and Pediatric Postgraduate Course of the Department of Urology, University of Miami School of Medicine, Miami, FL, January 1985.

"Renal CT". Postgraduate Course of the Interamerican College of Radiology, Mexico, September 1983.

"Lymphoma: Radiological Spectrum". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami Beach, FL, April 1983.

"Radiologia del Pancreas". Postgraduate Course of the XVI Congreso Nacional de Radiologia, Madrid, Spain, September 1982.

"CT and Biopsy in Pancreatic Carcinoma". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami Beach, FL, April 1982.

"Pancreatitis". Postgraduate Course of the Interamerican College of Radiology and Mt. Sinai Medical Center, Miami Beach, FL, April 1982

Scientific Papers:

"Computed Tomography and Fluoroscopy-guided sacroplasty for pain relief in patients with sacral insufficiency fractures"
Weissman A, Berkmen T, Gonzalez Aldo, **Nunez Jr. D.** Presented at RSNA Chicago IL, Dec 2005

"Renal Ultrasound in the ER for acute renal failure": Hilchey SD, Ledbetter MS, Benson CB, **Nunez Jr. D**
Presented at 12 Annual Meeting-American Society of Emergency Radiology, San Francisco CA, March 2001

"Thyroid dose estimates in routine screening for suspected cervical spine injury: a comparison between helical CT of the entire cervical spine and a radiographic trauma series" Rybicki FJ, Nawfel RD, Ledbetter MS, **Nunez Jr D**
Presented at RSNA, Chicago, IL. November 2000

"Are the trauma cervical spine radiographs necessary when helical CT is routine?" Rybicki FJ, Knoll B, McKenney K, **Nunez Jr D**
Presented at American Society of Emergency Radiology, Orlando, FL. April 2000

"An ultrasound hemoperitoneum score predicts the need for laparotomy in blunt trauma". McKenney KL, McKenney MG, **Nuñez Jr. D.** Presented at American Society of Emergency Radiology, Las Vegas, Nevada, March 1999.

"The feasibility of non-enhanced Helical Computed Tomography in the assessment of acute flank plain". Broder J, **Nuñez Jr D.** Presented at Resident Day University of Miami School of Medicine, Miami, Florida, June 20th, 1998.

"Initial imaging assessment of the traumatized cervical spine: do we need anterior/posterior and atlanto axial views with routine use of Helical CT. Knoll B, **Nuñez D.** Presented at Fellows Week, University of Miami School of Medicine, Miami, Florida, June 1998.

"Direct versus Indirect Signs of Traumatic Aortic Injury Revealed by Helical CT: Performance characteristics and interobserver agreement". Fishman JE, **Nuñez D**, Kane A, Rivas LA, Jacobs WE. Presented at the American Roentgen Society Meeting, May 1998.

"Helical CT of vascular injuries". Whittick W, **Nuñez Jr. D.** Presented at the 20th Annual Radiology Residence day meeting, Miami, Florida, June 1997.

"Helical CT angiography in penetrating injuries to the neck". LeBlang SD, **Nuñez Jr. D.** Presented at the 20th Annual Radiology Residence day meeting, Miami, Florida, June 1997.

"Helical CT angiography in penetrating neck injuries". LeBlang SD, **Nuñez Jr. D.** Presented at the Annual Meeting American Society of Emergency Radiology, New Orleans, LA, March 1997.

"Spiral CT of ureteral pelvic junction obstruction". Amendola MA, Lebeille R, **Nuñez Jr. D.** Presented at the RSNA 82nd Annual Meeting, Chicago, Illinois, November 1996.

"Ultrasound as the primary screening modality in blunt abdominal trauma". McKenney KL, McKennedy MG, **Nuñez Jr. D.** Presented at the RSNA 82nd Annual Meeting, Chicago, Illinois, November 1996

"CT cystography in the diagnosis of bladder ruptured". Ruiz G, Rivas L, **Nuñez Jr. D.** Presented at the Annual Fellows day meeting, Miami, Florida, May, 1996.

"The value hepatic angiography and embolization in the treatment of liver injury". Youngman V, **Nuñez Jr. D.** Presented at the Annual Fellows day meeting, Miami, Florida, May 1996.

"Helical CT of the cervical spine: how many fractures are we missing". Presented at the Annual Meeting of the American Society of Emergency Radiology, Orlando, Florida, April 1996.

"Cost reduction using Ultrasound in blunt abdominal trauma". McKenney KL, McKenney MG, **Nuñez Jr. D**. Presented at the Annual Meeting of the American Society of Emergency Radiology, Orlando, Florida, April 1996.

"Helical CT in penetrating neck trauma" Franca E, **Nuñez Jr. D**. Presented at the 18th Annual Radiology Residents Day Meeting, Miami FL., June 1995

"Helical CT in the evaluation of blunt Thoracic Trauma" Jacobs W, Fishman J, **Nuñez Jr. D**. Presented at the 18th Annual Radiology Residents Day Meeting, Miami FL, June 1995

"Color doppler imaging in penetrating neck trauma". LeBlang S, Montalvo B, **Nuñez Jr. D**, Kochan J, Becerra JL, Ginzburg E. Presented at the American Society of Emergency Radiology in Scottsdale, Arizona, March 1995.

"Ultrasound: Test of choice in blunt abdominal trauma". McKenney M, Najjar R, Lentz KA, Martin L, Sleeman D, Lopez C, Sosa J, Kirton O, **Nuñez Jr. D**. Presented at the 8th Scientific Assembly of the Eastern Association for the Surgery of Trauma. Sanibel, Florida January, 1995.

"Contribution of CT in penetrating neck trauma". LeBlang S, **Nuñez Jr. D**, Serafini A, Post J, Montalvo B, Becerra JL. Presented at the ASER, Scottsdale, Arizona, March 1995.

"Initial sonographic assessment of blunt abdominal trauma". McKenney M, Lentz KA, **Nuñez Jr. D**, Sosa JL, Martin L, Axelrod A, Kirton O, Sleeman D, Oldham C: Presented at the Western Trauma Association, Crested Butte, Colorado, March 1994.

"Helical CT of the abdomen: Proposed scanning protocol for trauma patients". **Nuñez Jr. D**, Wester J, Lentz KA, Alvarez RT. Presented at the ASER, Arizona, March 1995.

"Interpreting the trauma ultrasound: Observations in 62 positive cases". Lentz KA, McKenney M, McDowell L, **Nuñez Jr. D**. Presented at the ASER in Scottsdale, Arizona, March 1995.

"A new approach for the diagnostic work-up of penetrating neck trauma". LeBlang S, **Nuñez Jr. D**, Montalvo B. Presented at the 17th Annual Radiology Residents Day, December 1994.

"Plain films versus spiral CT in evaluation of cervical spinal injuries". Ahmad A, **Nuñez Jr. D**, Coin CG. Presented at the 17th Annual Radiology Residents Day, December 1994.

"CT of the neck in penetrating trauma: predictive value for vascular injury." LeBlang SD, **Nuñez Jr. D**, Post JD, Serafini A, Montalvo BM, et. al. presented at the RSNA 80th Annual Meeting, Chicago, IL, November 1994.

"Cervical spine injury in multiple trauma victims: value of spiral CT as a screening modality." **Nuñez Jr. D**, Ahmad A, Coin CG, Becerra JL, Lentz KA, Quencer RM presented at the ASNR Annual Meeting, Nashville, TN, May 1994.

"Color doppler imaging in penetrating neck trauma." Montalvo B, LeBlang SD, **Nuñez Jr. D**, Becerra JL, Kochan J, et. al. presented at the ASNR Annual Meeting, Nashville, TN, May 1994.

"Clearing the cervical spine injury in multiple trauma victims: a time effective protocol using spiral CT." **Nuñez Jr. D**, Ahmad A, Coin CG, Becerra JL, Henry R presented at the 5th annual Meeting of the ASER, Orlando, FL, April 1994.

"Color doppler imaging in traumatic neck injuries." Montalvo B, LeBlang SD, **Nuñez Jr. D**, Becerra JL, Kochan J, et. al. presented at the American Institute of Ultrasound in Medicine 38th Annual Convention, Baltimore, MD, March 1994

"Can ultrasound replace diagnostic peritoneal lavage in blunt abdominal trauma." Lentz K, McKenney M, **Nuñez Jr. D**, Axelrod A, Kirton MO, et. al. presented at the RSNA 79th Annual meeting, Chicago, IL, November 1993.

"Scoutview digital radiography of pelvic fractures." Coin CG, LeBlang S, **Nuñez Jr. D**, Becerra JL, Henry R, et. al. presented at the RSNA 79th Annual meeting, Chicago, IL, November 1993.

"Plain films versus spiral computed tomography in the evaluation of cervical spine injuries." Coin CG, Ahmad AA, Becerra JL, **Nuñez Jr. D**, Soto RF, et. al. presented at the RSNA 79th Annual Meeting, Chicago, IL, November 1993.

"Spiral CT of the cervical spine: primary role in multiple trauma patients." **Nuñez Jr. D**, Ahmad AA, Coin CG, Becerra JL, Quencer R presented at the RSNA 79th Annual meeting, Chicago, IL, November 1993.

"Neurointerventional therapy of the vertebral artery after traumatic occlusion". Becerra JL, Kochan J, **Nuñez Jr. D**, DePrima S, Coin CG, et. al. presented at the ASER 4th Annual Meeting. San Diego, CA, March 1993. ASNR Annual Meeting, Vancouver, CA, May 1993.

"Scoutview digital radiography in evaluation of trauma patients." Coin CG, LeBlang S, Becerra JL, **Nuñez Jr. D**, Henry R presented at the ASER 4th Annual Meeting, San Diego, CA, March 1993.

"Proposals for post residency training in emergency radiology". **Nuñez Jr. D**, Oldham SA, Quencer R presented at the ASER 4th Annual Meeting, San Diego, CA, March 1993.

"Trauma patients: are plain films sufficient to clear the cervical spine?" Coin CG, Ahmad A, Becerra JL, **Nuñez Jr. D**, Henry R presented at the ASER 4th Annual Meeting, San Diego, CA, March 1993.

"Ultrasound Evaluation of the Traumatized Abdomen". Lentz K, **Nuñez Jr. D** presented at the Radiology Residents' Day Scientific Program, University of Miami School of Medicine, Miami, FL, December 1992. "Best Paper Award".

"Interventional radiology in retroperitoneal trauma. **Nuñez Jr. D** presented at the Interamerican College of Radiology Congress, Rio de Janeiro, Brazil, November 4-7, 1992.

"Imaging guided drainage of abdominal post traumatic hematomas". Mendez K, Casillas VJ, Montalvo BM, Yrizarry JM, **Nuñez Jr. D** presented at the 78th Scientific Assembly RSNA, Chicago, Illinois, November 1992.

"The radiologist in the emergency department". **Nuñez Jr. D** presented at the Interamerican College of Radiology Congress, Rio de Janeiro, Brazil, November 4-7, 1992.

"Percutaneous management of appendiceal abscesses". **Nuñez Jr. D**, Yrizarry JM, Casillas VJ presented at the International Congress of Radiology, Paris, France, July 1989.

"Liver abscesses: surgical or radiological management?". Al-Refai F, **Nuñez Jr. D**, Yrizarry JM, Russell E presented at the 71st Annual Scientific Assembly of the Radiological Society of North America, Chicago, IL, November 17-22, 1985.

"Percutaneous transjejunal biliary dilatation: alternate management for benign strictures". Russell E, **Nuñez Jr. D**, Huber JS, Yrizarry JM, Hutson DG, Williams A presented at the 71st Annual Scientific Assembly of the Radiological Society of North America, Chicago, IL, November 17-22, 1985.

"Percutaneous management of upper abdominal fluid collection". **Nuñez Jr. D**, Yrizarry JM presented at the International Congress of Radiology". Hawaii, July 1985.

"Percutaneous nephrostomy: technical considerations and redefinition's for current applications". Marti A, **Nuñez Jr. D**, Lynne C presented at the Seventh Annual Residents Day, University of Miami/Jackson Memorial Medical Center, Miami, FL, May 1984. "Best Paper Award".

"Computed tomography of the psoas muscle". **Nuñez Jr. D**, Malave S, Leon E presented at the International Course and Symposium of Computed Tomography, Harvard Medical School, Las Vegas, NV, April 1980

"Pediatric angiography". **Nuñez Jr. D** presented at the Radiological Special Procedures Seminar, University of Miami School of Medicine, Miami, FL, March 1977.

"Retrieval techniques". **Nuñez Jr. D** presented at the Radiological Special Procedures Seminar, University of Miami School of Medicine, Miami, FL, March 1977.

"Tc pertechnetate vs. Tc DTPA in cerebral scintigraphy". **Nuñez Jr. D**, Shapiro R presented at the Interamerican Congress of Neuroradiology, Caracas, Venezuela, October 1975.

Scientific Exhibits:

Gonzalez-Beicos A, Fung AW, Sanchez M, **Nuñez Jr D**. Trauma to the ankylotic spine: Imaging spectrum of vertebral and soft tissue injuries. Exhibited at the Radiological Society of North America, Chicago IL, Dec 2005

Rao, S, Wasyliw C, **Nunez Jr. D.** Spectrum of Imaging findings in Hyperextension Injuries of the Neck. Exhibited at the Radiological Society of North America, Chicago IL, Dec 2003

Torres-Leon M, Munera F, **Nunez Jr. D** Vascular injuries of the neck and thoracic inlet: Helical CT/angiographic correlations. Exhibited at the Radiological Society of North America, Chicago.IL, Dec. 2002

Broder JD, **Nuñez Jr. D**. Spiral CT in trauma, indications and contributions to case management. Exhibited at the Radiological Society of North America Annual Meeting, Chicago, IL, November 1996.

Zuluaga A, **Nuñez Jr. D,** Fuentes D, Rivas L. Cervical Spine trauma series: How much do we learn by routinely using helical CT?. Exhibited at the Radiological Society of North America Annual Meeting, Chicago IL, November 1995.

Schill S, Kiszonas R, **Nuñez Jr. D** The widened dense mediastinum. Exhibited at the Radiological Society of North America Annual Meeting, Chicago IL, November 1995.

Fuentes-Bernardo DA, **Nuñez Jr. D**. Evaluation of intestinal and mesenteric injury following abdominal trauma: Usefulness and findings in CT. Exhibited at the American Roentgen Ray Society, Washington DC, May 1995.

Christoph CL, Posos G, Mata M, Kane-Takenfeld A, **Nuñez Jr. D**. Computed tomography of pediatric abdominal trauma. Exhibited at the American Roentgen Ray Society, Washington DC May 1995.

Gomez-Jorge J, **Nuñez Jr. D**, Lentz KA, Becerra JL, Henry RP.: "Trauma related abscesses and fluid collections: the value of imaging guided percutaneous interventions". Exhibited at the 80th Annual Meeting of the RSNA, Chicago, IL, November 1994.

LeBlang SD, Serafini A, **Nuñez Jr. D**, Montalvo BM, Post JD, et. al.: "The contribution of CT in penetrating neck injuries". Exhibited at the 80th Annual Meeting of the RSNA, Chicago, IL, November 1994.

Jacobs WE, Ahmad AA, Rivas L, **Nuñez Jr. D**: "The role of helical CT in the evaluation of traumatic vascular injury". Exhibited at 80th Annual Meeting of the RSNA, Chicago, IL, November 1994.

Nuñez Jr. D, Gomez-Jorge JT, Mendez KR, Lentz KA, Becerra JL, et. al.: "Posttraumatic angiography: spectrum of lesions treated with transcatheter interventions". Exhibited at the 80th Annual Meeting of the RSNA, Chicago, IL, November 1994.

Wester DJ, **Nuñez Jr. D**, Lentz KA, Martin LC: "Non operative management of liver lacerations: CT observations". Exhibited at the 80th Annual Meeting of the RSNA, Chicago, IL, November 1994.

LeBlang, Montalvo B, **Nuñez Jr. D**, Becerra JL, Kochan J, et. al.: Color doppler imaging in penetrating neck trauma. Exhibited at the ASNR 1994 Annual Meeting, Nashville, TN, May 1994.

LeBlang SD, Montalvo B, **Nuñez Jr. D**, Becerra JL, Kochan J, et. al.: "Color Doppler Imaging in Traumatic Neck Injuries." Exhibited at the Radiological Society of North America. Chicago, IL, 1993. Certificate of Merit Award RSNA

1993 Selected Scientific Winning Exhibit as a CD-ROM Supplement to Radiographics.

Ahmad AA, **Nuñez Jr. D**, Soto R, Echnique A, Montalvo B: "Spiral CT in the Evaluation of Blunt Abdominal Trauma." Exhibited at the Radiological Society of North America. Chicago, IL, 1993.

LeBlang SD, **Nuñez Jr. D**, Montalvo B, Lentz K, Becerra JL, et. al.: "Trauma center ultrasonography: newer applications impacting on case management." Exhibited at the Radiological Society of North America. Chicago, IL, 1993.

Ahmad AA, Coin CG, Soto RF, Echnique A, **Nuñez Jr. D**, et. al.: "Evaluation of Cervical Spine Injuries in Trauma Patients: Usefulness and Limitations of Plain Films, Conventional and Spiral Computed Tomography. Exhibited at the Radiological Society of North America. Chicago, IL, 1993.

Beerman R, **Nuñez Jr. D**: "Radiographic Evaluation of the Cocaine Smuggler." Exhibited at the Annual Roentgen Ray Society Meeting. Boston, MA, 1985.

Russell E, **Nuñez Jr. D**, Yrizarry J: "The Anatomical Aspects of Knee Arthrography." Exhibited at the Radiological Society of North America. Chicago, IL, 1978.

Nuñez Jr. D, Russell E, Yrizarry J: "Portosystemic Collaterals." Exhibited at the Special Procedures Seminar, Department of Radiology, University of Miami School of Medicine. Miami, FL, 1977.

VI. TEACHING

27. Teaching Awards Received:

"Best Teacher Award" Department of Radiology, Universidad Central de Venezuela Medical School - 1987.
"Best Teacher Award" Department of Radiology Hospital of St Raphael, Yale Medical School, 2005

28. Teaching Specialization:

1. Undergraduate:

a) Emergency Radiology Course to Junior Medical Students: 1 week/year consistent of plenary lectures and practical sessions (1992-1999).

b) Trauma Radiology Course - to Senior Medical Students on weekly sessions of 1 1/2 hours in the Department of Radiology at University of Miami (1996-1999).

2. Graduate:

Daily Emergency Radiology and NeuroRadiology case review and discussion with Radiology Residents at University of Miami (1992-1999), Brigham & Women Hospital (1999-2001) and Hospital of St Rapahel (2001 to present)

3. Housestaff:

Daily reviews and case discussions in Neuroradiology, Head and Neck and Emergency Radiology

29. Thesis and Dissertation Advising:

Advisor to senior scientific projects of graduating Radiology Residents and Fellows:

Lectures series in Neuroradiology and Head and Neck Radiology to Residents and Fellows of the Yale affiliated Radiology Programs (2001 to present)

Advisees and trainees at Hospital of St. Raphael: Mario Torres Leon, Sameet Rao, Christopher Wasyliw, Charles Lesh (2003-2005)

Advisees and trainees at Brigham and Women's Hospital: Brian Hu, Peter Halt, Sean Hilchey and Frank Rybicki (1999-2001)

Advisees and trainees at University of Miami Medical Center:

Steve Christie- Routine Subdural Windows in Brain CT examinations: Are they necessary? June 1999.

Al Rivera- Angiographic management of liver injuries, June 1999

Jon Broder – Helical CT in the Evaluation of Renal Colic, June 1998.

Barbara Knoll – Do we need the AP views to clear the cervical spine when using helical CT routinely? June 1998

Wendy Whittick, MD, "Helical CT of vascular injuries" June 1997.

Suzanne D. LeBlang, MD, "Helical CT angiography in penetrating neck injuries" June 1997.

Graciela Ruiz, MD, "CT Cystography in the Evaluation of Bladder Rupture" June 1996.

Sergio L. Selva, MD, "Transcatheter Embolization in Splenic Trauma" June 1996

Vicky Youngman, DO, "Transcatheter Embolization of Traumatic Hepatic Arterial Injuries" May, 1996.

Felipe Munera, MD, "Low Suspicion Gun Shot Wound to the Abdomen: Is there a Role for CT?" May, 1996.

Wayne Jacobs, M.D., "Helical CT in the evaluation of aortic injuries"

June, 1995.

Ed Franca, M.D., "Helical CT angiography in the evaluation of penetrating neck injuries" June, 1995.

Susan LeBlang, M.D., "A new approach for the diagnostic work-up of penetrating neck trauma" 1994. (Best paper award)

Adel Ahmad, M.D., "Plain film versus spiral CT in the evaluation of cervical spine injuries" 1994.

John Wester, M.D., "Nonoperative management of liver injuries: CT observations" 1994.

Kimberley Lentz, M.D., "Ultrasound evaluation of the traumatized abdomen" 1993. (Best paper award)

Alex Marti, M.D., "Percutaneous nephrostomy: technical considerations and re-definitions for current applications" 1984. (Best paper award)

VII SERVICE

30. University Committee and Administrative Responsibilities:

Capital Budget Committee Co-Chair, Hospital of St Raphael, 2003 to present

Graduate Medical Education Committee, Hospital of St Raphael.
Jan 2003 to present.

Emergency Department Physician Advisory Committee.
Hospital of St. Raphael. 2002-2004

PACS and Radiology Informatics Committee. Hospital of St Raphael. 2002

Emergency Medicine Chair Search Committee. Hospital of St Raphael 2004

Director of Postgraduate Education- Department of Radiology Brigham and Women's Hospital, Feb- Sept. 2001

Technical Operations Committee Department of Radiology Brigham and Women's Hospital, 1999

Trauma Quality Management Committee- Brigham and Women's Hospital, 1999

Emergency Services Steering Committee, Jackson Memorial Hospital, 1998

Resident Selection Committee. Department of Radiology, University of Miami School of Medicine, 1992, 1994, 1996.

Member - Medical School Curriculum Committee, 1996-1999.

Coordinator - Educational Programs and Fellowships for Visiting Radiologists Department of Radiology University of Miami/Jackson Memorial Medical Center, 1994-1998

International Health Center University of Miami/JMH 1996

United States Department of Transportation Multidisciplinary Crash Study Committee. Ryder Trauma Center - Jackson Memorial Medical Center, 1993.

Coordinator of Radiology Grand Rounds. University of Miami School of Medicine, 1993-1999.

Emergency Care Center Quality Assurance Committee. Jackson Memorial Medical Center, 1992-1999.

Trauma Quality Management Committee. Ryder Trauma Center - Jackson Memorial Medical Center, 1992-1999.

Annamarie C. Rose, RT (R) (MR)

2641 Long Hill Road
Guilford, CT 06437
Home (203) 457-9880

Office (203) 789-4120
acrose@srhs.org

Administrator Manager with 24 years of progressive management experience in an aggressive free standing out patient Magnetic Resonance Imaging Facility.

PROFESSIONAL EXPERIENCE

Saint Raphael Magnetic Resonance Center
New Haven, Connecticut

Saint Raphael Magnetic Resonance Center is a free standing out patient MRI facility performing 9,400 MRI procedures per year. SRMRC houses two super-conducting 1.5 Tesla and 3.0 Tesla magnets that provide MRI services for inpatients and outpatients residing in the New Haven County and neighboring towns, staffs 20 employees and 15 radiologists.

Administrator Manager, (1988-present)

- Responsible for the development of the strategic plan and annual implementation plan.
- Responsible for a staff of 16 employees including but not limited to clerical and technological staff scheduling, employee evaluations.
- Development of an ongoing Quality Assurance Program, SRMRC Compliance Program, SRMRC HIPPA Compliance Manual and Risk Management.
- Designed, implemented and oversees all aspects of insurance/patient billing practices.
- Implementing new developments in the clinical setting for MR imaging.
- Development, revisions, creating and maintaining protocols for new applications development: including cardiac, spectroscopy, breast, MR Angiography, Diffuison and perfusion.
- Liaison between staff, physicians, upper management and referring physicians.
- Responsible for purchasing medial imaging and patient medical equipment.
- Overseeing and coordinating the installation of the Siemens 1.5T Symphony, 3T Trio and department renovations.
- Coordinating all national medical supply and service contracting.
- Responsible for monthly computation of volume and finances.
- Responsible for annual preparation and presentation the Fiscal Year Proformas
- Responsible for all insurance contractible agreements.
- Demonstrating respect and regard for the dignity of all patient, family, visitors, and fellow employee to ensure a professional, responsive, and courteous environment.

Yale New Haven Hospital
New Haven, Connecticut

Evening MRI Technologist Supervisor, MRI Department (1985-1988)

- Responsible for scheduling of MRI technologists
- Implemented new protocols
- Performing a wide variety of technical and professional tasks utilizing complex diagnostic imaging equipment in a quality and efficient manner.

- Demonstrating respect and regard for the dignity of all patient, family, visitors, and fellow employee to ensure a professional, responsive, and courteous environment.

Florence General Hospital
Florence, South Carolina

CT Technologist Supervisor, CT Department (1980-1985)

- Overseeing the installation of the GE 8800 CT scanner, and developing scheduling guidelines with the department.
- Responsible for scheduling of CT technologists
- Implemented new protocols
- Performing a wide variety of technical and professional tasks utilizing complex diagnostic imaging equipment in a quality and efficient manner.
- Demonstrating respect and regard for the dignity of all patient, family, visitors, and fellow employee to ensure a professional, responsive, and courteous environment.

Quinnipiac College
Hamden, Connecticut

Clinical Instructor for MRI Imaging (1992-1994)

- Clinical Instructor to the Senior classes on the clinical and applications of MRI imaging

EDUCATION
GE Milwaukee MRI clinical training, 1988
South Central Community College, AS Radiological Sciences, 1979
Yale New Haven Hospital, Clinical Certificate, Radiological Sciences, 1979
Hamden High School, 1977

PROFESSIONAL ACCREDITATIONS

ARRT (RT) 1979 - Present
ARRT (MR) 1994 – Present
Connecticut State Licenses 1994 – Present

MEMBERSHIPS

ASRT 1995 – Present
MRMS 1994 – Present
ISMRI 1988 – Present

Attachment C

SRMC's ACR Certificates

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology

Magnetic Resonance Imaging Services of

Saint Raphael Magnetic Resonance Center

330 Orchard Street
New Haven, Connecticut 06511

were surveyed by the
Committee on MRI Accreditation of the
Commission on Quality and Safety

The following magnet was approved

Siemens SYMPHONY 1999

For

Head, Spine, Body, MSK, MRA, Cardiac

Accredited from:

July 30, 2010 through July 30, 2013

CHAIRMAN, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 02625-02

ACR®
AMERICAN COLLEGE OF RADIOLOGY

American College of Radiology
Magnetic Resonance Imaging Services of

Saint Raphael Magnetic Resonance Center

330 Orchard Street
New Haven, Connecticut 06511

were surveyed by the
Committee on MRI Accreditation of the
Commission on Quality and Safety

The following magnet was approved

Siemens TRIO 2003

For

Head, Spine, Body, MSK, MRA

Accredited from:

August 25, 2010 through July 30, 2013

CHAIRMAN, COMMITTEE ON MRI ACCREDITATION

PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY

MRAP# 02625-03

Attachment D

SRMC's Internal Financial Statements

Saint Raphael Magnetic Resonance Center
Balance Sheet
FY 2011

Balance Sheet	Sep 30, 11
TOTAL ASSETS	4,904,874.20
LIABILITIES & EQUITY	
Total Liabilities	517,280.88
Total Equity	4,387,593.32
TOTAL LIABILITIES & EQUITY	4,904,874.20

Saint Raphael Magnetic Resonance Center
Income Statement
FY 2011

Total Facility:

	FY 2011
GROSS PATIENT REVENUE	
Non-Government	$8,709,011
Medicare	3,538,036
Medicaid and Other Medical Assis	1,224,705
Other Government	136,078
Total Net Patient Patient Revenue	13,607,830
Other Operating Revenue	(23,678)
Revenue from Operations	13,584,152
OPERATING EXPENSES	
Salaries and Fringe Benefits	1,218,512
Professional / Contracted Services	2,661,615
Supplies and Drugs	262,657
Bad Debts/Contractual Allowance:	6,837,837
Other Operating Expense	-
Subtotal	10,980,621
Depreciation/Amortization	293,597
Interest Expense	13,923
Lease Expense	
Total Operating Expense	11,288,141
Gain/(Loss) from Operations	2,296,011
Plus: Non-Operating Revenue	10,223
Revenue Over/(Under) Expense	$2,306,234

Attachment E

Financial Attachment I

Saint Raphael Magnetic Resonance Center

12. C (i). Please provide one year of actual results and three years of projections of Total Facility revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility: Description	FY 2011 Actual Results	FY 2012 Projected W/out CON	FY 2012 Projected Incremental	FY 2012 Projected With CON	FY 2013 Projected W/out CON	FY 2013 Projected Incremental	FY 2013 Projected With CON	FY 2014 Projected W/out CON	FY 2014 Projected Incremental	FY 2014 Projected With CON	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON
GROSS PATIENT REVENUE													
Non-Government	$8,709,011	$8,780,947	$0	$8,780,947	$8,796,101	$187,200	$8,983,301	$8,972,023	$93,600	$9,065,623	$9,241,184	$117,000	$9,358,184
Medicare	3,538,036	3,567,260	-	3,567,260	3,573,416	-	3,573,416	3,644,885	-	3,644,885	3,754,231	-	3,754,231
Medicaid and Other Medical Assistance	1,224,705	1,234,821	-	1,234,821	1,236,952	-	1,236,952	1,261,691	-	1,261,691	1,286,925	-	1,286,925
Other Government	136,078	137,202	-	137,202	137,439		137,439	140,188		140,188	142,991		142,991
Total Net Patient Patient Revenue	13,607,830	13,720,230	-	13,720,230	13,743,908	187,200	13,931,108	14,018,786	93,600	14,112,386	14,425,331	117,000	14,542,331
Other Operating Revenue	(23,678)	(23,678)	-	(23,678)	(23,678)								
Revenue from Operations	13,584,152	13,696,552	-	13,696,552	13,720,230	187,200	13,931,108	14,018,786	93,600	14,112,386	14,425,331	117,000	14,542,331
OPERATING EXPENSES													
Salaries and Fringe Benefits	1,218,512	1,230,697	-	1,230,697	1,248,975	18,735	1,267,709	1,280,199	8,961	1,289,161	1,312,204	11,547	1,323,752
Professional / Contracted Services/ Other	2,661,615	2,688,231	-	2,688,231	2,714,847	40,723	2,755,570	2,782,718	19,479	2,802,198	2,852,286	25,100	2,877,387
Supplies and Drugs	262,657	265,284	-	265,284	265,284	3,979	269,263	271,916	1,903	273,819	278,714	2,453	281,166
Bad Debts/Contractual Allowances	6,837,837	6,906,215	-	6,906,215	6,906,215		6,906,215	7,078,871		7,078,871	7,255,843		7,255,843
Other Operating Expense	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal	10,980,621	11,090,427	-	11,090,427	11,135,321	63,437	11,198,758	11,413,704	30,344	11,444,048	11,699,047	39,100	11,738,147
Depreciation/Amortization	293,597	293,597	-	293,597	293,597		293,597	293,597		293,597	293,597		293,597
Interest Expense	13,923	13,923	-	13,923	13,923		13,923	13,923		13,923	13,923		13,923
Lease Expense							-			-			-
Total Operating Expense	11,288,141	11,397,947	-	11,397,947	11,442,841	63,437	11,506,278	11,721,224	30,344	11,751,568	12,006,567	39,100	12,045,667
Gain/(Loss) from Operations	2,296,011	2,298,605	-	2,298,605	2,277,389	123,763	2,424,831	2,297,562	63,256	2,360,819	2,418,765	77,900	2,496,664
Plus: Non-Operating Revenue	10,223	10,223	-	10,223	10,223		10,223	10,223		10,223	10,223		10,223
Revenue Over/(Under) Expense	$2,306,234	$2,308,828	$0	$2,308,828	$2,287,612	$123,763	$2,435,054	$2,307,785	$63,256	$2,371,042	$2,428,988	$77,900	$2,506,887
FTEs		12	0	12	12	0	12	13	0	13	14	0	14
*Volume Statistics: 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.													
MRI Scans		9,213	0	9,213	9,284	230	9,514	9,427	350	9,776	9,646	499	10,145

Assumptions:

Revenue:
Gross patient revenue provided as per SRMRC financials
Revenue per scan assumed to remain flat.

Expenses:
Incremental expenses increase proportionaltely to incremental revenue
Annual inflationary increases range between 1-2.5%/year.
Bad Debt includes contractual allowances.

Attachment F

Financial SRMRC's Charges

SRMRC Charge Listing

CPT	DECRIPTION	Charge
70336	**MRI - TEMPOROMANDIBULAR JOINT**	$ 1,440.00
70540	**MRI-Orbi, face and neck w/o contrast**	$ 1,420.00
70542	with contrast	$ 1,795.00
70543	w/o and with contrast	$ 2,215.00
70544	**MRA-Head w/o contrast**	$ 1,395.00
70545	with contrast	$ 1,725.00
70546	w/o and with contrast	$ 2,160.00
70547	**MRA-Neck w/o contrast**	$ 1,395.00
70548	with contrast	$ 1,725.00
70549	w/o and with contrast	$ 2,160.00
70551	**MRI-Brain w/o contrast**	$ 1,440.00
70552	with contrast	$ 1,820.00
70553	w/o and w/contrast	$ 2,250.00
70554	**MRI-Brain , functional**	$ 1,980.00
70555	requiring physician administration	$ 2,270.00
71550	**MRI-Chest, without contrast**	$ 1,440.00
71551	with contrast	$ 1,810.00
71552	w/o and w/contrast	$ 2,235.00
71555	**MRA-Chest with or w/o contrast**	$ 1,930.00
72141	**MRI-Cervical spine w/o contrast**	$ 1,460.00
72142	with contrast	$ 1,840.00
72146	**MRI-Thoracic spine without contrast**	$ 1,460.00
72147	with contrast	$ 1,825.00
72148	**MRI-Lumbar spine w/o contrast**	$ 1,445.00
72149	with contrast	$ 1,820.00
72156	**MRI-Cervical spine w/o and w/contrast**	$ 2,285.00
72157	**MRI-Thoracic spine w/o and w/contrast**	$ 2,285.00
72158	**MRI-Lumbar spine w/o contrast and w/contrast**	$ 2,255.00
72159	**MRA-Spinal canal**	$ 2,135.00
72195	**MRI-Pelvis w/o contrast**	$ 1,440.00
72196	with contrast	$ 1,810.00
72197	w/o and w/contrast	$ 2,235.00
72198	**MRA-Pelvis with or without contrast**	$ 1,920.00
73218	**MRI-Upper extremity other than joint w/o contrast**	$ 1,420.00
73219	with contrast	$ 1,795.00
73220	w/o and w/contrast	$ 2,220.00
73221	**MRI-Upper extremity joint w/o contrast**	$ 1,425.00
73222	with contrast	$ 1,795.00
73223	w/o and w/contrast	$ 2,215.00
73225	**MRA-Upper extremity with or without contrast**	$ 2,100.00
73718	**MRI-Lower extremity other than joint w/o contrast**	$ 1,420.00
73719	with contrast	$ 1,795.00
73720	w/o and w/contrast	$ 2,215.00

SRMRC Charge Listing

73721	**MRI-Lower extremity, joint, without contrast**	$ 1,425.00
73722	**MRI-Lower extremity, joint, with contrast**	$ 1,795.00
73723	w/o and w/contrast	$ 2,215.00
73725	**MRA-Lower extremity with or without contrast**	$ 1,925.00
74181	**MRI-Abdomen without contrast**	$ 1,440.00
74182	with contrast	$ 1,810.00
74183	w/o and w/contrast	$ 2,235.00
74185	**MRA-Abdomen with or without**	$ 1,915.00
75557	**Cardiac MRI for morphology w/o contrast**	$ 1,545.00
75559	with street imaging	$ 1,695.00
75561	**Cardiac MRI for morphology w/o and w/contrast**	$ 2,095.00
75563	with stress imaging	$ 2,375.00
76376	**3D Rendering w/interpretation, independent station**	$ 250.00
76377	requiring image postprocessing	$ 320.00
77021	**Magnetic resonance guidance for needle placement**	$ 1,505.00
77058	**MRI-Breast, with and/or with contrast unilateral**	$ 2,135.00
77059	**Bilateral**	$ 2,135.00

PAGE INTENTIONALLY LEFT BLANK

YALE NEW HAVEN HEALTH

RECEIVED
FEB 16 2012
OFFICE OF HEALTH CARE ACCESS

Planning & Business Development
2 Howe Street, 3rd Floor
New Haven, CT 06519
Phone: (203) 688-2609
Fax: (203) 688-5013

Fax Transmission Sheet

To:	Kim Martone, Director of Operations	**From:**	Jean Ahn
Fax:	(860) 418-7053	**Date:**	02-16-12
Phone:		**Pages:**	4 (including fax cover)
Re:	YNHH-HSR Letter of Support	**CC:**	

☐ Urgent ☑ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Please see attached Letter of Support for the YNHH-HSR Certificate of Need.

This message originates from Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

December 13, 2011

Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

RECEIVED
FEB 16 2012

Christopher O'Connor
President and CEO
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Dear Marna and Chris:

We, the undersigned members of the Greater New Haven Delegation of the Connecticut General Assembly are pleased to support the proposed integration between the Hospital of Saint Raphael and Yale-New Haven Hospital. Both institutions have a long standing history of delivering the highest quality of care to the greater New Haven community. We believe that as one integrated institution, this practice will continue, and New Haven residents, as well as people in the broader region, will have greater access to an advanced, well-coordinated healthcare network.

We are aware of the financial difficulties that the Hospital of Saint Raphael has faced over the last few years. Due to the increasing demands on healthcare providers, many community hospitals find it necessary to seek alternative solutions to sustain themselves. We are pleased that a Connecticut solution will address this matter, and that Yale-New Haven Hospital will be able to make investments in the Hospital of Saint Raphael campus and to continue to have that campus available to provide needed services.

Additionally, the integration between Yale-New Haven Hospital and the Hospital of Saint Raphael is timely, in that Yale-New Haven Hospital's patient base continues to increase, therefore leading to capacity concerns. The Hospital of Saint Raphael is currently licensed as a 511 bed hospital, but currently operates only 400 of those beds. The integration of the two facilities will help to address the capacity limitations at Yale-New Haven Hospital.

The integration between Yale-New Haven Hospital and the Hospital of Saint Raphael makes sense. The agreement between the two facilities protects the Ethical and Religious Directives for Catholic Health Care Services at the Saint Raphael campus, preserves needed healthcare services, and respects the existing relationships between organized labor and employees.

On behalf of the greater New Haven community, we strongly support the integration of the Hospital of Saint Raphael with Yale-New Haven Hospital.

Sincerely,

Representative Al Adinolfi

Representative James M. Albis

Representative Terrance Backer

Representative Juan Candelaria

Representative Vincent Candelora

Representative James Crawford

Senator Joseph Crisco, Jr.

Senator Eileen Daily

Representative Stephen Dargan

Representative Paul Davis

Representative Patricia Dillon

Representative Louis Esposito, Jr.

Senator Leonard Fasano

Representative Mary Fritz

Senator Toni Harp

Representative Gary Holder-Winfield

Representative Laura Hoydick

Senator Kevin C. Kelly

Representative Themis Klarides

Representative Roland J. Lemar

Senator Martin Looney

Representative Robert Megna

Senator Edward Meyer

Representative Lawrence Miller

Representative Vickie Nardello

Representative Mary Mushinsky

Representative Lonnie Reed

Representative Kim Rose

Representative Richard Roy

Representative Brendan J. Sharkey

Senator Gayle Slossberg

Representative Peter Villano

Representative Toni Walker

Representative Patricia Widlitz

Representative Dave Yaccarino

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

March 8, 2012 VIA FAX ONLY

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System &
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Ahn and Ms. Estes,

On February 9, 2012, the Office of Health Care Access ("OHCA") received your initial Certificate of Need ("CON") application for Yale-New Haven Hospital's ("YNHH") acquisition of the Saint Raphael Healthcare System Inc. ("SRHS"), including the Hospital of Saint Raphael ("HSR").

OHCA has reviewed the CON application and requests additional information pursuant to General Statutes § 19a-639a(c):

Project Description and Need: Change of Ownership or Control – pages 20 through 25

1. Please describe the following:

    a. SHRHS' ownership and control of Saint Regis Health Center, Inc. d/b/a Sister Virginie Grimes Center;
    b. HSR's ownership and control of Connecticut CK Leasing, LLC;
    c. DePaul Health Services Corporation, Inc.'s ownership and control of Saint Raphael Dialysis Center Partnership; and
    d. The businesses engaged in by Connecticut CK Leasing, LLC and Saint Raphael Dialysis Center Partnership and any services they provide to inpatients or outpatients of HSR.

2. On page 21, applicants state that HSR provides "a number of community based programs" and outlines some of these programs in a list.

   Please indicate whether each of these programs is expected to continue following the acquisition. In addition, please provide information regarding all other HSR community based programs and indicate whether each of these additional programs will continue following the acquisition. If any program will be terminated as a result of or directly following the acquisition, describe the reason for such termination, how the decision was made and how the need will be met.

3. On page 22, applicants state that "[d]espite many efforts to mitigate financial losses, HSR recognized that without outside assistance and investment, it could not survive long term as a standalone entity."

   Please describe in detail the efforts HSR has taken to mitigate financial losses and provide detailed evidence supporting the conclusion that HSR could not survive as a standalone entity.

4. Applicants indicate, on page 24, that, "absent the proposed acquisition of HSR, YNHH will have to construct a 5th bed tower..." and further indicate that such tower is estimated to cost approximately $400 million and take nearly five years to complete.

   Please describe:

   a. The number and types of beds (by service category) that were estimated to be contained in the tower.
   b. How the cost and timeline estimates for the tower were determined.

5. Also on page 24, applicants state that "YNHH will make significant investments in the HSR campus to improve its facilities and technological capabilities."

   Please address the following:

   a. Describe, in detail, the nature of the facility improvements that will be made.
   b. Describe, in detail, the nature of the technological improvements that will be made.
   c. Describe how decisions will be made regarding these facility and technological improvements.
   d. Provide an estimated completion date for the improvements described in subsections (a) and (b), respectively.

6. Also on page 24, applicants state that "HSR's long term debt will be extinguished and resources will be provided to address the current Church plan pension shortfall."

   Please provide the following:

   a. The amount of long term debt that HSR currently carries and the amount that will be extinguished;
   b. The amount of the current Church plan pension shortfall and the amount that the shortfall will be reduced; and
   c. The source of the funds that will be used to make the payments described in subsections (a) and (b).

7. Please address the following:

   a. How are the current 421 operational beds at HSR allocated between medical/surgical, pediatric, obstetric, rehabilitation and psychiatric services.
   b. Would YNNH's acquisition of HSR result in any change to the current allocation of beds on the HSR campus.
   c. What would be necessary to make all of HSR's 511 licensed beds operational (up from the current 421 operational beds).
   d. Beyond the current 421 operational beds at HSR, how many additional beds could be phased into operation before the end of FY 2015, what would the likely phasing schedule be and what would be necessary to achieve this.
   e. From 10/08 to the month of applicants' completeness response, what has been the average monthly census for HSR based on both total beds and medical/surgical beds (please provide this data in chart and table form similar to that found on pps. 15-17 of YNNH's CON Application to Increase the Hospital's Licensed Bed Count by 70 under Docket No. 12-31745-CON).
   f. Assuming YNHH is licensed at 1,407 general hospital beds post-acquisition of HSR, and based on the projected inpatient utilization of both campuses, when would YNHH expect to exceed an 80% occupancy level based on average monthly census projections (please provide evidence of all assumptions and calculations on which such projection is based, and a chart of YNHH's bed need for each year until the 80% threshold is reached).
   g. Provide the same information as requested in subsection (f) above, but restrict the projection to when 80% occupancy of the combined medical/surgical beds on both campuses would be exceeded.
   h. Assuming YNHH is licensed at 1,477 general hospital beds post-acquisition of HSR, and based on the projected inpatient utilization of both campuses, when would YNHH expect to exceed an 80% occupancy level based on average monthly census projections (please provide evidence of all assumptions and calculations on which such projection is based).
   i. Provide the same information as requested in subsection (h) above, but restrict the projection to when 80% occupancy of the combined medical/surgical beds on both campuses would be exceeded.

8. On pages 24 and 25, applicants indicate that they engaged Deloitte "to identify cost savings which could be achieved through the acquisition" and that these cost savings are expected to exceed a half of a billion dollars over the next five years.

   Please provide:

   a. A copy of the Deloitte report;
   b. The applicants' cost savings plan; and
   c. An explanation of how applicants foresee that the savings will reduce costs of health care services for patients served by YNHH if the CON application is granted.

9. On page 25, applicants state that "[b]oth HSR and YNHH have focused on maintaining access and improving the quality of care despite the ever-present financial challenges of the industry."

   Please explain, in detail, HSR's efforts to maintain access and improve quality of care since 10/08.

10. Please describe, in detail, how the acquisition of HSR by YNHH will affect the following:

    a. Teaching and residency programs currently located at HSR and YNHH;
    b. Research and clinical trials conducted at HSR and YNHH;
    c. Emergency department services currently located at HSR and YNHH;
    d. Charity care and financial assistance programs currently operating at HSR and YNHH; and
    e. The rates currently charged for hospital services at HSR and YNNH.

Determination of Need by HSR – pages 26 through 27

11. Please describe, in detail, the steps that HSR took to address its financial situation. In addition, provide detailed evidence for the conclusion that HSR will be unable to achieve financial stability in the future. Please include information regarding the following cost saving efforts in the discussion:

    a. Aggressive negotiations with managed care organizations;
    b. Productivity enhancements;
    c. Supply chain cost reductions;
    d. Adjustments to fringe benefits; and
    e. Postponement of essential renovations and equipment purchases.

12. On page 26, applicants indicate that in early 2010, the SRHS Board's Ad Hoc Strategy Committee "began to explore and evaluate options to ensure continuation of the mission of Saint Raphael's and the Sisters into the future."

    Please provide evidence of the Committee's exploration and evaluation of options. Include information regarding the other options besides integration with YNHH that were explored.

13. Provide any reports prepared by Navigant Consulting relating to the analysis of health systems that it performed for HSR.

14. Provide a copy of the letter of intent signed by YNHH and HSR in March 2011.

Benefits to HSR – pages 27 through 29

15. On page 27, applicants state that HSR identified YNHH as its optimal partner for a number of reasons outlined in the application. Please address the following:

    a. Describe any clinical staff/clinical positions at HSR that would not be retained after the acquisition.
    b. Explain what Centers of Excellence would be created and located at the HSR campus.
    c. How will the HSR campus be held out/identified to the public post-acquisition by YNHH?

16. On pages 28 and 29, applicants state that "[i]n the first five years, YNHH plans to invest $129.5 million" in the HSR campus for a variety of purposes. Please address the following:

    a. Is the $129.5 million investment separate and distinct from the $160 million being paid by Buyer pursuant to Section 2.3 of the Asset Purchase Agreement set forth at Attachment III to the CON application?
    b. List the deferred capital purchases and projects on the HSR campus the investment will address.
    c. List the investments in clinical service infrastructure that will be made on the HSR campus.
    d. Explain when YNHH would expect the existing information technology systems on the HSR campus to be integrated with YNHH's and when the implementation of the Epic electronic medical record system would be completed on the HSR campus.

17. Describe, in detail, the "new, integrated organization [that] will preserve clinical services and ensure HSR's charitable assets for future generations" referenced on page 29. Please also provide the following information regarding the Charitable Funds defined at Section 5.5 of the Asset Purchase Agreement:

    a. What amount of Charitable Funds, if any, will be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets and how will they be used for the benefit of the Facilities?
    b. What amount of Charitable Funds that cannot be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets will be used by Sellers at or for the benefit of the Facilities and how will they be used?
    c. What amount of Charitable Funds shall be used by Sellers to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven area and how will they be used?

Determination of Need by YNHH – pages 29 through 35

18. On page 32 in Graphs I and II, respectively, applicants provided information on YNHH's occupancy based on the midnight census and the contact census for all services and for medical/surgical beds as compared to total beds and 80% occupancy levels. Please provide HSR's occupancy based on its census data from FY 2011 to FY 2012 (year to date) in the same format.

19. YNHH recently submitted a CON application to add 70 beds which will be temporarily located in its East Pavilion. Assuming that CON is granted, please explain what will happen to these 70 beds if the CON application for the acquisition of HSR is not approved and, alternatively, if the CON application for the acquisition of HSR is approved.

20. Please provide a copy of YNHH's long range financial plan showing the need for an additional 74 beds by 2016 even if 70 additional beds are added pursuant to Docket No. 12-31745-CON.

21. Please provide copies of the inpatient volume projections submitted to the Connecticut Attorney General and the Federal Trade Commission.

22. Please provide evidence of YNHH's decision-making process regarding the location of the new bed tower that has been contemplated as part of its long range financial planning efforts.

Benefits to YNHH – pages 35 through 40

23. On page 35, applicants state that "[t]he opportunity to avoid duplicative investments and focus on key strategies, such as primary care development, will enhance access to services for patients in the region."

    Please describe the discussions HSR and YNHH have had surrounding the development of primary care and the avoidance of duplication of services.

24. On page 36, applicants state that "discussions have been held with the State of Connecticut Attorney General and the Federal Trade Commission to initiate governmental approval of the transaction."

    Please describe the status of those discussions and provide a timeline for when decisions from the Attorney General's Office and the Federal Trade Commission might be expected if they have not already been rendered.

25. On page 37, applicants state that they "have worked to identify a number of options to achieve cost savings and work flow efficiencies."

    Please describe these cost savings and work flow efficiencies.

    a. Please provide additional detail regarding which subspecialties will be, or are likely to be consolidated, on one campus (indicating which campus) and include the reasoning behind each decision.
    b. What subspecialties will be, or are likely to be, offered on both campuses? Explain how these service lines were selected.

26. On page 37, applicants state that "Deloitte has estimated cost savings from clinical and business operational integrations of at least $300 million over five years."

    Please provide information that describes these cost savings in detail, including a breakdown of the approximate amount of money saved by each measure.

27. Please describe how the acquisition will improve efficiency, access to health care and quality for the area's growing elderly population.

28. Please provide an unredacted copy of the Asset Purchase Agreement and all exhibits thereto.

Quality Measures – pages 40 through 43

29. To the extent not already provided, please describe the $85 million in facility upgrades that YNHH plans to undertake on the HSR campus and the estimated amounts that will be spent in each year.

30. To the extent not already provided, please describe the type of routine capital expenditures that will amount to $25 million in expenditures over the next five years and the estimated amounts that will be spent in each year.

31. When will the EPIC installation at YNHH be complete? If the acquisition is approved, how long after Closing is it estimated that EPIC installation at HSR would begin?

Proposed Capital Expenditures/Costs and Patient Population Mix – pages 45 through 52

32. Please describe what makes up the $60,248,000 in the "Other Non-Construction (Other Asset Purchases)" line of the proposed capital expenditure chart on page 45.

33. On page 45, applicants state that specific capital costs for HSR's assets equal $147,879,000. Please provide information on how much of the remaining $12,021,000 in capital expense is being allocated to the purchase of DePaul Health Services Corporation, Inc.'s ownership interest in the Saint Raphael Magnetic Resonance Center (SRMRC).

34. Please summarize any analyses or reports from Barclays Capital, other underwriters or YNHH's financial advisors regarding YNHH's credit rating and ability to obtain the $160 million in bond financing necessary to complete the proposed acquisition.

35. On page 49, with respect to the assumptions for patient population mix, please explain why volumes for HSR are assumed to be flat through the projection period.

Financial Attachments I & II – pages 50-52 and Attachments VII and VIII

36. On page 231 (Attachment I for YNHH), please explain, in detail, the underlying assumptions for the increases in bad debt and interest expense connected with the HSR acquisition?

37. On page 234 (Attachment I for HSR), please explain, in detail, the underlying assumptions for inpatient discharges dropping in FY 2012 and remaining flat throughout the projection period without the YNHH affiliation taking place.

38. On page 234 (Attachment I for HSR), please explain, in detail, the underlying assumptions for outpatient visits increasing in FY 2012 and remaining flat throughout the projection period without the YNHH affiliation taking place.

39. On page 238, please explain the basis for the net negative adjustment to hospital inpatient and outpatient revenue due to health care reform.

40. On pages 50-51, please explain in more detail how YNHH intends to establish budget neutral agreements "with new payment terms that will not result in an adverse financial impact to the managed care payers or the self-funded employers they represent" if the affiliation occurs. Please also explain whether YNHH would be able to negotiate similar budget neutral agreements if the affiliation with HSR did not occur and how the affiliation impacts YNHH's ability to negotiate with managed care plans as well as other private health insurers.

MRI CON Questions and Responses – Appendix I

41. On page 246, applicants state that inpatient "scan volume is projected to increase in proportion to an expected increase in the average daily census (ADC) at the Saint Raphael campus following the acquisition by YNHH … ADC is projected to increase by 40 in FY 2012, 60 in FY 2014 and 85 in FY 2015." Yet, at page 236 of the CON Application, no increase in HSR utilization is assumed. Please explain this apparent discrepancy.

42. Will there be any change in the radiologists who provide professional services interpreting the SRMRC MRI scans as a result of YNNH's acquisition of HSR?

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response. Information filed must be numbered sequentially from the applicants' document preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101. Please reference "Docket Number: 12-31747-CON" and submit one (1) original and five (5) hard copies of your response. In addition, please submit a scanned copy of your response, including all attachments, on CD using MS Word format or Adobe Acrobat.

Upon receipt of the responses to this letter and after incorporating the provided information into the initial submission, OHCA staff will perform a detailed review of the entire CON application. If you have any questions concerning this letter, please feel free to contact Steven W. Lazarus at OHCA at (860) 418-7012.

Sincerely,

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2823
RECIPIENT ADDRESS	912036885013
DESTINATION ID	
ST. TIME	03/08 16:44
TIME USE	05'06
PAGES SENT	10
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jean Ahn

FAX: (203) 688-5013

AGENCY:

FROM: Steven Lazar

DATE: 3/8/12 TIME: 3:35

NUMBER OF PAGES: 10
(including transmittal sheet

Comments: Completeness Letter for DN: 12-31747
Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2824
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	03/08 16:53
TIME USE	03'45
PAGES SENT	10
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Teina Estes

FAX: (203) 867-5665

AGENCY:

FROM: Steven Lazarus

DATE: 3/8/12 TIME: 3'35

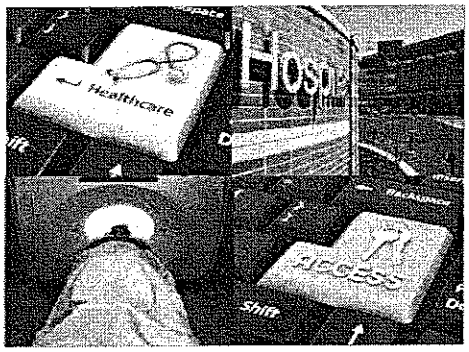
NUMBER OF PAGES: 10
(including transmittal sheet

Comments:
Completion Letter for Dr. 12-31747
Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

OHCA Main
Certificate of Need
Consumer Assistance Process
Facilities Plan
OHCA Forms
Freedom of Information
Hospital Financial Data
Laws and Regulations
OHCA Publications
Glossary
Contact OHCA
Legal Notices and Status Reports

TRAINConnecticut
H.I.P.A.A NOTICE
HealthCare Reform
Check the Calendar
Receive Updates by E-mail. Sign-Up for E-alerts
CT Alert
WE CAN'T ALERT YOU IF WE CAN'T REACH YOU



Welcome to the Office of Health Care Access. Our Mission is to ensure that the citizens of Connecticut have access to a quality health care delivery system.

CT State-Wide Health Care Facilities and Services Plan Advisory Body

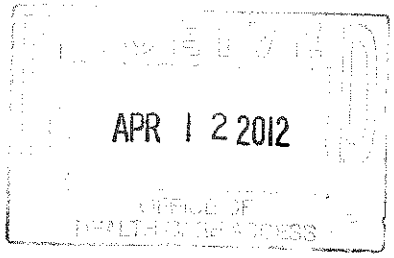
Outpatient Data Work Group

News:

- **NEW !!!** On February 17, 2012 OHCA received the CON Application of Community Mental Health Affiliates, Inc. (CMHA) for the transfer of ownership of CMHA from Central Connecticut Health Alliance to CMHA. Filed under Docket No.: 12-31750-CON.
- **NEW !!!** On February 24, 2012, OHCA Deemed Complete the CON application of WBC Connecticut East, LLC to establish a Partial Hospital and Intensive outpatient program for the treatment of adults and adolescents with Eating Disorders in South Windsor, filed under Docket No.: 11-31731-CON.
- **NEW !!!** On February 23, 2012, OHCA deemed Complete the CON Application of MCI Healthcare LLC d/b/a Mountainside Treatment Center for the increase of licensed bed capacity by 16, filed under Docket No.: 11-31734-CON.
- **NEW !!!** On February 9, 2012 OHCA received the CON Application of Yale-New Haven Hospital and Saint Raphael Healthcare System d/b/a Hospital of Saint Raphael, Inc. for Yale-New Haven Hospital to acquire ownership of Saint Raphael Healthcare System, Inc. and certain associated assets. Filed under Docket No.: 12-31747-CON.
- On January 30, 2012, OHCA deemed Complete the CON Application of Eastern Connecticut Health Network for the acquisition of four MRI Scanners located in the towns of Enfield, Glastonbury, Middletown and South Windsor, as filed under Docket Number 11-31737-CON.
- On January 27, 2012 OHCA received the CON Application for Yale-New Haven Hospital's proposal to increase its licensed general hospital bed count by 70, from 896 to 966 licensed beds, at a total capital expenditure of $1,438,919, Docket Number 12-31745-CON.
- On January 17, 2012, OHCA deemed Complete the CON Application of Lawrence & Memorial Hospital for the acquisition of a PET-CT scanner to be located at its L&M Diagnostic Imaging at Crossroads in Waterford, as filed under Docket Number 11-31730-CON.
- On January 6, 2012, OHCA deemed Complete the CON Application of Eastern Connecticut Health Network and Manchester Memorial Hospital for the transfer of ownership of Evergreen Imaging Center to an affiliate of ECHN, as filed under Docket Number 11-31736-CON.
- On December 09, 2011 OHCA received the CON Application of Eastern Connecticut Health Network, Inc. and Mandell & Blau, M.D.s, P.C. for the Acquisition by Eastern Connecticut Health Network, Inc. of the Open MRI scanners currently operated by Mandell & Blau, M.D.'s P.C. under Docket No.: 11-31737-CON.

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael



VIA HAND DELIVERY

April 12, 2012

Lisa Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: ***Certificate of Need Application; Docket Number 12-31747-CON***
Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Deputy Commissioner Davis:

Enclosed are responses of Yale-New Haven Hospital, Inc. ("YNHH") and the Hospital of Saint Raphael ("HSR") to the completeness questions posed by the Office of Health Care Access ("OHCA") on March 8, 2012.

We appreciate the opportunity to provide OHCA with additional information regarding the proposed transaction. In preparing responses to each of OHCA's questions, we have endeavored to provide comprehensive information regarding the proposed acquisition and the Applicants' plans to continue to provide critical health care services in the future. In cases where confidential, sensitive commercial information has been requested, it will be submitted under separate cover upon an acceptable protocol from the Department of Public Health for the protection of confidential submissions by the Applicants. We hope that the information submitted provides OHCA with all of the information needed to render the application complete and to move forward with its evaluation of this important transaction.

We believe that the proposed transaction is critical for ensuring continued and improved access to critical health care services in the New Haven region and beyond. Since the date of filing of the application, the needs of both YNHH and HSR have become more acute. Capacity issues at YNHH continue to tax YNHH's existing facilities and, of more immediate concern, HSR's deteriorating financial situation threatens its continued viability as key personnel leave and HSR is unable to recruit replacement personnel.

In order to achieve the benefits of the proposed transaction – as outlined in detail in our application and the enclosed responses to OHCA's completeness questions – it is crucial that the transaction be consummated by no later than July 1, 2012. As each month passes, the window in which the parties can collectively contribute to improved health care delivery in their communities grows smaller – and will quickly close.

which the parties can collectively contribute to improved health care delivery in their communities grows smaller – and will quickly close.

The Applicants have been cooperating with the Connecticut Attorney Generals' Office and the Federal Trade Commission to facilitate their timely review of the transaction. Each of these agencies is moving forward with a thorough and independent review, which we believe will be completed in June. The parties have worked closely with the FTC and the AG's Office, for example, to schedule all investigational hearings to be completed by the end of April. YNHH and HSR certified substantial compliance with the FTC's Second Request on April 2, 2012, triggering a 60-day timeline for decision by the FTC – consistent with a July 1 closing if the transaction is permitted to go forward.

We appreciate and understand the complexity of the proposed transaction and the importance of OHCA's review of it. We also understand that OHCA is currently facing significant staffing constraints and is burdened with numerous responsibilities. But at this point, timing is critical to the success of the transaction, assuming it garners the required regulatory clearance. A delay in decision-making may effectively be a denial, eliminating the Applicants' opportunity to provide continued care at HSR's campus. We therefore respectfully request OHCA's assistance in reviewing the application on an expedited basis. We will do whatever we can to assist OHCA and facilitate its timely review of the proposed transaction.

Thank you in advance for your consideration.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Richard D'Aquila
Title: President and Chief Operating Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: Steven W. Lazarus, Associate Health Care Analyst, Office of Health Care Access
Kimberly Martone, Director of Operations, Office of Health Care Access
Marianne I. Horn, Legal Director, Office of Health Care Access
William J. Aseltyne, General Counsel, Yale-New Haven Hospital, Inc.
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael

Yale-New Haven Hospital
Saint Raphael Healthcare System
Hospital of Saint Raphael

Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. & Hospital of Saint Raphael

Docket Number: 12-31747-CON

Responses to Completeness Questions

April 12, 2012

Yale-New Haven Hospital
Saint Raphael Healthcare System & Hospital of Saint Raphael

Certificate of Need Application
Docket Number: 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of
the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Responses to Completeness Questions
Table of Contents

	Description	Page Number
	Completeness Question Responses	105-157
Attachments		
I	Average Age of Plant – CT Hospitals (2011)	158-160
II	Calculations and Assumptions for Bed Need and Capacity	161-166
III	HSR's Plan for Excellence/Quality Improvement & Patient Safety Plan (2009)	167-191
IV	HSR's Quality Documents: • Quality Improvement and Patient Safety Committee Annual Summary Fiscal Year 2009 • Quality Improvement and Patient Safety Committee Annual Summary Fiscal Year 2010 • Quality Improvement and Patient Safety Committee Annual Summary Calendar Year 2011 • Hospital of Saint Raphael Quality Indicator Grid FY 2011 • Board Quality Indicator Report FY 03 to FY 09 • Public Reporting Initiative JCAHO Core Measures/Hospital Quality Alliance Indicator Reports: October 2007 – March 2009 and April 2009 – December 2010.	192-229
V	Connecticut Hospitals – Capital Spending as a Percentage of Depreciation (from DPH data)	230-231
VI	HSR - Additional Capital Needs	232-243
VII	HFMA Report 6: The Outlook for Capital Access and Spending	244-264
VIII	Signed Letter of Intent between YNHH and SRHS/HSR	265-285

PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION

Yale-New Haven Hospital
Saint Raphael Healthcare System & Hospital of Saint Raphael

Certificate of Need Application
Docket Number: 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of
the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Responses to Completeness Questions

1. Please describe the following:
   a. SRHS's ownership and control of Saint Regis Health Center, Inc. d/b/a Sister Virginie Grimes Center;
   Response
   Saint Regis Health Center Inc. d/b/a Sister Anne Virginie Grimes Center is a wholly owned Subsidiary of SRHS.

   b. HSR' s ownership and control of Connecticut CK Leasing, LLC
   Response
   HSR has a 49.1% interest in Connecticut CK Leasing, LLC.

   c. DePaul Health Services Corporation, Inc.'s ownership and control of Saint Raphael Dialysis Center Partnership; and
   Response
   DePaul Health Services Corporation has a 49.9% ownership in the Saint Raphael Dialysis Center Partnership.

   d. The businesses engaged in by Connecticut CK Leasing, LLC and Saint Raphael Dialysis Center Partnership and any services they provide to inpatients or outpatients of HSR.
   Response
   Connecticut CK Leasing LLC is a business engaged in stereotactic radiosurgery ("SRS") Cyberknife, a technology that deploys highly focused beams of radiation to deliver the highest level of accuracy and efficiency possible. It is also a breakthrough from traditional cranial only stereotactic radiosurgery/radiotherapy as it includes treatment of extra-cranial lesions such as of the prostate, spine, liver, and lung. The radiation treatment is delivered with sub-millimeter isocenter accuracy, targets multiple locations during a single session and accurately tracks tumors that move with breathing.

Treatment occurs as outpatient procedures of one to two hours with as few as one to five treatments are needed. No inpatient procedures are performed.

The Saint Raphael Dialysis Center Partnership is engaged in the business of operating the chronic kidney dialysis outpatient center at 137 Water Street, New Haven, Connecticut, in addition to three other locations, 34 East Industrial Road, Branford; 266 State Street, North Haven; So. Commerce Park Drive, Milford (the "Outpatient Dialysis Services") and managing HSR's inpatient acute kidney dialysis service (the "Acute Dialysis Management Services").

2. On page 21, applicants state that HSR provides "a number of community based programs" and outlines some of these programs in a list.

   Please indicate whether each of these programs is expected to continue following the acquisition. In addition, please provide information regarding all other HSR community based programs and indicate whether each of these additional programs will continue following the acquisition. If any program will be terminated as a result of or directly following the acquisition, describe the reason for such termination, how the decision was made and how the need will be met.

   1. For each of the programs listed, indicate whether the program is expected to continue following the acquisition.
      Response
      Each of the community programs listed on page 21 of the CON application (also listed below), are expected to continue following the acquisition.
      - **Father Michael J. McGivney Cancer Center in Hamden**
      - **Occupational Health Program**
      - **Blood Draw Centers Amity/New Haven and Hamden**
      - **Midwifery Services in Shelton**
      - **Geriatric Assessment Centers in Branford and Hamden**
      - **ElderCare Geriatric Clinics**
      - **Project Mothercare**
      - **Smiles to Go! Dental Van**
      - **School based health clinics**

   2. Provide information regarding other community based programs and indicate whether or not they will continue following acquisition.
      Response
      At this time, the following additional community based services are provided by HSR and are expected to continue.

      - **CareCard - is a free health and wellness program for adults 55 years of age and older. Activities range from free and low-cost health screenings (i.e. cholesterol, diabetes, etc.), exercise programming, free legal advice, lectures on a variety of health topics, monthly book club, and social and recreational events. Currently, there are over 15,000 members who reside in Greater**

New Haven. Activities are offered at both community locations (senior centers, churches, residential living facilities) and at the hospital's New Haven, Hamden and Branford locations.

In New Haven, there are 2,635 members. CareCard activities are provided on a regular basis at the three (3) senior centers and Casa Otonal. Last year, 536 older adults participated in our programming offered at New Haven Senior Centers and Casa Otonal.

- **Lifeline – is a 24-hour personal/medical alert service. In the event of an emergency, the subscriber presses the personal help button and within seconds is connected to the response center that can immediately dispatch help (24/7). Lifeline recently added the AutoAlert options designed to detect if a person falls and is unable to push the button on their own and will automatically place a help call. This is a fee for service program. A sliding scale and full scholarships are available to qualified subscribers. Currently, there are 1,300 Lifeline subscribers. Four hundred sixteen (416) reside in New Haven. (17% sliding scale, 38% on Connecticut Home Care Program, 2% full scholarship).**

- **Parish Nurse - Parish Nursing is a unique, specialized practice of professional nursing which focuses on the promotion of health within the context of the values, beliefs, and practices of a faith community, such as a church, its mission and ministry to its members and the community it serves. The parish nurse is typically a member of the congregation who assumes responsibility for the planning and implementing of this prevention-related outreach program for its congregation. The role of Saint Raphael's Parish Nurse Coordinator is to serve as a support and linkage to help facilitate the use of available resources in the congregation and in the community. Currently there are 48 participating parishes, and 176 nurse volunteers.**

- **WIC—Women, Infants & Children in Need - A supplemental program which provides vouchers for specific foods—milk, cheeses, eggs, fruit juices, dried beans and peas, peanut butter, and iron fortified cereal and infant formula. Eligible participants enroll in the program at their local WIC office, like the one at Saint Raphael's which serves more than 2,500 clients in Greater New Haven. The Hospital of Saint Raphael currently serves as the lead agency and fiduciary for the New Haven WIC Program that includes sites at the Hospital of Saint Raphael, Yale-New Haven Hospital, Fair Haven Community Health Center, Cornell Scott-Hill Health Center, and several satellite sites throughout the Greater New Haven area.**

- **Nurturing Families Network - A community service program focusing on new parents and the challenges they face. The program includes:**

- Home Visiting — For first time mothers who qualify this program provides a home visitor to help the mother care for her baby as she adjusts to the many demands of becoming a parent.
- Nurturing Connections — Nurturing Connections is a telephone support program for first-time parents. A trained program volunteer calls the new family regularly to offer helpful parenting information, emotional support, child development information and information about community resources. Families will meet with the Connections Coordinator in the hospital during a prenatal visit or after delivery and can attend an education group event hosted throughout the year.

- New Haven Healthy Start - "Too many, too small, too soon"- New Haven Health Start is a program that helps pregnant women deliver healthy and happy babies. In a program that partners with Saint Raphael, its primary goal is to reduce the infant mortality and morbidity in the City of New Haven. The program's current objectives are to:
  - Help reduce New Haven's remaining health disparity in infant mortality;
  - Increase its emphasis on multi-prolonged outreach strategy;
  - Strengthen connections with new community resources;
  - Enhance case management capabilities for working with women at high-risk of poor birth outcomes. (Special outreach made to teens, the homeless, and those who lack insurance coverage and who have had previous poor birth outcomes).

- Protect Brotherhood - Project Brotherhood is dedicated to helping Greater New Haven area men 50 and over (45 and older for African-American men and 40+ for those with a family history putting them at higher risk) make the healthy lifestyle choices needed to prevent prostate cancer. The program offers free prostate screenings in April & September.

- Sister to Sister Program - Since 1995, the Hospital of Saint Raphael has been a participant in the Connecticut Breast and Cervical Cancer Early Detection Program (CBCCEDP). This initiative, sponsored by the Centers for Disease Control and Prevention, is offered at the Hospital of Saint Raphael in conjunction with the State of Connecticut Department of Public Health. The CBCCEDP provides free breast and cervical cancer screening and diagnostic services, and through a special initiative, provides coverage for the treatment of these cancers. Since its inception in 1996, the Sister to Sister program has assisted 1,900 women — nearly 75% of whom were low-income minorities.

- Off Campus Classroom (O.C.C.): Launched in 2004, the O.C.C. (Off Campus Classroom) at the Hospital of Saint Raphael is a New Haven Public School Work Experience Program for intellectually disabled high school students. Students attend school at Saint Raphael's through the academic

year (September-June) and participate in classroom studies and job skills training. Managed through the Volunteer Services department and supervised daily by an on-site special education teacher and para-professional, the students are matched with an employee who serves as their mentor and work site supervisor.

- **The H.O.P.E. (Having an Opportunity to Prepare for Employment) Program: The H.O.P.E. Program was developed in 1996 in response to the State's Welfare to Work legislation mandating that welfare recipients be placed in a 21 month window to re-enter the workforce. This job-skills training program has been touted as a welfare-to-work model and has received national, regional and state awards for its design and impact on the community. To date over 350 women and men have completed the program with a hire rate of approximately 60%. Managed through the Volunteer Services department, HOPE participants are placed in volunteer internships throughout the healthcare system.**

- **AIDS/HIV Services: Both inpatient and outpatient services for people with AIDS are available through our Haelen Center. Located in the Family Health Center on the main Hospital of Saint Raphael campus, the Haelen Center provides social services, education, pastoral care, counseling and testing. Outpatients with HIV and AIDS can receive medical care and treatment from a team that includes physicians, physician associates, nurses, social workers, pastoral counselors, HIV counselors/educators and nutritionists.**

- **Bereavement Support Programs - Seminars and support groups are intended as a source of strength and hope for adults coping with bereavement following the death of a loved one. Programs are offered at the campus and are offered free-of-charge.**

- **The Family-Based Recovery Program integrates substance abuse treatment with family treatment designed to enhance parenting and parent-child attachment in families of infants (birth to 24 months) who have been exposed to parental substance abuse in-utero and/or environmentally. The service works in tandem with DCF child protective services staff to promote the safety, permanence and well-being of children and families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma informed, culturally competent, and responsive to the individual needs of each child and family.**

3. Please describe in detail the efforts HSR has taken to mitigate financial losses and provide detailed evidence supporting the conclusion that HSR could not survive as a standalone entity.

Response

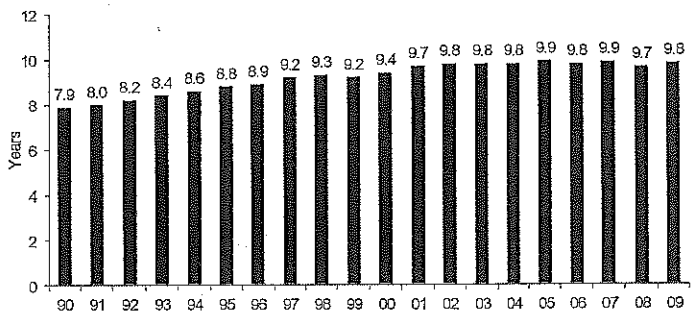
Since 2008, HSR has faced extraordinary financial challenges and crises of a nature and magnitude beyond those faced by most acute care hospitals in Connecticut and the nation. To meet these challenges, HSR has reduced costs (including, but not limited to, eliminating pension funding and benefits, reducing staffed bed capacity, etc.), enhanced revenue capture and financial controls, cut capital expenditures, refrained from numerous investments (in plant, people, infrastructure, information technology and medical equipment), and significantly raised its reimbursement from an increasingly small commercial patient base. Each one of these measures has been essential in avoiding insolvency. However, many of these measures significantly reduced the ability of Saint Raphael's to offer affordable care in an attractive, progressive environment in which physicians and other health care professionals take care of patients. Annual budgets included the estimated impact of many of these measures and financial statements at Saint Raphael's reflect the actual impact of these measures.

As part of, and in addition to budgeted cost reduction measures, Saint Raphael's repeatedly implemented financial turnaround plan actions, which included necessary revenue-enhancing and cost-cutting measures to both achieve budgeted performance and offset unfavorable variances in the event that budgeted performance had not been or was not likely to be met. The ongoing financial turnaround plan actions that HSR has undertaken to mitigate financial losses are referred to as the "Financial Bridge Plan". Financial Bridge Plan targets were initially included as a component of Saint Raphael's annual budgets ($14.4 million of improvements in fiscal 2009 and $8.0 million in fiscal 2010), with annual targets established above those budgeted values. For fiscal 2011 and beyond, such targets were not included as a component of the annual budget. A three-year chronology of the actual Financial Bridge Plan results (both budgeted and unbudgeted) for fiscal years 2009-2010-2011 is included in the response to Question 11. The Financial Bridge Plan was an integral component of the improvements in financial performance over this period of time. It is important to understand that once a cost-cutting and/or revenue-enhancement effort was implemented, the subsequent year impacts became a part of the ongoing budget detail and were no longer considered (or valued) as part of the Financial Bridge Plan reporting (meaning that many of the actions that enabled Saint Raphael's to avoid insolvency are already reflected in annual budget details and current financial statements).

Even with all of the dramatic investment reductions in people, facilities and equipment, and the significant increases in commercial reimbursement, Saint Raphael's still faces a significant amount of long-term debt, an enormous pension fund deficit, and a deteriorating payer mix. And it does so with declining volume in a facility that has doubled in age in only five years to become the oldest in the State (according to Connecticut hospitals' 2011 audited financial statements obtained from OHCA and summarized in Attachment I). HSR's physical plant is also more than two and one-half times older (26.2 years) than the national average as reported in the American

Hospital Association's Trendwatch Chartbook 2011 (Chart 4.10, showing average hospital age to be 9.8 years in 2009 – see below).

Chart 4.10: Median Average Age of Plant, 1990 – 2009



Source: Ingenix, *Almanac of Hospital Financial and Operating Indicators*, 2005, 2008, 2009, 2010, and 2011 and CHIPS, *The Almanac of Hospital and Financial Operating Indicators*, 1994 and 1998-7.

American Hospital Association Avalere

Based on its declining competitiveness, precarious financial state, and increasingly bleak outlook, Saint Raphael's concluded that it cannot remain a viable standalone provider of healthcare services. Evidence supporting this conclusion includes the following:

- **<u>Qualified audit opinion</u>- HSR has received a "going-concern" qualification in each auditor's report which accompanies the annual audited financial statements since fiscal 2008 which are on file with OHCA. This qualification relates to the inadequate financial performance over the last years which resulted in HSR's inability to achieve the financial covenant requirements of its long-term debt agreements. There are insufficient current assets available to satisfy current liabilities (which include all long-term debt amounts under the various Connecticut Health and Educational Facilities Authority's debt issuances) if the credit-enhancers to this long-term debt were to declare an event of default. It is possible that the credit-enhancers could declare an event of default at any time. The other ramification of noncompliance with the covenants of the long-term debt agreements is that there is currently no ability for HSR to access the debt markets as a source of capital funding.**

- **<u>Employee and benefit matters</u>- HSR ceased all post-retirement pension benefit accruals for all employees effective during fiscal 2010, including the defined benefit pension plan, the defined contribution pension plan, and the 401(k) plan match. Financial performance has been insufficient for these benefit programs to be reinstituted; and the financial projections included in the Certificate of Need also**

indicate that available resources will be inadequate to reinstitute these pension programs. Without pension benefits, the ability to attract and retain a robust and talented workforce diminishes. As positions become vacant and must be filled via non-employee alternatives, the ability to provide necessary services at a reasonable cost becomes increasingly difficult. Financial performance is also not projected to allow for the funding of the sizeable under-funding in the defined benefit pension plan.

- **Unmet capital needs- As further detailed in response to Question 11e, limitations on capital acquisitions over the last several years due to the lack of available funds continues to put HSR at a competitive disadvantage. Without adequate investment in the physical plant and medical technology, the lack of new treatment modalities and technology upgrades leads physicians to admit their patients elsewhere for care and treatment. Access to capital in the debt markets is not possible due to the ongoing financial covenant violations on the existing long-term debt. The inadequate levels of capital acquisitions have no possibility of being remedied without an affiliation transaction.**

- **Volume declines- HSR has experienced inpatient volume declines over the last several years, which have continued into FY2012. Further volume declines are projected if HSR remains a standalone hospital. Based on recent experience, volume declines have tended to be larger than those predicted year over year. The ability to remain financially viable becomes increasingly difficult in the face of declining volume. Only the ability to attract new physicians to the area (and to Saint Raphael's) would likely reverse this trend, and only a financially strong hospital with very competitive compensation and benefits packages would attract physicians to the area (assuming they are willing and able to move to the area). Due to the complexity and uncertainty of HSR as a standalone hospital, volume projections were held flat beyond FY 2014.**

- **Economic factors- Payment rates from Medicare and Medicaid sources (approximately 70% of HSR net revenues) are expected to decline with the implementation of health care reform legislation as well as budget deficit reduction activity. Commercial payment rate increases (commercial payments account for approximately 30% of HSR net revenues) will be more difficult to negotiate due to current economic conditions. Again, the ability to remain financially viable becomes increasingly difficult as payment increases are less than cost increases.**

- **Days cash on hand: As of February 29, 2012, HSR had 22.1 days cash on hand. This is a very low level and significantly impacts the organization's ability to manage through any interruptions in business. Existing loan agreement covenants include a minimum days cash on hand of 40 days through 2013 and 45 days thereafter. Even if days cash on hand increased significantly (i.e., tripled), it would remain far below national averages for acute care hospitals and would be just over the average in Connecticut (62 days as noted in OHCA's Annual Report on the**

Financial Status of Connecticut's Short Term Acute Care Hospitals for FY 2010, p. 15, see OHCA's website).

- **Negative fund balance- As of February 29, 2012 Saint Raphael's had a negative fund balance of $23.4 million, due in large part to the underfunded position of the defined benefit pension plan. Existing loan agreement covenants include a minimum fund balance requirement of $54 million.**

4. Applicants indicate, on page 24, that, "absent the proposed acquisition of HSR, YNHH will have to construct a 5th bed tower …" and further indicate that such tower is estimated to cost approximately $400 million and take nearly five years to complete.

   Please describe:
   a. The number and types of beds (by service category) that were estimated to be contained in the tower.
   b. How the cost and timeline estimates for the tower were determined.

   Response

   As an alternative to the acquisition of HSR, YNHH's plan contemplates a new bed tower with approximately 250 beds. The new bed tower may become YNHH's new Children's hospital, housing women's and children's services. Because of the enhanced proximity for medical/surgical services that exists with the current Children's hospital (West Pavilion), the West Pavilion would be renovated and reconfigured to provide adult medical care. Services currently provided in the Children's Hospital would be moved from their current location in the West Pavilion to the new bed tower, as would birthing and newborn services.

   The original expected $400 million cost and the timeline for the new bed tower were estimated on the basis of YNHH's actual experience with the planning and construction of its North Pavilion, which houses the Smilow Cancer Center and was completed in 2010. Since that cost estimate was completed, YNHH has updated its plans. It now expects the new bed tower to be approximately 500,000 square feet in size, which would increase the cost of the new bed tower to be approximately $537 million which includes $470 million for the bed tower plus $32 million of capitalized interest and $35 million for renovations of the West Pavilion.

   The table below compares the updated plan for a 500,000 square foot new bed tower with the Smilow Cancer Center:

Comparison of New Bed Tower and Smilow Cancer Hospital

	New Bed Tower	Smilow
Size (sq. ft)	500,000	500,000
CON	12 months	9-10 months
City Permits	12 months (starts 6 months into CON process)	12 months (started 6 months into CON process)
Construction	<40 months	40 months
Beds	250	168
Cost	$537 million	$467 million
Total time	<4 years, 10 months	4 years, 6 months

For a description of and cost estimates for the additional portions of the project, please see the Response to Question 22.

5. Also on page 24, applicants state that "YNHH will make significant investments in the HSR campus to improve its facilities and technological capabilities."

Response

YNHH plans to invest $129.5 million in the HSR campus during the first five years. This amount consists of $85 million earmarked for infrastructure and facility improvement and appearance, $25 million for routine capital, $5.1 million for information technology integration and $14.4 million to implement EPIC at the HSR campus.

Responses to subsections (a-d) provide detail on the facility and technological improvements to be addressed. The $25 million for routine capital was developed using an accounting standard of 130% of depreciation. Due to HSR's current financial condition its current level of capital expenditures has been less than 130% of depreciation. The $25 million investment from YNHH fills the gap between HSR's baseline capital spending and the level of 130% of depreciation. Routine capital items include primary medical and non-medical equipment, and some miscellaneous items.

Please address the following:

a. Describe, in detail, the nature of the facility improvements that will be made.

Response

The $85 million for facility improvements can be further broken down into two segments: $60 million for Mechanical, Electrical and Plumbing infrastructure (MEP), and $25 million for architecturally related facility and appearance improvements. The vast majority of the MEP money will be spent on Mechanical and Electrical systems. Mechanical work will focus on equipment, ductwork, temperature controls and piping/miscellaneous, while the Electrical will focus on gear & distribution, lighting & branch, communication systems and special systems.

YNHH studied the HSR Campus physical plant carefully through a thorough due diligence effort and identified the need for the proposed investment as summarized below.

MECHANICAL ($43.4 million)

Physical Plant

- **Boilers and Steam Distribution: Two of the three HSR boilers were installed in 1974, and while well maintained, have exceeded their useful lives and should be replaced.**
- **Condensate Reclaim System: While well maintained it has exceeded its useful life and should be replaced.**
- **Chiller Plant: Consists of four chillers. Three of the four chillers should be considered for replacement. Additionally, the west side of the campus is served by an 8" pipe that should be replaced to better support the load. There are three cooling towers two of which should be replaced. The condenser water system is served by seven condenser water pumps, all of which have exceeded their expected lives and should be replaced.**
- **Medical Gas Cylinder Storage Room: This space will require mechanical ventilation.**
- **Verdi Building Lab Exhaust Fans (located in Physical Plant): The fans were installed in 1974 and do not have any redundancy. While well maintained, the fans have exceeded their useful life and should be replaced.**

Verdi Building

- **Air Handling units S-1 through S-6 require replacement. Floors 3, 4 and 5 are patient care floors with dedicated custom built air handling units located on the floors they serve. These units require replacement.**

Center Building

- **This building was constructed in 1989 and the mechanical equipment serving the building was installed at that time and requires replacement. Air Handling Units AC-5 and AC-6 require replacement.**

Tower Buildings

- **Air Handling Units AC-2 and AC-4 are packaged roof top units. The units require replacement.**

Main Building

- **Air Handling Units AC-7 and AC-8 are packaged roof top units. The units require replacement.**

ELECTRICAL ($10.4 million)

Central Heating and Cooling Plant (CHCP) 15 kV Switchgear

- **This switchgear is no longer manufactured and service parts are not readily available. The gear is approximately 37 years old and should be scheduled for replacement.**

CHCP Major 480/277 V Distribution Equipment

- **HC-1, HC-2, and HC-3 substations should be scheduled for replacement in five years. Ambulatory Building Substation #4 should be considered for replacement in five years.**

CHCP 480/277 V Emergency Generators and Paralleling Switchboard

- **The Transfer Switches should be scheduled for replacement within the next five years.**

Main Building Major 208/120 V Distribution

- **The switchboards are beyond their useful life and should be replaced.**

Verdi Building Major 480/277 V and 208/120 V Distribution

- **Due to its age it should be replaced within the next five years.**

PLUMBING ($6.1 million)

Physical Plant

- **Domestic Water Distribution: The first floor domestic water booster pump skid is original to the building and should be scheduled for replacement within five years.**

Celentano Building, Main Building, Private Building, Sister Louise Anthony Building and Center Building

Domestic Water Distribution: The domestic water booster pump skid is at the end of its life cycle and should be replaced within the next two years.

ARCHITECTURAL ($25 million)

- **Although HSR has 511 licensed beds, 27 have been removed from service due to renovations which have been necessary over the past several years. YNHH plans to operationalize 15 of these 27 beds and the majority of architectural work will be focused on adding these beds as shown below and doing a general appearance upgrade throughout public spaces and patient spaces as needed. The beds to be added are:**
  - **Add 2 beds to Verdi 4 North and Celentano 3 (both medical floors);**
  - **Add 2 beds to Child Psych; and**
  - **Convert the same day admission area to inpatient unit which would yield 9 beds.**

A total of 15 additional beds can be operationalized by FY 2013.

b. Describe, in detail, the nature of the technological improvements that will be made.

Response

YNHH has estimated that it will invest a total of $19.5 million in information technology at the HSR campus. It is estimated that $5.1 million will be for non-Epic IT integration which includes upgrade of the HSR campus LAN to 10 G, upgrade of the HSR campus wireless network to a wireless capability/standard of 802.11 A/N, and replacement of aged end-user computing equipment as the basis of instituting a routine device replacement program. The remaining $14.4 million is the capital expense required to implement Epic at the HSR campus.

c. Describe how decisions will be made regarding these facility and technological improvements

Response

All items listed in answer 5.a above will be given a priority and based on the priority list the work will be accomplished over a five year period. Prioritization will be based on a variety of factors including regulatory requirements, updated facility assessments, patient volumes and annual budget amounts. The decision will be made by YNHH Senior Leadership.

d. Provide an estimated completion date for the improvements described in subsections (a) and (b), respectively.

Response

An estimated time frame cannot be established until the priority list is developed, design work is accomplished and the work is bid by a construction manager and a time line then established. This will not be accomplished until after the transaction closes.

6. Please provide the following:

a. The amount of long-term debt that HSR currently carries and the amount that will be extinguished;

Response

HSR's long-term debt as of September 30, 2011 and February 29, 2012 was $67.7 million and $67.1 million, respectively. All of this long-term debt will be extinguished as part of the acquisition transaction. The sources of funds to extinguish this debt will be a combination of HSR's available cash on hand and a portion of the $160 million purchase price.

b. The amount of the current Church plan pension shortfall and the amount that the shortfall will be reduced;

Response

HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011, the date used to negotiate the agreed-upon purchase price of $160 million. Included in the agreed-upon purchase price of $160 million was this approximately $86 million shortfall; accordingly, the pension shortfall will be reduced by the approximately $86 million. The estimated Church plan pension shortfall on a termination basis as of December 31, 2011 (the most recent information available) was estimated to be approximately $135 million, based upon changes in the market value of pension trust assets and the discount rate required to be used in the calculation of the pension liabilities.

The sources of funds available to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price. The actual amount of a shortfall in the pension obligation, if any, will be determined based on the actual market conditions at the time of any such plan termination.

c. The source of the funds that will be used to make the payments described in subsections (a) and (b).

Response

Please refer to the response to question 6(a) and (b) above.

7. Please address the following:
   a. How are the current 421 operational beds at HSR allocated between medical/surgical, pediatric, obstetric, rehabilitation and psychiatric services?

Response

HSR is licensed for 511 beds and 22 bassinets but is currently operating 423 beds (2 units: Verdi 4N-30 beds and SLA 3: 31 beds are closed but the beds are present). HSR has maximum physical plant capacity for 484 beds. A total of 27 beds were removed as a result of renovations which have occurred over the past few years. These renovations involved: (1) former Verdi 4 East was renovated to an Intensive Rehab Unit. A portion of the unit was used to construct a gym and the PT office staff space. Ten (10) beds were removed; (2) Verdi 4 West was renovated and 8 beds were removed; and (3) FY2012, Verdi 5 East was renovated and 3 beds were removed. An additional six beds were eliminated due to the conversion of semi-private to private rooms or the conversion of rooms to shared unit-based space.

The table below summarizes each of HSR's units and provides a count of current operational beds as well as maximum capacity for beds by unit and service line.

HSR Physical bed capacity and staffed bed capacity (no bassinets)

Unit	Floor	Unit Name	Operational Beds	Maximum Capacity as of 4/12
V4W	4	Verdi West	22	22
V4N	4	Verdi North - currently closed	0	30
SLA4	4	Sister Louise Anthony	22	22
Cel 3	3	Celentano	24	24
Cel 4	4	Celentano	26	26
Med Total			**94**	**124**
SLA3	3	Sister Louise Anthony - currently closed	0	31
V5W	5	Verdi West	32	32
V5N	5	Verdi North	32	32
V3S	3	Verdi South	24	24
Surg Total			**88**	**119**
V3E	3	Verdi East	12	12
V3E	3	Verdi East	18	18
SLA2	2	Sister Louise Anthony	24	24
V5E	5	Verdi East	29	29
Tele Total			**83**	**83**
CTICU	2	Center Building	16	16
SICU	2	Verdi West	15	15
MICA	3	Verdi North	8	8
MICS	3	Verdi North	14	14
CICA	3	Verdi West	10	10
CICS	3	Verdi West	12	12
ICU			**75**	**75**
Rehab	4	Verdi East	18	18
CPES	5	Celentano	18	18
CEL 1	1	Celentano	25	25
SLA5	5	Sister Louise Anthony	11	11
OB/GYN/PEDS	6	Main Building	11	11
Specialty			83	83
Subtotal Beds			423	484
Temporarily out of service			88	27
Total Licensed			**511**	**511**

b. Would YNHH's acquisition of HSR result in any change to the current allocation of beds on the HSR campus?

Response

The clinical plan for the HSR campus is ongoing and specific beds by service by campus have not yet been finalized. These efforts will not be complete until the transaction occurs. It is planned that Trauma services will be consolidated at the YNHH campus shortly after the close of the transaction, however in order to allow for adequate planning relative to other clinical integration, no changes to beds and other clinical services are anticipated to occur until after 10 months post closing. Efforts will be pursued to operationalize as many of the 511 licensed beds as possible. Please refer to the response to question 7c below for more information.

c. What would be necessary to make all of HSR's 511 licensed beds operational (up from the current 421 operational beds)?

Response
As provided in the table in response to question 7(a), HSR currently has two medical/surgical units (61 beds) that are closed. These units would be re-opened after the close of the transaction thus providing 484 beds in FY 2012.

Discussions regarding options and requirements to operationalize the remaining twenty seven (27) beds have led to the following preliminary plans:

- **Add 2 beds to Verdi 4 North and Celentano 3 (both medical floors);**
- **Add 2 beds to Child Psych; and**
- **Convert the same day admission area to an inpatient unit which would yield 9 beds.**

This will yield a total of 15 of the 27 beds that can be operationalized once necessary renovations and staffing occurs (planned for FY 2013).

The renovation costs associated with the conversion of the same day admission area are included in the $25 million dollars identified for architectural improvements on the HSR campus (see response to question 5a).

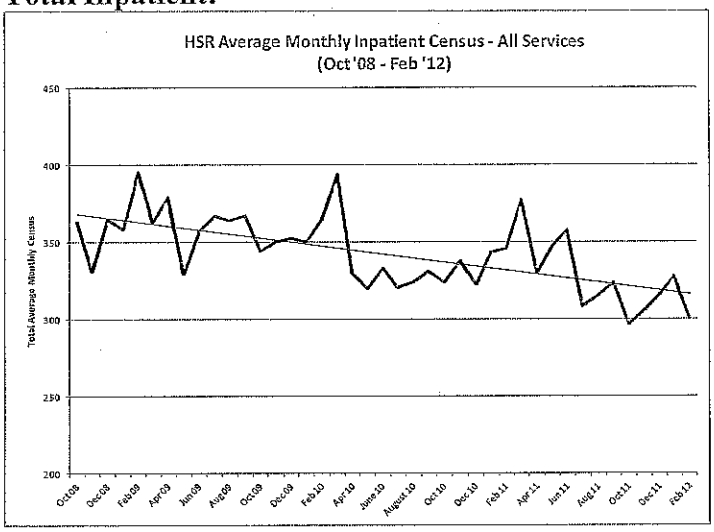
Therefore a total of 499 beds would be operational at the HSR campus beginning in FY 2013. The table below summarizes HSR's bed capacity between FY 2012 and FY 2015.

HSR Planned Bed Capacity				
	FY 2012	FY 2013	FY 2014	FY 2015
Beds	484	499	499	499
Bassinets	22	22	22	22
TOTAL	506	521	521	521

d. Beyond the current 421 operational beds at HSR, how many additional beds could be phased into operation before the end of FY 2015, what would the likely phasing schedule be and what would be necessary to achieve this?
Response
Please refer to the response to question 7 (c).

e. From 10/08 to the month of applicants' completeness response, what has been the average monthly census for HSR based on both total beds and medical/surgical beds (please provide this data in chart and table form similar to that found on pps. 15-17 of YNHH's CON application to Increase the Hospital's Licensed Bed County by 70 under Docket No. 12-31745-CON.
Response
Average monthly census for HSR based on total beds and medical/surgical beds is provided in the graphs and tables below.

Total Inpatient:



Total HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2009	Census based on Discharge Data	Chg from 2008
October 2008	363	(2)
November 2008	331	(40)
December 2008	365	8
January 2009	358	(18)
February 2009	395	(30)
March 2009	363	(46)
April 2009	379	(8)
May 2009	330	(30)
June 2009	357	(8)
July 2009	367	19
August 2009	364	14
September 2009	367	35
Total Average	361	(9)

Includes newborns, NICU

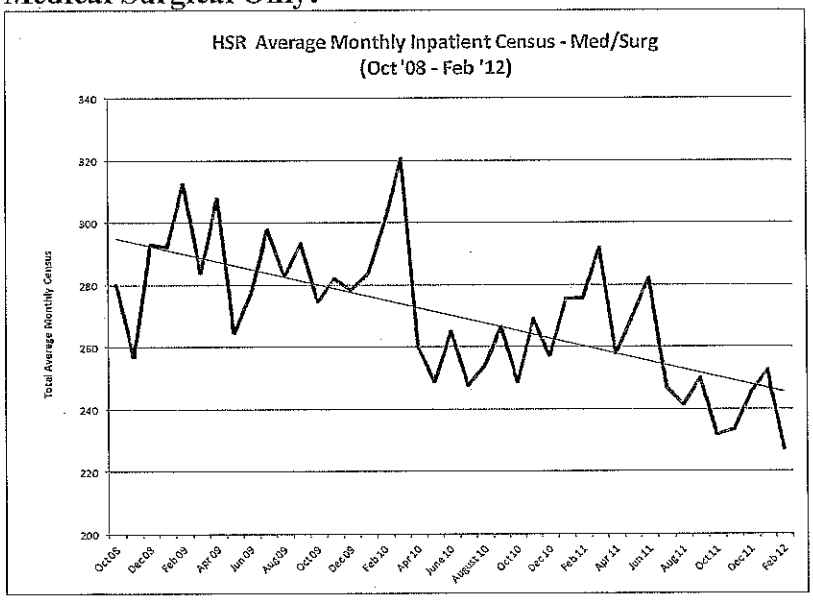
Total HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2010	Census based on Discharge Data	Chg from 2009
October 2009	344	(18)
November 2009	350	19
December 2009	352	(12)
January 2010	350	(8)
February 2010	364	(31)
March 2010	394	31
April 2010	330	(49)
May 2010	320	(10)
June 2010	333	(24)
July 2010	320	(47)
August 2010	324	(40)
September 2010	331	(36)
Total Average	343	(19)

Includes newborns, NICU

Total HSR Average Monthly Census (Based on Inpatient Discharge Data*)				Total HSR Average Monthly Census (Based on Inpatient Discharge Data*)		
FY2011	Census based on Discharge Data	Chg from 2010		FY2012	Census based on Discharge Data	Chg from 2011
October 2010	324	(21)		October 2011	297	(27)
November 2010	337	(13)		November 2011	306	(31)
December 2010	322	(30)		December 2011	316	(7)
January 2011	343	(7)		January 2012	327	(16)
February 2011	346	(19)		February 2012	300	(45)
March 2011	377	(16)		March 2012		
April 2011	330	1		April 2012		
May 2011	348	28		May 2012		
June 2011	357	24		June 2012		
July 2011	308	(12)		July 2012		
August 2011	315	(8)		August 2012		
September 2011	323	(7)		September 2012		
Total Average	336	(7)		Total Average	309	(27)
Includes newborns, NICU				Includes newborns, NICU		

Medical Surgical Only:



Med/Surg HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2009	Census based on Discharge Data	Chg from 2008
October 2008	280	4
November 2008	257	(43)
December 2008	293	5
January 2009	292	(20)
February 2009	312	(20)
March 2009	284	(46)
April 2009	308	1
May 2009	265	(20)
June 2009	278	(5)
July 2009	298	24
August 2009	283	13
September 2009	293	38
Total Average	287	(6)

Med/Surg HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2010	Census based on Discharge Data	Chg from 2009
October 2009	275	(5)
November 2009	282	25
December 2009	278	(15)
January 2010	284	(9)
February 2010	300	(12)
March 2010	321	37
April 2010	260	(48)
May 2010	249	(16)
June 2010	265	(12)
July 2010	248	(50)
August 2010	254	(29)
September 2010	267	(27)
Total Average	273	(13)

Med/Surg HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2011	Census based on Discharge Data	Chg from 2010
October 2010	249	(26)
November 2010	269	(13)
December 2010	257	(21)
January 2011	276	(8)
February 2011	276	(24)
March 2011	292	(29)
April 2011	258	(2)
May 2011	270	21
June 2011	282	17
July 2011	247	(1)
August 2011	241	(13)
September 2011	250	(17)
Total Average	264	(10)

Med/Surg HSR Average Monthly Census (Based on Inpatient Discharge Data*)

FY2012	Census based on Discharge Data	Chg from 2011
October 2011	232	(17)
November 2011	234	(35)
December 2011	245	(12)
January 2012	252	(23)
February 2012	227	(49)
March 2012		
April 2012		
May 2012		
June 2012		
July 2012		
August 2012		
September 2012		
Total Average	238	(25)

f. Assuming YNHH is licensed at 1,407 general hospital beds post-acquisition of HSR, and based on the projected inpatient utilization of both campuses, when would YNHH expect to exceed 80% occupancy level based on average monthly census projections (please provide evidence of all assumptions and calculations on which such projection is based, and a chart of YNHH's bed need for each year until the 80% threshold is reached).

Response

The applicants assume that OHCA's question above referencing 1,407 beds is based on the current bed count of 874 (excludes bassinets), the 22 pediatric beds located at Bridgeport Hospital and HSR's 511 licensed beds. The 22 beds at Bridgeport Hospital have been excluded from these responses since they do not have any impact on these calculations. Additionally, as has been described above in response to question 7(a), the bed capacity at HSR is currently 484 but can be increased to 499 during the projection time frame. There are 12 beds (511-499=12) that are not planned to be operational during the projection time frame as a location has not yet been identified.

Therefore, if YNHH is not permitted to add 70 additional beds but does acquire HSR, maximum bed capacity will reach 1,373 beds (874+499 = 1,373) at the New Haven campus, as opposed to 1,407 during the projection time period as shown below (bassinets are shown separately):

YNHH Planned Bed Capacity				
	FY 2012	FY 2013	FY 2014	FY 2015
Beds (w/out 70 Beds):				
York St. Campus	874	874	874	874
HSR Campus	484	499	499	499
Total Beds	1,358	1,373	1,373	1,373
Bassinets:				
York St. Campus	92	92	92	92
HSR Campus	22	22	22	22
Total Bassinets	114	114	114	114
Total Beds & Bassinets	1,472	1,487	1,487	1,487

The responses to questions 7 (f-i) have been outlined in this response and address projected bed need and bed utilization for the following three scenarios during FY 2012 – 2016:

1) **YNHH plus 70 additional beds requested in CON Docket 12-31745-CON**
2) **YNHH (without 70 additional beds) plus the acquisition of HSR; and**
3) **YNHH plus 70 additional beds and the acquisition of HSR.**

The following table summarizes the bed capacity for YNHH (excluding bassinets) for each of the three scenarios during the projection time frame noted above.

Projected YNHH Bed Capacity		FY 2012	FY 2013	FY 2014	FY 2015
Scenario 1	YNHH + 70	897	944	944	944
Scenario 2	YNHH without 70 and HSR	1,358	1,373	1,373	1,373
Scenario 3	YNHH + 70 + HSR	1,381	1,443	1,443	1,443

Notes: Scenario 1 assumes 23 beds are added in FY 2012 and all 70 are in operation in FY 2013. Scenario 2 assumes YNHH beds remain at 874 and HSR adds 484 beds in FY 2012 and 15 additional, for a total of 499 in FY 2013.
Scenario 3 assumes YNHH adds 23 beds in FY 2012 and all 70 are in operation in FY 2013, plus HSR's 484 beds in FY 2012 and 499 beds for FY 2013-FY 2015.

In order to determine when YNHH will exceed 80% occupancy as per OHCA's question, projected annual ADC for YNHH was calculated from the discharges and patient day projections for each fiscal year. Bed use by bed type for each department and service in FY 2011 was applied to the projections. For example, in FY 2011 90% of orthopedic patient days occurred in adult beds, while 10% occurred in pediatric beds. Two percent of orthopedic adult patient days occurred in critical care beds.

Annual ADC for the HSR campus has been combined with YNHH's projected patient days per the projections submitted in the original CON application. Bed utilization was carried forward from FY 2011. Bed need was calculated by applying target utilization rates to actual and projected annual ADC. Target utilization rates applied included: Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

The following description identifies when 80% occupancy is exceeded overall for each scenario (note: excludes bassinets).

<u>Scenario 1. YNHH plus 70 additional beds (no HSR).</u>

- **As shown in the table provided in the response to question 7(f), YNHH would add 23 beds in FY 2012 and all 70 beds would be operational in FY 2013. However, this option alone does not provide enough beds for YNHH to operate below 80% occupancy overall between 2012 and 2016. In FY 2012, YNHH will be operating at 85% occupancy which declines to 82% in FY 2013 and increases back to 85% occupancy by FY 2015.**

<u>Scenario 2. YNHH plus acquisition of HSR (without 70 additional beds).</u>

- **If YNHH acquires HSR but is not permitted to add 70 beds to its current license on its New Haven campus, YNHH will reach 80% occupancy overall in FY 2012 and by FY 2015 will be at 82% occupancy.**

<u>Scenario 3: YNHH plus 70 additional beds and the acquisition of HSR.</u>

- **If YNHH adds 70 beds and acquires HSR, it will not reach 80% occupancy overall until after 2016. Clearly this scenario is the only option which provides sufficient beds for YNHH's projected demand through FY 2016.**

Detailed calculations and assumptions are provided in summary tables in Attachment II.

g. Provide the same information as requested in subsection (f) above, but restrict the projection to when 80% occupancy of the combined medical/surgical beds on both campuses would be exceeded.

<u>Response</u>

For medical/surgical beds only:

Scenario 1. YNHH plus 70 additional beds (no HSR).

- **YNHH would add 23 beds in FY 2012 and all 70 beds would be operational in FY 2013. In FY 2012, YNHH will be operating at 86% occupancy which declines to 82% in FY 2013 and increases back to 85% occupancy by FY 2015.**

Scenario 2. YNHH plus acquisition of HSR (without 70 additional beds).

- **If YNHH acquires HSR but is not permitted to add 70 beds to its current license on its New Haven campus, YNHH will reach 80% occupancy overall in FY 2012 and exceed it by FY 2015.**

Scenario 3: YNHH plus 70 additional beds and the acquisition of HSR.

- **If YNHH adds 70 beds and acquires HSR, it will not reach 80% occupancy overall until after 2016. Clearly this scenario is the only option which provides sufficient beds for YNHH's projected demand through FY 2016.**

Detailed calculations and assumptions are also provided in the summary tables previously referenced as Attachment II.

h. Assuming YNHH is licensed at 1,477 general hospital beds post acquisition of HSR, and based on the projected inpatient utilization at both campuses when would YNHH expect to exceed an 80% occupancy level based on average monthly census projections (please provide evidence of all assumptions and calculations on which such projection is based, and a chart of YNHH's bed need for each year until the 80% threshold is reached).

Response

As stated in the response to question 7 (f), the Applicants assume that OHCA's reference to 1,477 beds assumes YNHH adds 70 beds to its current 874 beds, acquires HSR and is including the 22 beds located at Bridgeport Hospital. As previously stated, the 22 beds located at Bridgeport Hospital have not been included in these responses as they do not impact these calculations.

If YNHH does add 70 additional beds and acquires HSR, maximum bed capacity will reach 1,443, as opposed to 1,477, beds in New Haven during the projection time frame as shown below (bassinets are shown separately):

YNHH Planned Bed Capacity				
Beds (w/70 Beds):				
York St. Campus*	897	944	944	944
HSR Campus**	484	499	499	499
Total Beds	**1,381**	**1,443**	**1,443**	**1,443**
Bassinets:				
York St. Campus	92	92	92	92
HSR Campus	22	22	22	22
Total Bassinets	**114**	**114**	**114**	**114**
Total Beds & Bassinets:	**1,495**	**1,557**	**1,557**	**1,557**

Please see the response to question 7f for identification of when 80% occupancy is reached (Scenario 3).

i. Provide the same information as requested in subsection (h) above, but restrict the projection to when 80% occupancy of the combined medical/surgical beds on both campuses would be exceeded.

Response

Please see the response to question 7f for identification of when 80% occupancy is reached.

8. On pages 24 and 25, applicants indicate that they engaged Deloitte "to identify cost savings which could be achieved through the acquisition" and that these cost savings are expected to exceed a half of a billion dollars over the next five years.

Please provide:

a. A copy of the Deloitte report;

Response

The Applicants direct OHCA to the responses to question 8(b), 25 and 26, which provide narrative information on the cost savings expected to be achieved from the transaction. The Deloitte report contains proprietary and highly sensitive commercial information, which would have anticompetitive consequences if publicly disclosed and would interfere with the Applicants' ability to implement the proposed acquisition should it gain the required regulatory approvals. The Applicants believe that irreparable harm could result from public disclosure of the report. Accordingly, the Deloitte report will be submitted under separate cover upon receipt of an acceptable protocol from the Department of Public Health for the protection of confidential submissions by the Applicants.

b. The applicants' cost savings plan; and

Response

YNHH and HSR currently expect that, over the next five years, the combined hospitals will be able to achieve a total cost savings of approximately $700 million.

As the Applicants noted in the CON application, they engaged Deloitte to help them identify cost savings that could be achieved through the acquisition. Deloitte, working closely with YNHH and HSR, identified almost $700 million in total potential cost savings resulting from the acquisition. This savings consisted of two categories: capital cost avoidance savings of almost $400 million, and operational cost savings of approximately $300 million.

The capital cost avoidance savings of almost $400 million results from avoiding the need to construct a fifth bed tower and to not replace certain capital equipment (daVinci robot, PET and CT) of approximately $8 million. As described at pages 29-35 of the initial CON application, in the absence of the acquisition of Saint Raphael's, YNHH would be compelled to construct a fifth bed tower to handle its growth in patient census. Construction of a fifth bed tower was originally estimated to cost approximately $400 million. Additional

planning has increased internal estimates for the tower to $590 million, as the new bed tower would also require a parking facility and a chiller plant. See Responses to Questions 4 and 22.

The potential operational cost savings were estimated at approximately $300 million over the first five years. It is expected that the operational cost savings would result from a combination of labor cost savings and savings in contractual obligations. The operational cost savings were separated into two parts: infrastructure (i.e., non-clinical) cost savings, and clinical cost savings. The infrastructure cost savings are expected to result from the integration of various business functions (including but not limited to finance, human resources, information technology, marketing, strategic planning, and legal) across the two hospital campuses (which are in close proximity). The infrastructure cost savings were estimated to amount to over $270 million over five years. On the clinical side, YNHH and Saint Raphael's engaged in a careful evaluation of the service lines offered at each of the hospitals and identified certain selected specialties that could be integrated. See Response to question 25. The cost savings resulting from the clinical integration were expected to be about $26 million over five years.

Since the submission of the initial CON application, additional work has been done with respect to integration planning. Specifically, the integration opportunities identified have been reviewed to develop specific implementation plans. This work will be ongoing until the transaction closes and beyond. Generally, however, implementation planning thus far has confirmed the majority of the operational cost savings identified. The parties' best estimate is that the operational cost savings will be close to the the amount calculated, the amount of capital cost avoidance savings will be significantly greater than the original estimates, with the result that the total cost savings expected to result from the acquisition appears likely to exceed the amount calculated during the Deloitte engagement.

c. An explanation of how applicants foresee the savings will reduce costs of health care services for patients served by YNHH if the CON application is granted.

Response

As described throughout the CON application, this proposal represents an opportunity for YNHH to gain much needed inpatient capacity at a much lower cost than constructing a new bed tower. Future charge increases for YNHH will be lower with this proposal than if a new bed tower has to be constructed, thus reducing the future costs of health care services for patients (e.g. co-insurance, deductibles, etc.) served by YNHH.

9. On page 25, applicants state that "both HSR and YNHH have focused on maintaining access and improving the quality of care despite the ever-present financial challenges of the industry."

Please explain, in detail, HSR's efforts to maintain access and improve quality of care since 10/08.

Response

Access

The Sisters, employees and physicians of Saint Raphael's are committed to the best patient care they can provide to everybody who needs it. And Saint Raphael's has succeeded in meeting its objective to continue providing the same level of charitable care even with its deteriorating financial condition. Unfortunately, financial challenges at the Hospital have significantly constrained the ability of Saint Raphael's to make the investment in people, plant, information technology and infrastructure that could provide even better care. And those same financial challenges threaten to erode the access to quality care that Saint Raphael's has traditionally provided. HSR has struggled significantly to maintain other avenues of patient access in the face of continued declines in volume, and will be forced to review the continued downsizing and/or closure of clinical programs in the future if deterioration of the institution's financial condition continues absent the transaction with YNHH.

Quality

In 2003, HSR developed an administrative policy entitled "Plan for Excellence/Quality Improvement" and "Plan for Excellence: Patient Safety Plan". A copy of the current (FY 2009) administrative policy is included in Attachment III. This document provides the organization with a framework for quality improvement and outlines the responsibility of each level of the organization as well as defines the reporting hierarchy to assure all information related to quality improvement, patient safety and regulatory compliance is shared with hospital leadership.

The Quality Improvement Patient Safety Committee meets minimally ten times per year. Each clinical department reports, to the committee, the quality activities and indicators specific to its area of care. A written report is submitted and members of the committee request further elaboration of the report for committee discussion and feedback. In addition to clinical departments, reports also are received from specific committees, including, but not limited to Transfusion Committee, Infection Control Committee, Code 254 Committee (Code 254=Cardiac/Respiratory Arrest Emergency Code), Procedural Sedation, Restraint Task Force Patient Safety Steering Committee, Organ Donation Committee, Patient Satisfaction and Rapid Response Team.

In addition to indicators selected by departments and committees, each year key clinical quality initiatives are defined by the Board of Trustees, the Quality Committee (of the Board) and Senior Leadership. Goals are set by these leaders. Quality Improvement teams are developed (or continued) with the goal to implement processes that will improve the current level of compliance. The results of the subsequent audits to monitor compliance are shared with hospital leadership, and some teams meet as frequently as once per week to ensure quality goals are met. The organization utilizes the performance model of Plan-Do-Check-Act (PDCA) to assure improved compliance. Data is presented in a graphic manner or in a quality grid. Information is shared on the hospital intranet and displayed on the hospital web site.

Included in Attachment IV are the following documents which further demonstrate the Hospital of Saint Raphael's effort to improve quality of care:

1. **Quality Improvement and Patient Safety Committee Annual Summary Fiscal Year 2009**
2. **Quality Improvement and Patient Safety Committee Annual Summary Fiscal Year 2010**
3. **Quality Improvement and Patient Safety Committee Annual Summary Calendar Year 2011**
4. **Hospital of Saint Raphael Quality Indicator Grid FY 2011**
5. **Board Quality Indicator Report FY 03 to FY 09**
6. **Public Reporting Initiative JCAHO Core Measures/Hospital Quality Alliance Indicator Reports: October 2007 – March 2009 and April 2009 – December 2010.**

10. Please describe, in detail, how the acquisition of HSR by YNHH will affect the following:

a. Teaching and residency programs currently located at HSR and YNHH;

Response

YNHH intends to integrate HSR's teaching and residency programs into YNHH's teaching and residency programs. HSR is currently the sponsor institution with respect to various graduate medical educational programs, including programs accredited by the American College of Graduate Medical Education (ACGME), the Commission on Dental Accreditation (CODA) and American Society of Health System Pharmacists (ASHP). YNHH and HSR will work together to ensure that HSR's ACGME accredited programs are transferred to and integrated with YNHH's ACGME accredited programs. These programs include residency and/or fellowship programs in the areas of Surgery, Diagnostic Radiology, Geriatrics, Nephrology, Cardiology and Oral and Maxillofacial Surgery. In addition, HSR's Internal Medicine residency program will be integrated with YNHH's Primary Care residency program. YNHH will also become the sponsoring institution for HSR's current residency programs accredited by CODA and ASHP.

In connection with the integration described above, existing residents and fellows will be able to continue their training under YNHH. YNHH intends to continue existing rotations and residency affiliations. Training will take place on both the YNHH and HSR campuses, and, consistent with existing residency affiliation agreements, at other hospitals and outpatient centers. Substantially all of the teaching staff at HSR will continue their teaching duties. Program Directors at HSR will work with Program Directors at YNHH to ensure uninterrupted training for residents and fellows.

b. Research and clinical trials conducted at HSR and YNHH;

Response
YNHH intends to expand the research and clinical trials conducted as a result of the transaction. After the closing of the transaction, patients at both campuses will have access to the clinical trials conducted at YNHH and YNHH will continue all of the clinical trials that were ongoing at HSR prior to the transaction.

c. Emergency department services currently located at HSR and YNHH;
Response
Emergency services will be maintained on both campuses. HSR currently employs physicians to staff its Emergency Department 24 hours per day, seven days per week. Northeast Medical Group, a nonprofit medical foundation affiliated with YNHH will enter into employment relationships with these physicians to ensure the continued availability of emergency medical services at the HSR facilities. The HSR Trauma Center will be consolidated into the YNHH Trauma Center.

d. Charity care and financial assistance programs currently operating at HSR and YNHH; and
Response
Yale-New Haven Hospital and the Hospital of Saint Raphael have financial assistance policies to support patients with limited financial needs. After the transaction, the financial assistance policies of Yale-New Haven Hospital will be used for services provided on both campuses. In all cases the Yale-New Haven Hospital policies are broader and offer financial assistance to a wider range of patients at or around the poverty level than existing HSR financial assistance policies. Specifically, both hospitals currently provide free care to any patient at or below 250% of the Federal Poverty Level. For patients above 250%, a discount to actual costs is provided to HSR patients of up to 350% of the Federal Poverty Level. YNHH extends this to 400%. At HSR, if total hospital bills exceed 20% of a patient's annual income, bills are discounted to cost. However, YNHH provides the same level of discount to patients who exceed 10% of their annual income. At HSR, further discounts up to 30% are provided to patients between 350% and 500% of the Federal Poverty Level. YNHH provides discounts to cost to 400% and beyond 400% will provide discounts up to 40% to any patient with financial or hardship needs.

With the exception of these differences where the YNHH policies provide additional assistance, all other financial assistance processes and collection practices are the same.

e. The rates currently charged for hospital services at HSR and YNHH.
Response
Existing charge masters at HSR and YNHH will remain in place for the first 8-12 months following the close of the transaction. YNHH will evaluate the services and charges at both campuses to ensure uniformity in approach for the

combined hospital. An evaluation of the overall charge structures / approaches will occur before any changes are made to charges. Therefore, there will continue to be two different charge masters until a full evaluation of all services and charges is undertaken following the close of the transaction. Facilitation of the move to one charge master will also be achieved with the implementation of Epic at HSR which is estimated to be in February of 2013.

11. Please describe, in detail, the steps that HSR took to address its financial situation. In addition, provide detailed evidence for the conclusion that HSR will be unable to achieve financial stability in the future. Please include information regarding the following cost saving efforts in the discussion:

Response

The most significant steps that HSR took to address its financial challenges were (a) aggressive negotiations with managed care organizations; (b) productivity enhancements; (c) supply chain cost reductions; (d) fringe benefit eliminations; and (e) cancellation and deferment of equipment, renovations, IT investments, and other capital projects.

As part of the Financial Bridge Plan process, HSR successfully renegotiated the only contracts that it could- managed care contracts with commercial payers Anthem, CIGNA, Aetna, HealthNet, United Healthcare/Oxford, and ConnectiCare- and obtained significant increases in reimbursement rates for the provision of medical services. Total commercial payment increases realized during fiscal years 2009-2010-2011 were in excess of $90 million. In addition, productivity enhancements and supply chain and other cost reductions were implemented.

As noted in response to Question 3, the Financial Bridge Plan has been integral to financial performance during fiscal years 2009-2010-2011. Financial Bridge Plan targets were initially included as a component of Saint Raphael's annual budgets ($14.4 million of improvements in fiscal 2009 and $8.0 million in fiscal 2010), with annual targets established above those budgeted values. For fiscal 2011 and beyond, such targets were not included as a component of the annual budget. A three-year chronology of the actual Financial Bridge Plan results (both budgeted and unbudgeted) for fiscal years 2009-2010-2011 is provided in the table below. The Financial Bridge Plan was an integral component of the improvements in financial performance over this period of time. It is important to understand that once a cost-cutting and/or revenue-enhancement effort was implemented, the subsequent year impacts became a part of the on-going budget detail and were no longer considered (or valued) as part of the Financial Bridge Plan reporting (meaning that many of the actions that have enabled Saint Raphael's to avoid insolvency are already reflected in annual budget details).

In addition to the Financial Bridge Plan, other significant steps were taken to improve financial performance. Pension benefits were eliminated beginning in fiscal 2010 to reduce expense levels, and defined benefit pension plan funding was reduced to conserve cash (as more fully described in section (d) below). Capital expenditures have

been consistently funded substantially below depreciation expense to conserve cash (as more fully described in section (e) below). Note that the average of Saint Raphael's plant has increased from 16.5 years in 2008 to 26.2 years in 2011, reflecting inadequate investment in plant and equipment during this timeframe. The operations of the unprofitable Hamden outpatient surgical center were discontinued during fiscal 2009, and the operations of the marginally profitable home care subsidiary were sold during fiscal 2010, again to improve operational results and conserve cash.

As outlined in response to Question 3, HSR has concluded that it cannot remain a viable standalone provider of hospital services. Evidence supporting this conclusion, as more fully detailed in the aforementioned response, includes the following: Qualified audit opinion due to non-achievement of long-term debt financial covenants; Employee and benefit matters; Unmet capital needs; volume declines; Economic factors; Days cash on hand; and Negative fund balance.

Saint Raphael's
Three-Year Financial Bridge Plan

Hospital of Saint Raphael
Bridge Plan Status Report
For the three years ended 9/30/11
000's omitted

	3 Years to 09/30/11	*Actual 09/30/11*	*Actual 09/30/10*	*Actual 09/30/09*
Revenues- Rates/Leakage:				
Financial Counselors/Conversion SP to Mcaid		$ 6,729	$ 890	$ -
DSH Increase (due to Medicaid conversions)		1,600	-	-
Patient Accounts: Denials Mngt		6,146	1,269	-
Commerical Payor Rates		1,722	4,500	2,459
Clinical Documentation/Coding		1,002	1,272	667
Medicare Rates/Federal Programs		1,076	5,611	1,610
Charge Capture		999	-	-
Patient Accounts: Collections		1,220	2,310	1,609
Patient Access: Front End Stockamp		500	2,005	-
Medical Group		607	400	3,308
Behavioral Health: Leakage/Rates		-	627	1,673
Grimes Health Center Rates		-	-	230
Revenue Total	$ 52,042	21,601	18,884	11,557
Expenses and Volume-related Revenue				
Patient Throughput		-	-	882
Supply Chain		1,170	4,202	2,065
Grimes Health Center		374	129	-
Labor Productivity		497	-	3,814
Medical Group		970	-	-
Care Management/LOS		2,371	832	-
Radiology		1,022	792	981
Pharmacy		870	749	-
Pathology		171	101	-
Cardiac Cath Lab		406	416	-
Operating Room/Surgery		165	36	576
Malpractice		-	3,600	
Fringe Benefits		-	-	971
Release of Restricted Funds for Operations		1,195	-	-
Other Departments		3,211	655	6,764
Expense Total	$ 39,985	12,422	11,510	16,053
Total Bridge Plan	$ 92,027	$ 34,023	$ 30,394	$ 27,610

NOTE: It is important to understand that once a cost-cutting and/or revenue-enhancement effort was implemented, the subsequent year impacts became a part of the on-going budget detail and were no longer considered (or valued) as part of the Financial Bridge Plan reporting

REVENUES- RATES/LEAKAGE

Commercial Payer Rates:
Beginning in FY2009, negotiations occurred with six major commercial payers to renegotiate payment rates to better approximate market rates over a period of years to improve HSR's financial position. HSR has taken a more aggressive position with commercial payers in subsequent negotiations.

Financial Counselors/Conversion Self Pay to Medicaid:
Hired a team of three financial counselors working out of Patient Access who assist Self Pay patients to apply for state assistance programs. Reimbursement is then received at Medicaid rates which otherwise would have often resulted in bad debt or free care.

Disproportionate Share Increase:
Increased levels of Medicaid utilization results in higher DSH payments from the Medicare program.

Denial Management:
Created Denials unit within Patient Accounting to appeal third party denials. Implemented Benchmark software system to track and report on sources of denials. Established Denial Management Steering Committee to address root causes.

Clinical Documentation/Coding:
Hired 3 clinical documentation specialists in the Health Information Management Department to assess opportunities to improve reimbursement through better Medical Record documentation and provide ongoing in-service education to clinical staff.

Medicare Rates/Federal Programs:
Various appeal issues related to Medicare reimbursement, primarily involving Area Wage Index and DSH were instituted. Changed policies and procedures related to Medicare bad debt to maximize reimbursement.

Charge Capture:
Created new position for Manager of Revenue Integrity and Maximization to identify opportunities to capture full charges and properly code for all services provided.

Collections:
Replaced collection agencies with two new vendors and outsourced self pay collections after 60 days. Ensured transition of accounts to collection agencies at 120 days.

Front End Stockamp:
Implemented Stockamp work-flow management and reporting system in Patient Access resulting in higher staff productivity and reduced denials on the back end.

Medical Group – Employed Physicians:
Various improvements related to charge capture, documentation, and coding in the Medical Group resulting in increased billing/collection of professional fees.

Behavioral Health:
Re-negotiated improved rates with Medicaid and Commercial payers.

Grimes Health Center Rates:
Re-negotiated improved rates with Medicaid program. Reductions in overtime and staff replacement expenses

EXPENSES AND VOLUME-RELATED REVENUE

Patient Throughput:
Redesign of processes to eliminate barriers to effective movement of patients from presentation to discharge; included identification of and appropriate billing for outpatient observation status cases.

Supply Chain:
Intensive effort working with internal Value Analysis teams to identify and implement initiatives to reduce the cost of supplies and purchased services.

Labor Productivity:
Reductions in FTE levels through "right-sizing" for current volume levels effectuated for various departments based on implementation of industry-wide staffing benchmarks.

Medical Group:
Efficiency improvements in scheduling and patient throughput resulting in growth in ambulatory clinic volume.

Care Management/LOS:
Implemented concurrent review of long-stay cases to identify earlier discharge opportunities. More timely review of denied bed cases resulting in more successful overturning of denied beds. Cost savings from utilizing internal staff rather than the outside physician advisory firm to review cases.

Radiology:
Revenue enhancements as well as inventory reductions in Interventional Radiology; additional volume in Mammography and OB/breast ultrasound areas resulting in added revenue; cost savings in isotope expenses.
Pharmacy:
Various cost savings efforts including appropriate use and dosage of antimicrobial therapies; standardization of radiology contrast media; and limiting use of certain anesthesia gases in favor of other equally effective but less costly alternatives.

Pathology:
Reduction in cost of blood and blood products; also, savings achieved through performing various tests in-house rather than utilizing reference labs.

Cardiac Cath Lab:
Additional referrals from the creation of the Cardiac Access Line. Additional growth because of development of several new programs, including hybrid revascularization, radial artery, peripheral vascular and complex ablation.

Operating Room/Surgery:
Reduction in damage of supplies through better staff training; more efficient use of resources; cost savings from re-negotiated prices of certain supplies.

Malpractice:
Malpractice expense significantly below budget in FY2010 with favorable loss experience.

Fringe Benefits:
Reflects expense savings achieved with suspension of postretirement pension benefits during FY2009.

Release of Restricted Funds for Operations:
Identification of incremental dollars from Restricted Funds accounts to be used for support of general operating expenses.

Other Departments:
Various cost savings (labor and non-labor) in various other hospital departments, including Nursing, Environmental Services, and Food and Nutrition; increases in volumes /revenue in Women's and Children's, Geriatrics, Occupational Health, and the Take Heart program.

(d) The elimination of postretirement pension benefits was effective during fiscal 2010. These reductions included the elimination of all accruals to participants of the defined benefit pension plan, defined contribution pension plan as well as employer matching funds to participants in 401(k) accounts. HSR employee participation in the Church plan pension (defined benefit pension plan, available to eligible employees hired through December 31, 2003) was frozen for benefits accumulated as of December 31, 2009. HSR employee participation in the defined contribution pension plan (available to eligible employees hired subsequent to December 31, 2003) was suspended for benefits earned as of December 31, 2009. HSR employee participation in a 401(k) savings plan employer match program was suspended as of April 2010. Postretirement pension benefits remain suspended as of this date, and the financial projections indicate the inability to reinstitute such pension benefits during the projection period.

(e) Capital expenditures to achieve a variety of goals, including replacing or upgrading aging physical plants and investing in new information and medical technology were

suspended. The ability of a hospital to make necessary capital expenditures is essential for it to provide quality care to the community. For example, one way to improve a hospital's case mix (and both private and public reimbursement) is to attract and retain physicians who perform higher-margin procedures. Strategies include offering employed physicians more competitive compensation, ensuring that nurses and other support personnel are competitively compensated, and, in many cases, spending well above annual depreciation levels of capital (including plant, property and equipment). At the very least, it is necessary for capital expenditures to keep pace with depreciation levels. This not only helps to recruit and retain employees, but also improves the ability to retain and expand the use of the hospital by independent physicians who could or do use other acute care facilities (or their own offices or surgical centers) to provide their services. An investment in the physical plant and technology also improves the patient's experience of the hospital and can have implications for the quality and safety of the care provided.

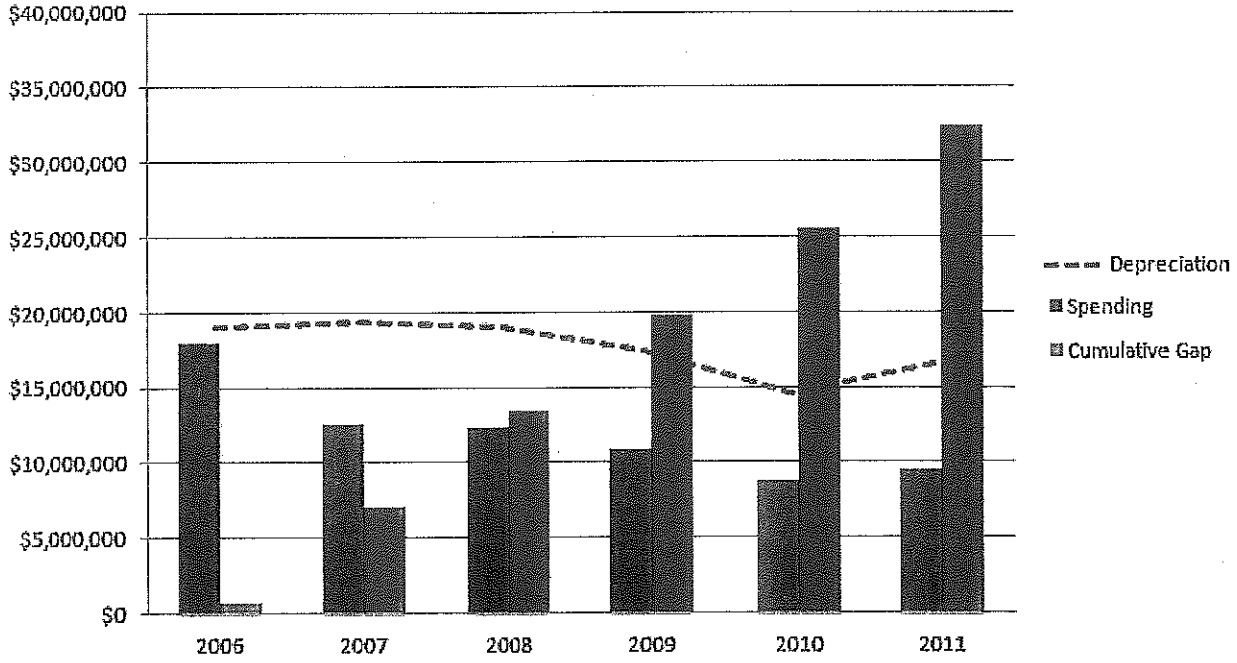
Absent the ability to invest in new diagnostic, intraoperative and postoperative equipment, or build out service lines with financial and clinical promise a hospital can expect to begin losing physicians. Losing physicians, and thus losing volume, means that the hospital will suffer deterioration in its mix of payors and patients, who themselves may be unsatisfied by their experience given the hospital's aging physical plant. From January 2008 through the end of the 2011 Fiscal Year, 165 physicians left Saint Raphael's. Among these departures were leading hepatopancreatobiliary, thoracic, OB/GYN and minimally invasive surgeons (including the Chairman of the Department of Surgery), who expressed significant concerns about the Hospital's current and future inability to develop and sustain an infrastructure that could support the stability and growth of their practices.

Despite these consequences, in order to remain viable and live within its financial constraints, Saint Raphael's has been cutting capital expenditures for several years, spending well below annual depreciation levels. Only expenditures substantially above annual depreciation could hope to reverse the adverse trends confronting Hospital management by signaling to current and future physicians (whether affiliates or employees) that the Hospital remains committed to their particular areas of expertise. Spending below depreciation levels forced the Hospital to forego even basic overhauls of patient floors and rooms and has made the capital expenditure prioritization process a matter of identifying the most urgent or overdue projects, rather than strategically investing for the future.

In FY 2010, for example, pressing internal needs forced the Hospital to continue making significant cuts in capital expenditures. As noted in the FY 2010 Budget, the expected increase in cash-on-hand to 20 days was largely the result of holding budgeted capital to $12.0 million, with depreciation approximating $18.0 million. The overall inability of the Hospital and System to generate an operating profit – and the need to maintain and grow cash-on-hand in order to satisfy debt covenants – has restrained the ability of management to increase capital expenditures.

Below is the progression from FY 2006 through FY 2011 of the Hospital's depreciation level and its annual capital investments. As the chart shows, Saint Raphael's capital expenditures are not only below the level of investment generally believed necessary to remain competitive as a hospital (115-125% of depreciation), but significantly below the level of annual depreciation itself.

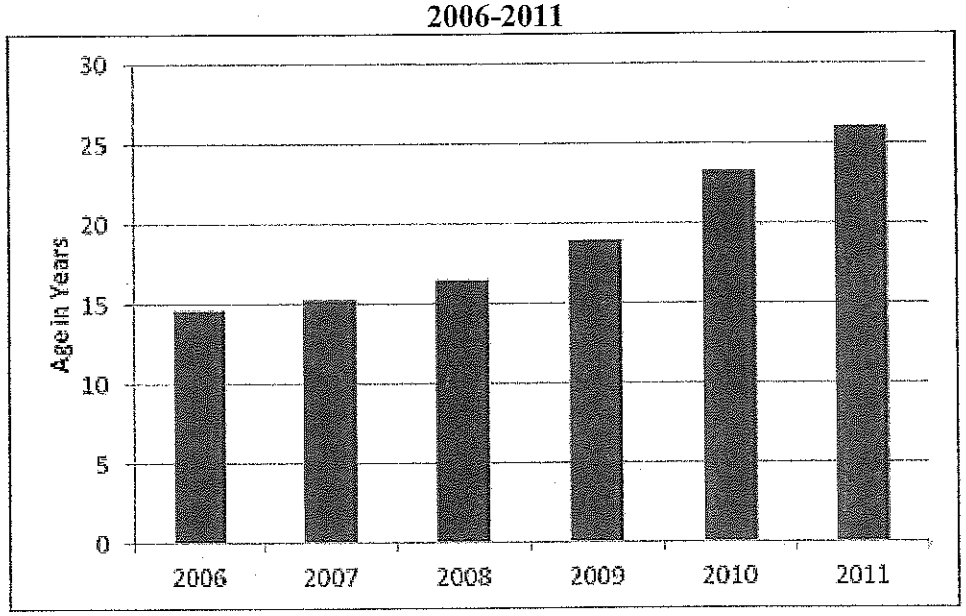
HSR Capital & Depreciation Spending & Cumulative Gap 2006-2011



Consider also that, according to the Connecticut Department of Public Health, Audited Financial Statements 2012 (summarized in Attachment V), as compared to other hospitals in Connecticut, Saint Raphael's was 25th out of 30 hospitals in terms of capital expenditures as a percentage of depreciation in 2010, with the average hospital spending at 112.4% of depreciation (i.e., at almost double the rate of Saint Raphael's).

Over that same FY 2006 through FY 2011 period, as the Hospital's capital expenditures were falling, the average age of its physical plant increased dramatically, from an average of 14.6 years in 2006 to an average of 26.2 years in 2011.

HSR Physical Plant Average Age
2006-2011



The Hospital's inability to fund capital expenditures is especially extraordinary with respect to two significant items: medical equipment and information technology. For example, the FY 2010 Capital Budget showed that although the medical departments had requested $34.8 million in medical equipment, the Hospital was able to commit only $3.8 million in that fiscal year, or just over 10% of requests. And, although management is keenly aware that health care reform will pressure hospitals in the near future to implement new IT systems to support electronic medical records ("EMR") efforts, Saint Raphael's was able to provide only $3.8 million in IT investment, which fell short of the $11.5 million requested (and well short of the far larger sum – upwards of $60 million - that would be required to adopt Epic on a standalone basis, the EMR system likely to be embraced by many local physicians).

And despite the massive shortfalls that are indicated by the Hospital's capital expenditure figures above, the situation is actually much more serious. The above figures represent the delta between capital expenditures requested by hospital physicians and staff versus the level of actual funding for those requests. However, in a situation where everyone at the hospital is aware of the scarcity of resources, employees tailor their requests to only the absolute essentials, knowing that funding is unavailable for anything but the bare minimum (and, actually, even less than that). The proposed transaction with YNHH profoundly improves the capital expenditure calculus for Saint Raphael's. YNHH has committed an additional $129.5 million over five years in spending on long-overdue facility upgrades, medical equipment, and information technology investments that restore Saint Raphael's facilities and infrastructure to a level commensurate with the level of care that it has historically provided

OHCA has requested a list of Additional Capital Needs that have been deferred, postponed or cancelled as a result of financial challenges at Saint Raphael's. That list,

entitled "Additional Capital Needs," is included as Attachment VI. Please note that there are other expenditures that the Hospital would like to make, and that physicians have requested, but HSR has limited the items in the attached list to those that are strictly necessary in order for the Hospital to provide the care that it has historically offered.

For supporting information regarding capital access and spending, see Healthcare Financial Management Association Report 6: The Outlook for Capital Access and Spending included in Attachment VII.

12. On page 26, applicants indicate that in early 2010, the SRHS Board's Ad Hoc Strategy Committee "began to explore and evaluate options to ensure continuation of the mission of Saint Raphael's and the Sisters into the future.

Please provide evidence of the Committee's exploration and evaluation of options. Include information regarding the other options besides integration with YNHH that were explored.

Response

At the end of 2008, Saint Raphael's teetered on the brink of insolvency and fell into default on bond covenants. Aware of its rapidly deteriorating financial situation, Saint Raphael's undertook a preliminary evaluation of alternative transactions, looking at national Catholic systems, as well as a national Catholic chain with a local affiliate. Eventually, Saint Raphael's focused exclusively on the national Catholic chain with a local affiliate, which was aware of the substantial financial adversity that the Hospital faced. Despite Saint Raphael's desperate circumstances, the national chain abandoned its discussions with Saint Raphael's, due to both Saint Raphael's financial condition and overall economic challenges, offering instead a potential loose collaboration with the local affiliate that would not provide access to capital and would prevent Saint Raphael's from exploring other options. Saint Raphael's decided that it would attempt to strengthen its balance sheet not only to avoid insolvency, but also to become a more attractive acquisition candidate.

In the fall of 2009, it was apparent that standalone viability remained doubtful. In early 2010, Saint Raphael's obtained outside counsel and reengaged Navigant Consulting (who had jointly advised Saint Raphael's and the local affiliate of a national Catholic chain) to evaluate the transactional landscape and chart a path forward. Internally, the management team notified the Board of Trustees and the Sisters and established an Ad Hoc Strategy Committee of the Board.

Saint Raphael's identified the most important criteria for affiliation from the outset: (1) retaining Catholicity to the maximum extent feasible; (2) a preference for remaining nonprofit; (3) a commitment to continued provision of accessible health care; (4) a continuing commitment to the local community of physicians, employees and patients; and (5) access to capital that would enable the Hospital to deal with long-standing financial obligations.

By the end of an 18-month process, Saint Raphael's had obtained a commitment from Yale-New Haven Hospital that met its principal criteria and could not be matched by any other acquirer with respect to benefits for Saint Raphael's and the community. Specifically, the transaction offers the following:

1. **Recognition of Catholic heritage.**
2. **Retention of nonprofit status.**
3. **Retention of local decision making,**
4. **Ability to improve the quality and the delivery of care.**
5. **Elimination of long-term debt.**
6. **Substantial narrowing of pension fund deficit.**
7. **Investment of $129.5 million in infrastructure beyond levels projected in budgets and projections for a standalone Saint Raphael's. Given current depreciation levels, this represents approximately an additional ten years of capital expenditures.**
8. **Implementation of Epic, providing a uniform, integrated, seamless, gold-standard Electronic Medical Record system for the entire community.**
9. **The avoidance of $590 million in costs resulting from the need for Yale-New Haven Hospital to construct a new bed tower and associated chiller plant and parking garage and for the parties to continue incurring costs that would be avoided through clinical integration.**

These benefits, identified at an early stage in the process, provide the parties confidence that this transaction offers unique and extensive benefits to the community that by definition cannot be duplicated by any other combination for either system. It is because of these benefits that the Sisters, the Board of Trustees and senior management confidently and reasonably concluded after a thorough evaluation of alternatives that no other buyer would offer a comparable set of benefits that would satisfy all of the objectives identified by the Sisters and the Board.

The nature and extent of the search and evaluation of alternatives only provided further confidence that the combination with Yale-New Haven Hospital was not an opportunity that either should risk losing. Although the search lasted 18 months, Saint Raphael's pursued a number of paths and discussions in parallel, all the while maintaining that a transaction remained necessary to support long-term viability.

Saint Raphael's also returned to discussions with the national Catholic chain with a local affiliate, despite the chain's abandonment of exclusive discussions with Saint Raphael's in the fall of 2008. The chain had returned to the acquisition trail in conjunction with a private equity partner. Because the nature and structure of the model were untested, because the buyer was for-profit, and because a transaction could leave the future of HSR in limbo, the Sisters and the Board decided that HSR should explore other options.

Saint Raphael's also explored statewide Catholic options, but its financial condition remained of concern to other Connecticut Catholic hospitals, most of which were facing their own significant financial challenges in other parts of the state.

Because Saint Raphael's also requires support from the Archbishop and Hartford Archdiocese for any transaction, it was doubtful that affiliation would be possible with any other state secular system that competes vigorously with other Connecticut Catholic hospitals, so management ruled out other secular options.

Finally, Saint Raphael's continued to pursue for-profit hospital chain options until signing the Letter of Intent with Yale-New Haven Hospital, even providing due diligence. Although it might be possible for hospitals to retain Catholicity when joining a secular for-profit hospital chain, transitioning to for-profit status remains difficult for some hospital owners and managers. So although the Sisters, Board and senior management would have preferred affiliation over liquidation, they clearly preferred retaining nonprofit status, and based on their knowledge about how non-local and for-profit financing and operations generally function, were confident that affiliation with Yale-New Haven Hospital would provide by far the greatest benefit in terms of access, quality, and cost efficiencies for the community.

HSR believes that the alternative transactions considered would not result in greater benefit to the community or to the retirees and employees. The applicants believe that the combined Saint Raphael's and YNHH entity will produce savings to the health care system and as a result a package of benefits for the community that no other alternative would be able to provide. YNHH's proposal achieves Saint Raphael's Board of Trustees' and senior management's fiduciary duty and efforts to receive as much as possible to satisfy its long-term debt and narrow the pension deficits.

13. Provide any reports prepared by Navigant Consulting relating to the analysis of health systems that it performed for HSR.

Response

The Applicants direct OHCA to the response to Question 12 above which provides narrative information on the options considered by SRHS and its Ad Hoc Strategy Committee. The reports prepared by Navigant Consulting contain proprietary and highly sensitive commercial information, which would have anticompetitive consequences if publicly disclosed and would interfere with the Applicants' ability to implement the proposed acquisition should it gain the required regulatory approvals. The Applicants believe that irreparable harm could result from public disclosure of the reports. Accordingly, the reports prepared by Navigant Consulting will be submitted under separate cover upon receipt of an acceptable protocol from the Department of Public Health for the protection of confidential submissions by the Applicants.

14. Provide a copy of the letter of intent signed by YNHH and HSR in March 2011.

Response

A copy of the signed letter of intent is included in Attachment VIII.

15. On page 27, applicants state that HSR identified YNHH as its optimal partner for a number of reasons outlined in the application. Please address the following:
    a. Describe any clinical staff/clinical positions at HSR that would not be retained after the acquisition.
    Response
    The clinical integration planning is ongoing and will continue after the transaction is closed. There may be changes to clinical positions.

    b. Explain what Centers of Excellence would be created and located at the HSR campus.
    Response
    At this time, primary family oriented birthing (including a birthing center), a bariatric surgery center of excellence and a musculoskeletal center of excellence is planned for the HSR campus. This will include orthopedics, pain management, spine, rehabilitation and podiatry.

    c. How will the HSR campus be held out/identified to the public post-acquisition by YNHH.
    Response
    The HSR campus will be identified as Yale-New Haven Hospital and the campus will be referred to as Yale-New Haven Hospital, Saint Raphael Campus.

16. On pages 28 and 29, applicants state that "[i]n the first five years, YNHH plans to invest $129.5 million" in the HSR campus for a variety of purposes. Please address the following:

    a. Is the $129.5 million investment separate and distinct from the $160 million being paid by Buyer pursuant to Section 2.3 of the Asset Purchase Agreement set forth as Attachment III to the CON application?
    Response
    The $129.5 million investment is separate and distinct from the $160 million being paid by YNHH pursuant to Section 2.3 of the Asset Purchase Agreement.

    b. List the deferred capital purchases and projects on the HSR campus the investment will address.
    Response
    Please refer to the response to question 5a-b.

    c. List the investments in clinical service infrastructure that will be made on the HSR campus.
    Response
    Please refer to the response to question 5a-b.

    d. Explain when YNHH would expect the existing information technology systems on the HSR campus to be integrated with YNHH's and when the implementation of the Epic electronic medical record system would be completed on the HSR campus.

Response
Epic installation at YNHH will occur primarily on February 1, 2013 although some of the clinics and ambulatory practices associated with YNHH will go-live on Epic in the weeks prior to and following February 1.

If the acquisition is approved, it is estimated that installation of Epic at HSR would begin 11 months after closing to allow the installation at the HSR campus to fit well into the overall Yale-New Haven Health System Epic schedule.

17. Describe, in detail, the "new, integrated organization that will preserve clinical services and ensure HSR's charitable assets for future generations" referenced on page 29. Please also provide the following information regarding the Charitable Funds defined at Section 5.5 of the Asset Purchase Agreement:

Response
The new, integrated organization will ensure the continuation of clinical services which historically have been provided by HSR and are in jeopardy due to HSR's financial condition. A new integrated organization, as described throughout this CON application, will ensure the continued provision and access to HSR's services and programs through YNHH's investment in the facility and commitment to the recognition of HSR's Catholic heritage and mission oriented services.

a. What amount of Charitable Funds, if any, will be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets and how will they be used for the benefit of the Facilities?

Response
The expected value of the donor restricted funds at the close will be approximately $26 million, with $13.5 million being permanently restricted. The remaining $12.5 million of temporarily restricted funds will be available to fund initiatives consistent with donor intent.

b. What amount of Charitable Funds that cannot be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets will be used by Sellers at or for the benefit of the Facilities and how will they be used?

Response
Any Charitable Funds that cannot be transferred to YNHH or a YNHH Affiliate will be used by HSR at or for the benefit of the HSR campus and consistent with donor intent. In the event that some Charitable Funds cannot be used for the benefit of the HSR or consistent with donor intent, the donor will be asked by HSR to consent to a transfer to YNHH or to a revised charitable purpose, or the parties will ask a court of competent jurisdiction to apply *cy pres*, that is, determining donor intent-to modify the donation in a manner that such funds may be used by YNHH or used to fund activities that benefit the delivery of health care services in the greater New Haven area consistent with the Catholic Ethical and Religious Directives for Healthcare Services.

c. What amount of Charitable Funds shall be used by Sellers to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven area and how will they be used?

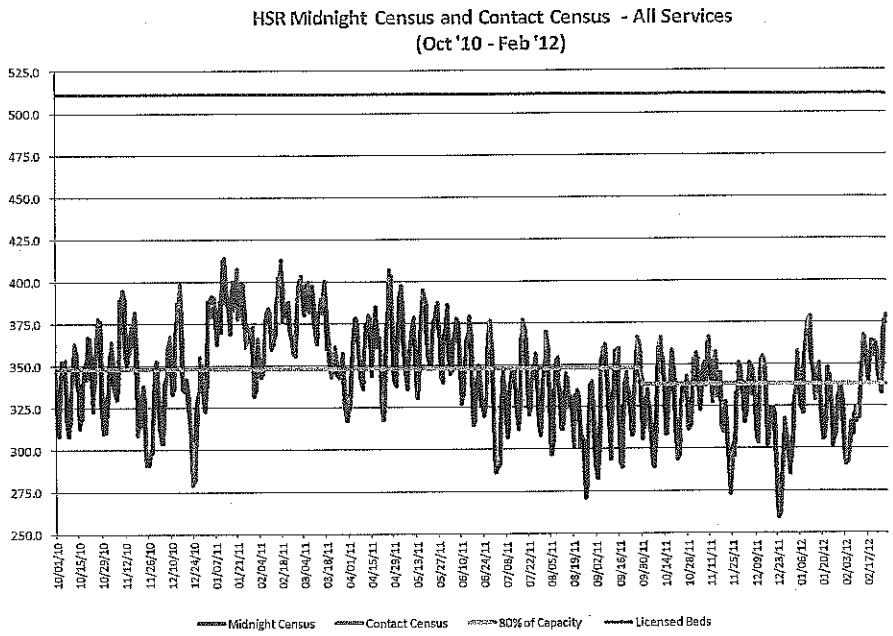
Response

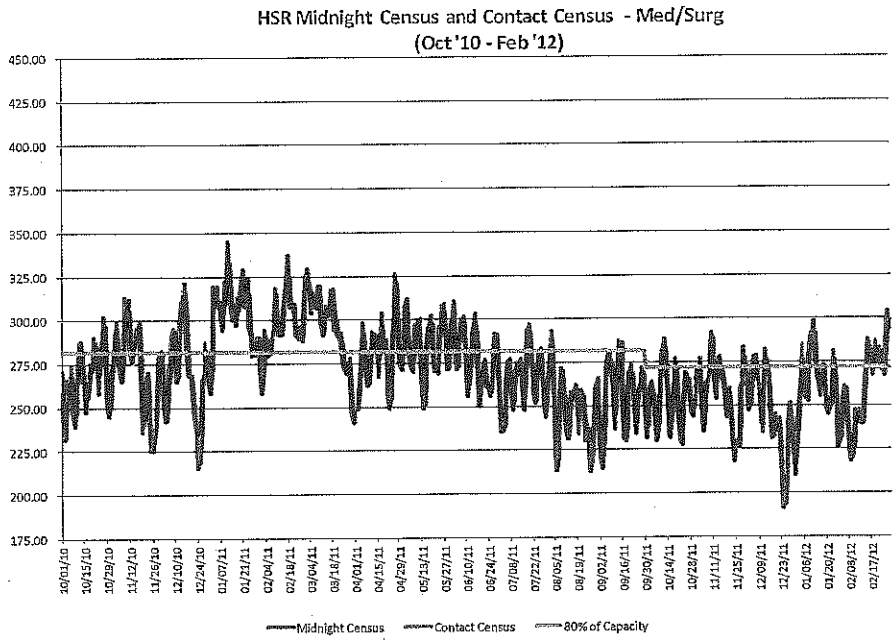
The amount of Charitable Funds that may be used to fund activities consistent with donor intent after the transaction closes cannot be estimated at this time. Such amount, if any, would be known only after the process described in 17(b) above was exhausted which would be after the transaction closes.

18. On page 32 in Graphs I and II, respectively, applicants provided information on YNHH's occupancy based on the midnight census and the contact census for all services and for medical/surgical beds as compared to total beds and 80% occupancy levels. Please provide HSR's occupancy based on its census data from FY 2011 to FY 2012 (year to date) in the same format.

Response

HSR's occupancy based on its census from FY 2011 and FY 2012 (year to date) in the same format as YNHH provided on page 32 are provided below.





19. YNHH recently submitted a CON application to add 70 beds which will be temporarily located in its East Pavilion. Assuming that CON is granted, please explain what will happen to these 70 beds if the CON application for the acquisition of HSR is not approved and, alternatively, if the CON application for the acquisition of HSR is approved.

Response

The requested 70 beds will remain in the East Pavilion and South Pavilion locations identified in DN: 12-31745-CON with or without regulatory approval of YNHH's application to acquire the Saint Raphael Healthcare System, Inc. and the Hospital of Saint Raphael

20. Please provide a copy of YNHH's long range financial plan showing the need for an additional 74 beds by 2016 even if 70 additional beds are added pursuant to Docket No. 12-31745-CON.

Response

Please refer to the response to question 7f and referenced calculations. By 2016, YNHH will have a deficit of 71 beds and bassinets (62 beds) without the acquisition of HSR and the requested 70 additional beds.

21. Please provide copies of the inpatient volume projections submitted to the Connecticut Attorney General and the Federal Trade Commission.

Response

The most detailed projections of YNHH's inpatient volume submitted to the Connecticut Attorney General and the Federal Trade Commission were contained at page 34 of the Applicant's Certificate of Need Application, Docket Number 12-31747-CON. These projections were provided to the Connecticut Attorney General and the Federal Trade Commission (FTC) on February 19, 2012.

22. Please provide evidence of YNHH's decision-making process regarding the location of the new bed tower that has been contemplated as part of its long range financial planning efforts.

Response

In FY 2008, YNHH undertook a significant review of its facility needs to assess its long-term need and plan for how to meet that need. The review considered YNHH's future need for bed space through 2016 and evaluated various means of meeting that need. YNHH concluded that it had no realistic alternative but to undertake an aggressive building plan to meet its future growth projections.

YNHH first considered whether, instead of building a separate new building, it might be able to increase capacity by adding a "vertical extension" – i.e., by increasing the height of the existing bed towers. This is not feasible, however, because the structure of the existing towers will not support vertical expansion without significant operational disruption and excessive construction costs.

YNHH concluded that it would have to build two towers in the foreseeable future. In Phase 1, YNHH would construct a new (fifth) hospital tower by 2017 to absorb its patient growth and also to permit YNHH to transfer some patients out of the East Pavilion. In Phase 2, YNHH would then build a replacement tower for the aging East Pavilion. YNHH first considered whether to construct its new (fifth) bed tower on the East side of Howard Avenue on a site adjacent to the (then under construction) North Tower. A new tower in this location would not be able to be tied in to the existing YNHH "pinwheel" grouped around the central medical complex, but this site was the closest possible site to the existing YNHH pinwheel.

Subsequently, YNHH concluded that this location East of Howard Avenue was not feasible. The parcel of land under consideration is occupied by the Connecticut Mental Health Center ("CMHC"), and YNHH concluded that it would take too long to arrange to acquire the land and build a replacement facility for CMHC before YNHH would be able to tear down the existing CMHC structure and commence its own construction.

When the East-of-Howard-Avenue site was recognized as impractical, YNHH shifted its focus to a site on the West side of Howard Avenue at the corner of Davenport Avenue. The new tower would have been located across Howard Avenue from its current towers. YNHH considered two possible configurations for the location. One option would have provided for a six floor bed tower that would have contained five new patient floors with a total of 150 new patient rooms. A second option would have provided for an eight floor bed tower with six new patient floors containing 132 new patient rooms. YNHH projected that the new bed tower would cost $300 million. While the proposed new tower on the West side of Howard Avenue could have been connected to the central medical complex with a pedestrian tunnel or walkway, it would not have been tied to the central medical complex support structure. Because of this, a new tower at this site would have required a separate power plant and parking facilities, as well as duplication of certain facilities, such as central supply, retail space and loading docks.

Upon further study, YNHH concluded that the West of Howard Avenue site also was not practical. Zoning laws precluded construction of a building of suitable size on that site. YNHH was uncertain whether it could get city approval for a waiver of zoning regulations to permit construction on that site and was also concerned about the prospect of opposition to its plans from residential neighbors along Vernon street.

YNHH management then shifted focus to a site one block to the North, at the intersection of Howard and Legion Avenues. This site, known as the Howard-Legion site, is also located on the West side of Howard Avenue. It is further away from the YNHH central medical complex, but not so far that it couldn't be connected by a pedestrian walkway or tunnel. The site has a number of advantages compared to the West-of-Howard-Avenue site. Most importantly, the site is zoned for commercial development and would permit YNHH to construct a tower containing 250 beds. Because YNHH's construction would be compatible with the existing zoning regulations, city approval would be considerably more likely, and the absence of residential neighbors greatly reduces the likelihood of residential opposition.

About three years ago, YNHH acquired part of the Howard-Legion site from the Intercontinental Hotel Group for approximately $14.5 million. However, the Intercontinental Hotel Group did not own the entire stretch of the block along Howard Ave. The remainder of the Howard-Legion site is currently occupied by an aging public housing building owned by the Housing Authority of the City of New Haven (the "Housing Authority"). YNHH obtained rights to this portion of the Howard-Legion site in 2009 by entering into an agreement with the Housing Authority of the City of New Haven to exchange the Howard-Legion site for a nearby YNHH-owned parcel of land that would be suitable for a new public housing building. Pursuant to the agreement, YNHH conveyed its parcel of land to the Housing Authority in October, 2009, and the Housing Authority thereafter began construction of a new public housing project on that site which was completed in late 2011. The Housing Authority still has to demolish the existing building on the Howard-Legion site and then convey that land to YNHH.

If the HSR transaction is not approved YNHH would plan to pursue a two-phase construction project. The first phase, located on the Southern portion of the site, would add a bed tower, totaling approximately 500,000 square feet, with a chiller plant and a parking garage. Completion would be anticipated in about 2017. The new bed tower may become YNHH's new Children's Hospital, housing women's and children's services. (Although YNHH's current Children's Hospital, located in the West Pavilion, is relatively new, the least disruptive plan would be to move the Children's Hospital to the new bed tower and then reconfigure the West Pavilion for adult care.) Once the Women's and Children's services move out of the West Pavilion, YNHH would renovate the West Pavilion at a total cost of about $35 million to absorb adult inpatient services. The cost of the new tower and the necessary renovations to the West Pavilion are internally estimated to be $537 million ($470 million for the tower plus $32 million in capitalized interest and $35 million for West Pavilion renovations to make space vacated by pediatrics and obstetrics usable for adult medical-surgical services). The

second phase of the project would commence sometime thereafter, and would build a replacement for the aging East Pavilion. This tower would be located on the Northern portion of the site.

As with the West of Howard Avenue location, the Howard-Legion site would permit the new tower to be connected to the central medical complex with a pedestrian tunnel or walkway, but the new tower would not be tied to the central medical complex support structure. As a result, the plan for a new bed tower at the Howard-Legion site would also require duplication of certain facilities. YNHH also expects that a new bed tower at the Howard-Legion site would require a new chiller plant and parking facility. This could drive up the cost of the project from about $537 million (for the new bed tower, capitalized interest and renovations to the West Pavilion) to a total project cost of about $622 million based on internal estimates for a 845 parking space garage of $25 million and a chiller plant of $60 million.

When YNHH entered into the Asset Purchase Agreement with Saint Raphael's, it slowed significantly its planning for construction of a new bed tower at the Howard-Legion site, as the acquisition would eliminate the need for a fifth bed tower. Nevertheless, YNHH has continued with its planning efforts. In the absence of the acquisition of Saint Raphael's, YNHH expects that completion of a fifth bed tower at the Howard-Legion site would take approximately five years.

23. On page 35, applicants state that "the opportunity to avoid duplicative investments and focus on key strategies, such as primary care development, will enhance access to services for patients in the region."

    Please describe the discussion HSR and YNHH have had surrounding the development or primary care and the avoidance of duplication of services.

    Response

    HSR and YNHH have not had discussions surrounding the development of primary care. Since the organizations are still competitors, strategy discussions of this nature have not have occurred. Avoidance of duplication of services has been addressed in response to question 25.

24. On page 36, applicants state that "discussions have been held with the State of Connecticut Attorney General and the Federal Trade Commission to initiate governmental approval of the transaction."

    Please describe the status of those discussions and provide a timeline for when decisions from the Attorney General's Office and the Federal Trade Commission might be expected if they have not already been rendered.

    Response

    Representatives of YNHH and Saint Raphael's held discussions with the State of Connecticut Attorney General on May 3, 2011, and with the State of Connecticut Attorney General and the Federal Trade Commission on October 12, 2011. On November 1, 2011, YNHH and Saint Raphael's filed Hart-Scott-Rodino Notification

and Report Forms with the Federal Trade Commission and the U.S. Department of Justice pursuant to 15 U.S.C. § 18a. On November 8, 2011 representatives of YNHH and Saint Raphael's held discussions with the Federal Trade Commission and the State of Connecticut Attorney General's office. On November 30, 2011, the Federal Trade Commission issued a Request for Additional Information to YNHH and Saint Raphael's. On March 19, 2012 representatives of YNHH and Saint Raphael's held discussions with the State of Connecticut Attorney General's office. YNHH and Saint Raphael's certified substantial compliance with the Federal Trade Commission's Request for Additional Information on April 2, 2012. Representatives of YNHH and HSR held discussions with the FTC on April 6, 2012. Representatives of HSR held discussions with the State of Connecticut Attorney General on April 9, 2012. The investigations of the State of Connecticut Attorney General and the Federal Trade Commission are ongoing.

YNHH and Saint Raphael's must observe a sixty-day waiting period from the date they certified substantial compliance with the Federal Trade Commission's Request for Additional Information before they are permitted to consummate the transaction. Unless YNHH and Saint Raphael's agree to a different time schedule, the parties expect the Federal Trade Commission and the State of Connecticut Attorney General to complete their respective investigations before this waiting period expires on June 1, 2012.

The parties plan to close the transaction by June 29, 2012, effective July 1, 2012. Completion of the transaction by this date is important for multiple reasons. Uncertainty surrounding the future of Saint Raphael's has led to significant concern among employees and physicians. Saint Raphael's has already started to lose physicians and staff, including the Chief Operating/Financial Officer, who left HSR effective April 4th, 2012 for another position. If completion of the transaction is delayed, further departures of key personnel are likely to begin to affect Saint Raphael's operations. Loss of personnel necessary for a smooth integration of YNHH and Saint Raphael's will also make it more difficult for the combined hospitals to achieve all of the efficiencies planned for the transaction. If Saint Raphael's financial condition continues to decline, it may be forced to lay off more employees, a further disruption to its workforce that could be avoided once the transaction closes. Because of its growing space constraints, YNHH is forced to push forward with its alternative plan of building a fifth bed tower. Beginning in August, 2012, YNHH is expecting to spend over $800,000 for engineering specifications, schematic designs and room layout studies for the new tower, an amount that could be avoided if the acquisition closes on schedule. More generally, the longer the delay beyond June 29 to consummate this transaction, the more time that will pass before the hospitals, employees, doctors, payors, patients and the community at large will begin to enjoy all the benefits of stabilized financial conditions at Saint Raphael's, a strengthened pension plan, new investments in facilities at Saint Raphael's, improvements in bed availability at YNHH, operational cost savings at both hospitals, and the integration of clinical services across the two campuses and the introduction of new centers of excellence for important service lines.

25. On page 37, applicants state that they "have worked to identify a number of options to achieve cost savings and work flow efficiencies."

Please describe these cost savings and work flow efficiencies.

Response

Cost savings options have been addressed in the response to question 8a, b. Work flow efficiencies have not been specifically identified but this was mentioned in the original CON submission as work flow relates to clinical and non-clinical integration, standardization of process and procedures in integrated areas and the use of Epic at both campuses which contribute to more efficient work flow in the majority of clinical areas. This work is ongoing and will not be completed until after the transaction is closed.

a. Please provide additional detail regarding which subspecialties will be, or are likely to be consolidated, on one campus (indicating which campus) and include the reasoning behind each decision.

Response

As previously indicated clinical integration planning is ongoing and will continue for many more months after the transaction closes. However, at this time, the following specialties are likely to be consolidated on one campus as described below:

YNHH Campus:

Cardiac Surgery: YNHH made significant investments in its cardiac surgery program with the recruitment of David Yuh, new section chief of Cardiac Surgery, as well as Abeel Mangi, new Surgical Director in the Center for Advanced Heart Failure, Mechanical Circulatory Support and Heart Transplantation. Due to the required technological investments and staffing expertise, the YNHH campus offers the most comprehensive setting and can accommodate volume for both campuses.

Trauma: YNHH offers a Level I adult and pediatric Trauma center, while HSR has a Level II trauma center. Following the acquisition, a single location for Trauma will be established at YNHH due to the Level I designation and wider scope of trauma services. A single Trauma site will also simplify transport from the field. Additionally, YNHH is currently completing renovations to its emergency department and there will be 4 new adult trauma bays and 1 for pediatrics, with each bay being able to accommodate 1-2 patients.

Medical, Thoracic, Gynecologic, Surgical and Breast Oncology: Smilow Cancer Hospital currently offers the most up-to-date technology and physician expertise in the treatment of cancer. The infrastructure and support of the Cancer Hospital along with Yale University School of Medicine's Designation as an NCI- Comprehensive Cancer Center, makes the YNHH campus the preferred campus for cancer treatment in these areas.

Pediatrics: **Inpatient pediatric care is highly specialized. HSR has not provided pediatric services to any significant degree for many years and currently transfer almost all pediatric patients to Yale New Haven Children's Hospital.**

High Risk Obstetrics: **YNHH is a key provider of maternal-fetal medicine and currently HSR refers most of its high risk obstetrical cases. High risk obstetrics should be located in the same location as a Level III nursery. YNHH has a level III nursery and has been the existing referral center for high risk obstetrics for many years.**

HSR Campus:
The establishment of a musculoskeletal institute including orthopedics, pain management, spine, rehabilitation, podiatry and possibly bariatric surgery is being planned.

b. What subspecialties will be, or are likely to be, offered on both campuses? Explain how these service lines were selected.

Response
Specialties that are likely to be offered at both campuses are described below:

Both Campuses:
General Medicine/Surgery: will be offered at both campuses. These are high volume services that cannot be consolidated and beds on both campuses are required to manage the volume.

Cardiology: will be provided on both campuses since it is required as specialty support to general medical and surgical services.

Vascular Surgery: will be provided on both campuses since it is required to support general surgery.

Urology: will be provided on both campuses since it is required to support general surgery.

Psychiatry (Adult and Child): will be offered at both campuses. These are high volume services that cannot be consolidated and beds on both campuses are required to manage the volume.

Low Risk Obstetrics: will be offered at both campuses. The volume for these services requires bassinets from both campuses and low risk cases can be cared for on either campus. It is anticipated that HSR will have the birthing center.

Gynecology: is primarily offered in the outpatient setting and will continue to be provided by institutions in their ambulatory surgery settings and on an inpatient basis.

Dentistry: both hospitals currently offer dental services, although HSR's service includes a maxillofacial residency program as well as dental services. YNHH's dental service supports its large transplant and pediatric programs. Therefore dental services will continue to be offered at both locations.

Emergency Medicine / Emergency Surgery: non-trauma emergency services will be offered at both campuses. Trauma cases, as noted above, will be sent to YNHH.

Essential support services from anesthesiology, pathology, laboratory medicine and radiology will be required for both campuses

26. On page 37, applicants state that "Deloitte has estimated cost savings from clinical and business operational integrations of at least $300 million over five years."

    Please provide information that describes these cost savings in detail, including a breakdown of the approximate amount of money saved by each measure.

    Response

    Please refer to the response to question 8b.

27. Please describe how the acquisition will improve efficiency, access to health care and quality for the area's growing elderly population.

    Response

    The proposed acquisition will improve efficiency, access and quality to the area's growing elderly population as well as all patients who will seek care from YNHH. Specifically for the elderly, HSR has a long history of offering hospital- and community-based services for this population. The elderly have always been identified as a special population within the mission of HSR. This acquisition will ensure that these services are maintained in the community, whereas another purchaser may have chosen not to continue these services. The HSR campus will likely be the location for a comprehensive musculoskeletal center offering acute inpatient, acute rehabilitation and sub-acute rehabilitation services through the Grimes Health Center. These services are most often provided to the elderly population who frequently suffer from musculoskeletal disorders as a result of the aging process. The concentration of these services at the HSR campus will facilitate access, care coordination, and efficient patient flow.

28. Please provide an unredacted copy of the Asset Purchase Agreement and all exhibits thereto.

    Response

    The Applicants redacted from the Asset Purchase Agreement proprietary, highly sensitive information that, if disclosed, would have potentially anticompetitive consequences and would undermine the Applicants' ability to implement the acquisition effectively should it gain the required regulatory approvals. The Applicants believe that irreparable harm could result from disclosure of the Asset Purchase Agreement with all exhibits. Accordingly, the unredacted Asset Purchase Agreement will be submitted under separate cover upon receipt of an acceptable

protocol from the Department of Public Health for the protection of confidential submissions by the Applicants.

29. To the extent not already provided, please describe the $85 million in facility upgrades that YNHH plans to undertake on the HSR campus and the estimated amounts that will be spent in each year.
Response
Please refer to the response to question 5a.

30. To the extent not already provided, please describe the type of routine capital expenditures that will amount to $25 million in expenditures over the next five years and the estimated amounts that will be spent in each year.
Response
Please refer to the response to question 5a.

31. When will the EPIC installation at YNHH be complete? If the acquisition is approved, how long after Closing is it estimated that EPIC installation at HSR would begin?
Response
Please see the response to question 16d.

32. Please describe what makes up the $60,248,000 in the "Other Non-Construction (Other Asset Purchases)" line of the proposed capital expenditure chart on page 45.
Response
The non construction category within the proposed capital expenditure section of the CON contains the following asset values within the Asset Purchase Agreement: inventory, investment funding for the captives insurance, trademark, and goodwill.

33. On page 45, applicants state that specific capital costs for HSR's assets equal $147,879,000. Please provide information on how much of the remaining $12,021,000 in capital expense is being allocated to the purchase of DePaul Health Services Corporation Inc.'s ownership interest in the Saint Raphael Magnetic Resonance Center (SRMRC).
Response
As per OHCA's direction, a separate CON will be filed for the change in ownership interest in SRMRC from DePaul Health Services to YNHH. The response to this question will be provided in that separate CON submission.

34. Please summarize any analyses or reports from Barclays Capital, other underwriters or YNHH's financial advisors regarding YNHH's credit rating and ability to obtain the $160 million in bond financing necessary to complete the proposed acquisition.
Response
Over the past year, Barclay's Capital has been advising YNHH regarding the HSR transaction and has continued to do so as the terms of the transaction have changed. They have done debt capacity evaluations and projections of financial ratios of special interest to the rating agencies. From this work, YNHH has concluded that the Hospital has the ability to obtain the necessary funding for the transaction.

35. On page 49, with respect to the assumptions for patient population mix, please explain why volumes for HSR are assumed to be flat through the projection period.

Response

The addition of HSR's volume to YNHH's projected volume was based on historical volume levels at HSR. HSR's volume was assumed to stay at that level and was then added to the increases projected for YNHH. Although HSR's volume has been declining, it has been assumed that with YNHH's acquisition of HSR, volume at the HSR campus will stabilize, reflecting greater financial stability for the HSR campus due to significant investments in medical equipment, infrastructure, and IT and plant.

36. On page 231 (Attachment I for YNHH), please explain, in detail, the underlying assumptions for the increases in bad debt and interest expense connected with the HSR acquisition?

Response

The assumption within the incremental change in bad debt centers on YNHH assuming the responsibility for HSR's revenue and volume. YNHH will also be responsible for the accompanying patient receivables. Furthermore the incremental bad debt amount assumes increases to patient charges based upon inflationary assumptions to YNHH's charge master in future years.

The increase in the interest expense is based on the additional debt in FY2012 related to the purchase of SRHS. In addition $100 million is borrowed in FY2014 and again in 2016 which is due to the capital outlays for renovation of the HSR campus.

37. On page 234 (Attachment I for HSR), please explain, in detail, the underlying assumptions for inpatient discharges dropping in FY 2012 and remaining flat throughout the projection period without the YNHH affiliation taking place.

Response

Inpatient volumes are assumed to decline in FY2012 from FY2011 levels (from 23,120 to 21,739 discharges), with a further decline in FY2013 (to 21,226). The assumed discharge volumes for FY2012 were developed based upon year-to-date December 2011 activity levels, with the reduction in overall activity levels over the prior year of 6% assumed to continue for the remainder of FY2012. For FY2013, a further decline in Medicine discharges of 5% was assumed based upon historical trends.

Discharge volumes were assumed in our previous submission to remain flat during FY2014 and beyond due to the complexity and uncertainty of HSR as a standalone hospital. As noted in the assumptions to the CON projections, due to the inherent unpredictability of the economy in the country and local region during the projection period, and the inherent inability to accurately estimate patient volumes and rates of payment from governmental and non-governmental payers during the projection period, the attached projections are susceptible to a wide range of variability. HSR believes that a variety of factors as discussed above (the aging medical staff, the financial constraints on HSR's ability to retain and recruit physicians and other health care professionals, the dramatic increase in the age of the facility and the continued constraints on adequate investment levels) suggest that inpatient volume will at best stay flat.

38. On page 234 (Attachment I for HSR), please explain in detail, the underlying assumptions for outpatient visits increasing in FY 2012 and remaining flat throughout the projection period without the YNHH affiliation taking place.

Response

The level of outpatient volume projected for FY2012 was developed during the creation of the FY2012 internal budget based on the estimated outpatient activity to the estimated inpatient activity. With year-to-date December 2011 outpatient activity approximating budget, the FY2012 outpatient volumes levels were assumed unchanged. As outpatient volumes have historically remained relatively constant with budgeted levels over the recent past, flat outpatient volumes were assumed for the projection period. As noted in the assumptions to the CON projections- due to the inherent unpredictability of the economy in the country and local region during the projection period, and the inherent inability to accurately estimate patient volumes and rates of payment from governmental and non-governmental payers during the projection period, the projections are susceptible to a wide range of variability. HSR believes that a variety of factors as discussed above (the aging medical staff, the financial constraints on HSR's ability to retain and recruit physicians and other health care professionals, the dramatic increase in the age of the facility and the continued constraints on adequate investment levels) suggest that outpatient volume will at best stay flat.

39. On page 238, please explain the basis for the negative adjustment to hospital inpatient and outpatient revenue due to health care reform.

Response

The net negative adjustments to HSR's projected net revenues are based upon management's best estimates of the impact of pending Federal and State health care reform legislation on historical payment rate changes. Historical payment rate changes were assumed in the development of the Governmental Net Revenue Rate Increases assumptions, with the estimated impact of the pending health care reform legislation separately identified. The estimated impact of this legislation includes the following components (dollars in thousands):

	FY 2013	FY 2014	FY 2015
Reductions in rate of payment increases	($6,600)	($13,100)	($15,700)
"Meaningful Use" Payment incentives	5,800	4,000	3,000
Net impact	($ 800)	($ 9,100)	($12,700)

As noted in the assumptions to the CON projections, due to the inherent unpredictability of the economy in the country and local region during the projection period, and the inherent inability to accurately estimate patient volumes and rates of payment from governmental and non-governmental payers during the projection period, the attached projections are susceptible to a wide range of variability.

40. On pages 50-51, please explain in more detail how YNHH intends to establish budget neutral agreements "with new payment terms that will not result in an adverse financial impact to the managed care payers or the self-funded employers they represent" if the affiliation occurs. Please also explain whether YNHH would be able to negotiate similar budget neutral agreements if the affiliation with HSR did not occur and how the affiliation impacts YNHH's ability to negotiate with managed care plans as well as other private health insurers.

Response

Conceptual discussions have been held with each of the major payers. While individual payers are aware of the contractual agreements at each facility, neither YNHH nor HSR is aware of the other hospital's rates. When the transaction is finalized and the agreements can be reviewed by YNHH, YNHH will assess the agreements, the rates by service, the volume of services, the form and type of payment, and the contract yields by payment category. A negotiation will occur that would arrive at a budget neutral result for the managed care payer. As the managed care payer is the contracting conduit for self-insured employers, this effect would translate to them as well.

Until such time that a new agreement is developed with payers, the terms of the current agreements with each hospital would prevail, even under a single YNHH billing number. Arrangements will be established with the payers to identify the location of the service so that payments can be made on a campus-specific basis until such a new agreement is established.

If the transaction does not occur, both parties will continue their separate managed care negotiations. There is no need to negotiate similar budget neutral agreements if the transaction does not occur as both parties are free to negotiate agreements as currently exists.

41. On page 246, applicants state that inpatient "scan volume is projected to increase in proportion to an expected increase in the average daily census (ADC) at the Saint Raphael campus following the acquisition by YNHH … ADC is projected to increase by 40 in FY 2012, 60 in FY 2014 and 85 in FY 2015." Yet, at page 236 of the CON Application, no increase in HSR utilization is assumed. Please explain this apparent discrepancy.

Response

As per OHCA's direction, a separate CON will be filed for the change in ownership interest in SRMRC from DePaul Health Services to YNHH. The response to this question will be provided in that separate CON submission.

42. Will there be any change in the radiologists who provide professional services interpreting the SRMRC MRI scans as a result of YNNH's acquisition of HSR?

Response

As per OHCA's direction, a separate CON will be filed for the change in ownership interest in SRMRC from DePaul Health Services to YNHH. The response to this question will be provided in that separate CON submission.

Attachment I

Average Age of Plant – CT Hospitals (2011)

Average Age of Plant - CT Hospitals (2011)

	Y-NHH	Backus Hospital	Bridgeport Hospital	Bristol Hospital	Charlotte Hungerford Hospital	Connecticut Childrens Hospital	Danbury Hospital	Day Kimball	Hospital of Saint Raphael	Greenwich Hospital	Griffin Hospital	Hartford Hospital	Hospital of Central Connecticut	John Dempsey	Johnson Memorial Hospital
	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011
Accumulated Depreciation	566,850,000	140,786,203	264,952,000	99,185,736	102,493,235	85,992,089	299,833,683	36,609,993	352,900,000	191,442,000	82,909,524	635,128,928	260,274,904	138,277,486	37,422,003
Depreciation Expense	67,948,000	16,971,187	17,879,000	5,714,642	6,178,082	11,000,584	27,369,949	4,608,128	13,478,000	18,906,000	5,837,895	43,924,697	12,790,361	9,298,913	3,253,980
Average Age of Plant	8.3	8.3	14.8	17.4	16.6	7.8	11.0	7.9	26.2	10.1	14.2	14.5	20.3	14.9	11.5

Source: 2011 Audited Financial Statements provided by OHCA.

Definition

This ratio measures the average age (in years) of an organization's fixed assets.
The lower the value is, the newer a business's buildings and equipment.
A low average age typically means that the organization is using current technology and that it will not need to make large capital expenditures in the near future.

Calculation

Accumulated Depreciation divided by Depreciation Expense

Average Age of Plant - CT Hosp

	Lawrence & Memorial Hospital	Manchester Memorial Hospital	Middlesex Hospital	MidState Medical Center	Milford Hospital	New Milford Hospital	Norwalk Hospital	Rockville General Hospital	St. Francis Hospital	St. Mary's Hospital	St. Vincent's Medical Center	Stamford Hospital	Waterbury Hospital	Total
	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011	FY 2011
Accumulated Depreciation	210,414,909	137,494,546	258,275,000	113,748,505	47,323,119	71,743,955	277,748,018	59,437,084	492,032,441	119,119,000	198,169,000	313,648,000	223,542,449	5,817,753,810
Depreciation Expense	17,199,566	7,107,904	21,737,000	13,144,617	3,208,305	5,855,136	19,175,533	3,672,297	29,989,988	8,977,000	22,954,000	28,352,000	9,313,313	455,846,077
Average Age of Plant	12.2	19.3	11.9	8.7	14.8	12.3	14.5	16.2	16.4	13.3	8.6	11.1	24.0	12.8

Attachment II

Calculations and Assumptions for Bed Need and Capacity

YNHH Bed Capacity and Bed Need[1] for FY 2012 based on Projected Annual ADC[2] according to Three Scenarios: 1. Addition of 70 beds, 2. Acquisition of HSR, 3. Addition of 70 beds and Acquisition of HSR

	YNHH FY 2012	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2012 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2012 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	476.2	203.1	533	556	859	882	596	254	850	-63	-40	9	32	89%	86%	79%	77%
Critical Care	92.3	59.9	107	107	182	182	115	75	190	-8	-8	-8	-8	86%	86%	84%	84%
Adult Med/Surg Subtotal	*568.5*	*262.1*	*640*	*663*	*1,041*	*1,064*	*711*	*329*	*1,040*	*-71*	*-48*	*1*	*24*	*89%*	*86%*	*80%*	*78%*
Children's Hospital																	
General Care	54.5	0.6	71	71	74	74	73.1	1	74	-2	-2	0	0	77%	77%	75%	75%
Critical Care	11.2		19	19	19	19	14.9		15	4	4	4	4	59%	59%	59%	59%
Children's Subtotal	*65.7*	*0.6*	*90*	*90*	*93*	*93*	*88*	*1*	*89*	*2*	*2*	*4*	*4*	*73%*	*73%*	*71%*	*71%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	73.4	21.4	73	73	98	98	82	24	106	-9	-9	-8	-8	101%	101%	97%	97%
Child Psychiatry	13.5	14.8	15	15	33	33	15	16	31	0	0	2	2	90%	90%	86%	86%
Maternity	39.3	10.9	56	56	75	75	52	15	67	4	4	8	8	70%	70%	67%	67%
Available Beds Total	**760.4**	**320.8**	**874**	**897**	**1,358**	**1,381**	**948**	**399**	**1,347**	**-74**	**-51**	**11**	**34**	**87%**	**85%**	**80%**	**78%**
NBSCU - Critical Care Bassinets	42.1	4.5	52	52	60	60	56	6	62	-4	-4	-2	-2	81%	81%	78%	78%
Newborn Bassinets	27.4	7.5	40	40	54	54	36	10	46	4	4	8	8	69%	69%	65%	65%
Bassinets Subtotal	**69.5**	**12.0**	**92**	**92**	**114**	**114**	**92**	**16**	**108**	**0**	**0**	**6**	**6**	**76%**	**76%**	**71%**	**71%**
Total	**829.9**	**332.8**	**966**	**989**	**1,472**	**1,495**	**1,040**	**415**	**1,455**	**-74**	**-51**	**17**	**40**	**86%**	**84%**	**79%**	**78%**

[1] Projected Bed Need was based on inpatient projections only. Observation patients and other outpatient care for in inpatient bed were excluded. Target Utilization; Adult med/surg and Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[2] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[3] for FY 2013 based on Projected Annual ADC[4] according to Three Scenarios

	YNHH FY 2013	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2013 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2013 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	485.0	203.1	533	596	872	935	606	254	860	-73	-10	12	75	91%	81%	79%	74%
Critical Care	94.4	59.9	107	114	182	189	118	75	193	-11	-4	-11	-4	88%	83%	85%	82%
Adult Med/Surg Subtotal	*579.4*	*262.1*	*640*	*710*	*1,054*	*1,124*	*724*	*329*	*1,053*	*-84*	*-14*	*1*	*71*	*91%*	*82%*	*80%*	*75%*
Children's Hospital																	
General Care	56.7	0.6	71	71	74	74	74	1	75	-3	-3	-1	-1	78%	78%	76%	76%
Critical Care	11.4		19	19	19	19	15		15	4	4	4	4	60%	60%	60%	60%
Children's Subtotal	*67.1*	*0.6*	*90*	*90*	*93*	*93*	*89*	*1*	*90*	*1*	*1*	*3*	*3*	*75%*	*75%*	*73%*	*73%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	74.5	21.4	73	73	98	98	83	24	107	-10	-10	-9	-9	102%	102%	98%	98%
Child Psychiatry	13.8	14.8	15	15	35	35	15	16	31	0	0	4	4	92%	92%	82%	82%
Maternity	39.8	10.9	56	56	75	75	53	15	68	3	3	7	7	71%	71%	68%	68%
Available Beds Total	**774.6**	**320.8**	**874**	**944**	**1,373**	**1,443**	**964**	**399**	**1,363**	**-90**	**-20**	**10**	**80**	**89%**	**82%**	**80%**	**76%**
NBSCU - Critical Care Bassinets	42.9	4.5	52	52	60	60	57	6	63	-5	-5	-3	-3	83%	83%	79%	79%
Newborn Bassinets	27.9	7.5	40	40	54	54	37	10	47	3	3	7	7	70%	70%	66%	66%
Bassinets Subtotal	**70.8**	**12.0**	**92**	**92**	**114**	**114**	**94**	**16**	**110**	**-2**	**-2**	**4**	**4**	**77%**	**77%**	**73%**	**73%**
Total	**845.4**	**332.8**	**966**	**1,036**	**1,487**	**1,557**	**1,058**	**415**	**1,473**	**-92**	**-22**	**14**	**84**	**88%**	**82%**	**79%**	**76%**

[3] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[4] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[5] for FY 2014 based on Projected Annual ADC[6] according to Three Scenarios

	YNHH FY 2014	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2014 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2014 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	482.9	203.1	533	596	872	935	603	254	857	-70	-7	15	78	91%	81%	79%	73%
Critical Care	96.5	59.9	107	114	182	189	121	75	196	-14	-7	-14	-7	90%	85%	86%	83%
Adult Med/Surg Subtotal	*579.4*	*262.1*	*640*	*710*	*1,054*	*1,124*	*724*	*329*	*1,053*	*-84*	*-14*	*1*	*71*	*91%*	*82%*	*80%*	*75%*
Children's Hospital																	
General Care	56.9	0.6	71	71	74	74	75	1	76	-4	-4	-2	-2	80%	80%	78%	78%
Critical Care	11.6		19	19	19	19	16		16	3	3	3	3	61%	61%	61%	61%
Children's Subtotal	*68.5*	*0.6*	*90*	*90*	*93*	*93*	*91*	*1*	*92*	*-1*	*-1*	*1*	*1*	*76%*	*76%*	*74%*	*74%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	75.7	21.4	73	73	98	98	84	24	108	-11	-11	-10	-10	104%	104%	99%	99%
Child Psychiatry	14.1	14.8	15	15	35	35	16	16	32	-1	-1	3	3	94%	94%	83%	83%
Maternity	40.3	10.9	56	56	75	75	54	15	69	2	2	6	6	72%	72%	68%	68%
Available Beds Total	**778.0**	**320.8**	**874**	**944**	**1,373**	**1,443**	**969**	**399**	**1,368**	**-95**	**-25**	**5**	**75**	**89%**	**82%**	**80%**	**76%**
NBSCU - Critical Care Bassinets	43.8	4.5	52	52	60	60	58	6	64	-6	-6	-4	-4	84%	84%	80%	80%
Newborn Bassinets	28.5	7.5	40	40	54	54	38	10	48	2	2	6	6	71%	71%	67%	67%
Bassinets Subtotal	**72.3**	**12.0**	**92**	**92**	**114**	**114**	**96**	**16**	**112**	**-4**	**-4**	**2**	**2**	**79%**	**79%**	**74%**	**74%**
Total	**850.3**	**332.8**	**966**	**1,036**	**1,487**	**1,557**	**1,065**	**415**	**1,480**	**-99**	**-29**	**7**	**77**	**88%**	**82%**	**80%**	**76%**

[5] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[6] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[7] for FY 2015 based on Projected Annual ADC[8] according to Three Scenarios

	YNHH FY 2015	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2015 Bed Need @ Target Utilization			Variance between Capacity & Need				FY 2015 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	503.5	203.1	533	596	872	935	630	254	884	-97	-34	-12	51	94%	84%	81%	76%
Critical Care	98.7	59.9	107	114	182	189	123	75	198	-16	-9	-16	-9	92%	87%	87%	84%
Adult Med/Surg Subtotal	*602.2*	*262.1*	*640*	*710*	*1,054*	*1,124*	*753*	*329*	*1,082*	*-113*	*-43*	*-28*	*42*	*94%*	*85%*	*82%*	*77%*
Children's Hospital																	
General Care	58.1	0.6	71	71	74	74	77	1	78	-6	-6	-4	-4	82%	82%	79%	79%
Critical Care	11.9		19	19	19	19	16		16	3	3	3	3	63%	63%	63%	63%
Children's Subtotal	*70.0*	*0.6*	90	90	93	93	*93*	*1*	*94*	*-3*	*-3*	*-1*	*-1*	*78%*	*78%*	*76%*	*76%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	76.8	21.4	73	73	98	98	85	24	109	-12	-12	-11	-11	105%	105%	100%	100%
Child Psychiatry	14.4	14.8	15	15	35	35	16	16	32	-1	-1	3	3	96%	96%	83%	83%
Maternity	40.8	10.9	56	56	75	75	54	15	69	2	2	6	6	73%	73%	69%	69%
Available Beds Total	**804.2**	**320.8**	**874**	**944**	**1,373**	**1,443**	**1,001**	**399**	**1,400**	**-127**	**-57**	**-27**	**43**	**92%**	**85%**	**82%**	**78%**
NBSCU - Critical Care Bassinets	44.7	4.5	52	52	60	60	60	6	66	-8	-8	-6	-6	86%	86%	82%	82%
Newborn Bassinets	29.1	7.5	40	40	54	54	39	10	49	1	1	5	5	73%	73%	68%	68%
Bassinets Subtotal	**73.8**	**12.0**	**92**	**92**	**114**	**114**	**99**	**16**	**115**	**-7**	**-7**	**-1**	**-1**	**80%**	**80%**	**75%**	**75%**
Total	**878.0**	**332.8**	**966**	**1,036**	**1,487**	**1,557**	**1,100**	**415**	**1,515**	**-134**	**-64**	**-28**	**42**	**91%**	**85%**	**81%**	**78%**

[7] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[8] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[9] for FY 2016 based on Projected Annual ADC[10] according to Three Scenarios

	YNHH FY 2016	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2016 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2016 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	501.4	203.1	533	596	872	935	627	254	881	-94	-31	-9	54	94%	84%	81%	75%
Critical Care	100.8	59.9	107	114	182	189	126	75	201	-19	-12	-19	-12	94%	88%	88%	85%
Adult Med/Surg Subtotal	*602.2*	*262.1*	*640*	*710*	*1,054*	*1,124*	*753*	*329*	*1,082*	*-113*	*-43*	*-28*	*42*	*94%*	*85%*	*82%*	*77%*
Children's Hospital																	
General Care	59.3	0.6	71	71	74	74	79	1	80	-8	-8	-6	-6	83%	83%	81%	81%
Critical Care	12.1		19	19	19	19	16		16	3	3	3	3	64%	64%	64%	64%
Children's Subtotal	*71.4*	*0.6*	*90*	*90*	*93*	*93*	*95*	*1*	*96*	*-5*	*-5*	*-3*	*-3*	*79%*	*79%*	*77%*	*77%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.0	21.4	73	73	98	98	87	24	111	-14	-14	-13	-13	107%	107%	101%	101%
Child Psychiatry	14.6	14.8	15	15	35	35	16	16	32	-1	-1	3	3	97%	97%	84%	84%
Maternity	41.3	10.9	56	56	75	75	55	15	70	1	1	5	5	74%	74%	70%	70%
Available Beds Total	**807.5**	**320.8**	**874**	**944**	**1,373**	**1,443**	**1,006**	**399**	**1,405**	**-132**	**-62**	**-32**	**38**	**92%**	**86%**	**82%**	**78%**
NBSCU - Critical Care Bassinets	45.6	4.5	52	52	60	60	61	6	67	-9	-9	-7	-7	88%	88%	83%	83%
Newborn Bassinets	29.7	7.5	40	40	54	54	40	10	50	0	0	4	4	74%	74%	69%	69%
Bassinets Subtotal	**75.3**	**12.0**	**92**	**92**	**114**	**114**	**101**	**16**	**117**	**-9**	**-9**	**-3**	**-3**	**82%**	**82%**	**77%**	**77%**
Total	**882.8**	**332.8**	**966**	**1,036**	**1,487**	**1,557**	**1,107**	**415**	**1,522**	**-141**	**-71**	**-35**	**35**	**91%**	**85%**	**82%**	**78%**

[9] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[10] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

Attachment III

HSR's Plan for Excellence/Quality Improvement & Patient Safety Plan (2009)

Hospital of Saint Raphael
Administrative Policies and Procedures

Administrative Policy: Q-10 HOSPITAL OF SAINT RAPHAEL PLAN FOR EXCELLENCE/QUALITY IMPROVEMENT – FY 09

Revised: October 2007, February 2008, May 2008, December 2008, April 2009

I. Purpose

The Plan for Excellence is organized and designed to support the values, mission and strategic goals of the Hospital of Saint Raphael. This shall be achieved through an ongoing effort by all individuals to continually improve systems, processes, and outcomes through individual and organizational performance. The Hospital is committed to providing for a safe environment for patients, employees, and visitors through a comprehensive program designed to identify, evaluate, control and prevent medical/healthcare errors and improve processes and outcomes throughout the organization.

A. Principles

1. The Hospital of Saint Raphael is committed, through the implementation of this plan, to the following principles:

   a. Commitment and involvement of senior management, medical staff leadership and the entire workforce in achieving excellence

   b. Focus on continuous improvement over time to improve systems and processes, reduce risks to patients and staff and to provide a safe environment for all.

   c. Utilize the mission, values, and strategic goals as the foundation of our plan for excellence. This includes a process/system approach to opportunities for improvement and error reduction rather than assigning individual blame

   d. Patient centered approach to care.

   e. Ongoing education and training in areas of Quality Improvement and Patient Safety to support hospital initiatives with a focus on just in time training.

   f. Coordination and collaboration of activities with shared responsibility of employees for the proactive identification and pursuit of opportunities for improving quality of patient care and services, patient safety, customer service and appropriate utilization of resources.

   g. Respect for all employees and medical staff members for their knowledge and contributions to patient care and safety.

   h. Assessment, project prioritization and goal formation are data driven and benchmarks are utilized, when appropriate.

B. Plan Goals

1. Achieve patient outcomes of the highest quality and safety and provide services that meet or exceed the expectations of our customers.

2. Provide an efficient and effective mechanism for the evaluation, improvement and risk reduction of processes.

3. Promote interdisciplinary/interdepartmental teams to improve existing processes and outcomes and sustain a safe improved performance.

4. Support processes to meet regulatory, licensure and accreditation requirements.

C. Scope of Activity

The scope of the Plan for Excellence includes an ongoing assessment and improvement of current systems,
processes and outcomes, using internal and external knowledge and experience, to prevent error occurrence
and maintain/improve patient safety. This plan is applicable to every department throughout the facility.

1. Departments/services shall participate in activities that address quality, proactive risk reduction,
patient safety, customer service and appropriate utilization of resources. This participation includes but
is not limited to:

a. Patient care and associated functions and services
b. Patient/customer satisfaction
c. Efficient and effective use of resources and delivery of services
d. Personnel competency
e. Regulatory compliance, including but not limited to adverse event reporting
f. Activities designed to foster a culture for patient safety
g. Pro active patient safety and risk reduction initiatives
h. Review of unanticipated patient outcomes resulting in injury or significant potential for injury. (See Sentinel Event Policy S-110)
i. Organizational and/or departmental priorities

2. Teams

a. Interdisciplinary Quality Improvement Teams

• Scope – Quality Improvement (QI) Teams are formed according to the scope of the project.

(i) QI teams are used when the project or action to be taken involves a change and/or improvement in a single process crossing two or more services.

(ii) Reengineering teams are used when the project or action to be taken involves redesigning
and/or improving the many processes affecting a service or function.

(iii) Clinical Guideline teams are used when the project or action to be taken involves the management of a clinical diagnosis across the continuum of care.

c. Sanction authority

- Team may be sanctioned by
  - (i) Quality Improvement Patient Safety Committee
  - (ii) Patient Safety Steering Committee
  - (iii) Departmental Leadership
  - (iv) Hospital Leadership
  - (v) Medical Staff Leadership

d. Membership

- Team members are determined by team leader, facilitator and sanction authority.
  - (i) Team leader – assigned by sanction authority
  - (ii) Team members – employees at any level and representing every aspect of the process under review
  - (iii) Facilitator as needed

II. Responsibilities

A. Board of Trustees

1. The Hospital of Saint Raphael System Board of Trustees has the final authority and responsibility for ensuring the provision and effectiveness of safe, high quality patient care and the implementation of a collaborative, comprehensive and integrated plan to achieve excellence in patient care. In meeting this responsibility, the Quality Committee of the System Board recommends strategic direction for achieving excellence, receives reports and oversees the system quality and risk reduction activities. As appropriate, the System Board shall hold the Quality Committee of the Board, Hospital medical staff and leaders responsible for the implementation of improvement and risk reduction efforts and for ensuring the same standard of care for all patients.

2. Because the improvement processes and the resultant information including peer review activities and documentation of the same (as defined under CGS 19a-17b and confidential disclosures under 19a-25), the Board of Trustees and organized Medical Staff placed the quality improvement program and the Quality Improvement/Patient Safety Committee (including all subcommittees) under the Medical Staff structure

3. In conjunction with the organization's leadership, the Board of Trustees commits to the provision of programmatic and financial support for quality improvement initiatives, risk reduction priorities and implementation of recommendations.

B. Hospital Leadership

1. Hospital leadership is committed to providing resources and support systems, for the planning, directing, coordination, provision, evaluation and improvement of safe health care services, responsive to the needs of patients' and the community

2. Hospital leaders:

a. Set expectations, prioritize activities and oversee their implementation for achieving safety and excellence in patient care delivery consistent with Quality Improvement/Patient Safety Committee expectations and SRHS core strategies.
b. Create an environment where individuals from all disciplines and departments are an integral part of the collaborative improvement process, which is marked by effective communication and creative thinking.
c. Consider the results of quality improvement and risk reduction assessment in strategic planning.
d. Establish priorities for organization-wide activities by focusing on those opportunities for improvement with the greatest impact on patient care, patient/customer satisfaction, safety and efficient and effective resource utilization.

C. Medical Staff

The Medical Executive Committee (MEC) is responsible to ensure that a comprehensive program is in place to address opportunities to improve patient care and safety, to assess the effectiveness of implemented plans, and to maintain a commitment to evidence based medicine.

1. The MEC participates in:

   a. Establishing priorities for improving patient care and safety
   b. Holding physicians and staff accountable for results
   c. Clinical monitoring and evaluation of patient care by individuals with clinical privileges
   d. Collaborating and communicating with other disciplines in projects to improve the quality and safety of patient care
   f. Planning and evaluation of the effectiveness and efficiency of the plan for excellence in patient care considering evidence based data and findings Meeting at least 10 times per year, receiving reports from The Quality Improvement Patient Safety Committee on significant improvement/risk reduction efforts and organizational wide indicators.

D. Quality Improvement/Patient Safety Committee (QIPSC)

1. The Quality Improvement Patient Safety Committee consists of hospital leaders representing key
areas/services of the organization and is supported by the Quality Improvement Department.

2. Members are expected to participate in 70% of the meetings scheduled.

3. Members include:

- Voting Members
  - Vice President and Chief Operating Officer, Chair, QIPSC
  - President or president-elect of the Medical Staff
  - Vice President of Mission Services
  - Vice President of Human Resources
  - Vice President for Patient Services

- Vice President of Information Services
- Chair, Department of Medicine
- Chair, Department of Surgery
- Chair, Infection Control Committee
- Chair, Medical Records Committee
- Patient Safety Coordinator

• Two year renewal appointments

(i) A minimum of two Non Medical Staff members appointed by the Chief Executive Officer

(ii) A minimum of three Medical Staff members appointed by the President of the Medical Staff.

b. Non-Voting Members (ex-officio)
Shall have a standing invitation to all meetings and receive presentation packets

- President & Chief Executive Officer
- Director of Quality Improvement
- Chair, Board Quality Committee and/or designee
- Chair, Emergency Medicine

Permanent Guest Status

- VP General Counsel
- Chairman of Safety Committee
- Director, Nursing Staff Development & Clinical Support
- Quality Improvement Department Support Staff

4. The committee shall oversee and coordinate the quality assessment and clinical risk assessment/reduction and improvement activities within the organization. Functions include:

- Approve the Hospital's Plan for Excellence, and oversee the quality/patient safety program reporting schedule is established on an annual basis.

- Receive, review and using objective criteria, approve project proposals that outline organizational initiatives for quality and patient safety.

- Empower cross-functional teams, which advance the goals and priorities of the plan and support integration of activities related to quality improvement, risk reduction and patient safety. Identify a member of leadership to provide operational support and throughput for these teams.

- Assign responsibility and accountability for required follow up.

- Encourage development and availability of systems to facilitate the collection, management and analysis of aggregate data for quality improvement, safety and risk reduction.

- Oversee compliance with recommendations related to quality and patient safety requirements of regulatory and accrediting groups.

- Encourage education for key personnel on the principles, methods and techniques of quality improvement/risk reduction/patient safety. Responsibility is delegated as appropriate.

- Conduct an annual review of the effectiveness of the hospital's activities to assess and improve quality of care /risk reduction/patient safety and organizational quality initiatives.

- Identify organizational quality initiatives for upcoming year.

- Recommend to hospital leadership the resources necessary to carry out the hospital plan for excellence.

- Meet at least ten times per year with reports to Medical Executive Committee and Quality Committee of the Board of Trustees.

- Identify specific Committees/Sub committees, who will report to the QIPSC. This will include the collection and analysis of data with regard to quality improvement activities, risk reduction strategies and patient safety.

- m. Maintain confidentiality and support peer review activities pursuant to the Connecticut State Statutes.

- Oversee analysis of sentinel events and/or root cause analysis and/or Failure Mode Effects Analysis (FMEA) reports and ensure that appropriate risk reduction strategies are evaluated and implemented.

E. Hospital Divisions/Departments

1. Perform ongoing assessment and/or evaluation of opportunities for improvement and risk reduction, including regulatory compliance.

2. Conduct quality improvement and patient safety activities related to important aspects of care and/ or key processes. Participates as requested on organization Quality Improvement/Risk Reduction teams.

3. Submit reports to the Quality Improvement/Patient Safety Committee on an established scheduled, as required.

4. Submit a Scope of Service document which includes a Quality Improvement Appraisal and Plan for each area.

5. Seeks opportunities to address quality and patient safety initiatives using a collaborative multidisciplinary approach.

6. Obtain endorsement from Vice President(s) or Chair of Department(s) for all Quality Improvement/Patient Safety/Risk Reduction plans, appraisals and reports.

7. Track the status of identified problems or opportunities to assure improvement or resolution.

8. Sustain an environment that facilitates communication and continual improvement in intra- and interdepartmental patient care services.

F. Patient-Focused Committees

1. The QIPSC will receive reports from the following which will include externally mandated data/information and internal initiatives and trended data to identify and monitor success of projects:
Pharmacy and Therapeutics Committee/Drug Usage review
Transfusion Committee /Blood Usage Review
Infection Control Committee
Medical Record Committee
254 Committee
IV Procedural Sedation
Restraint/Seclusion Task Force via reports from Psychiatry, Nursing and the Emergency Department
Organizational Quality/Patient Safety Initiatives
Patient Safety Steering Committee (Addendum G)
Pain Management Task Force

III. QUALITY IMPROVEMENT PROCESS

A. The process adopted for the Hospital of Saint Raphael Quality Improvement/Patient Safety program is PDCA (Addendum C)

- **P – Plan** – Plan the improvement and continued data collection
- **D – Do** – Implement the improvement and measurement
- **C – Check** – Analyze the results to evaluate improvement
- **A – Act** – Act to hold the gain and stabilize the process

B. Annually the Hospital, via the Quality Improvement/Patient Safety Committee, sets priorities for organizational quality initiatives and risk reduction projects and identifies the implementation process.
One high-risk process for pro-active risk assessment will be selected annually.

- See Addendum D for Quality Improvement Organizational Initiative Proposal
- See Addendum E for Selection Criteria for QIPS Committee Review and Addendum F for Rank Order Process

C. Annually, hospital departments identify opportunities for improvement/risk reduction, develop goals and
determine the approach for measuring and improving processes of patient care and service.

D. Elements utilized in identifying initiatives:

-
- Problem prone processes/procedures
- Financial impact

- Organizational impact
- Sensitivity to emerging needs
- Relationship to mission and core strategies

EF. When the hospital or department assess the need for modification/redesign of existing functions,
processes, or designs new programs, consideration is given to:
• Needs and safety of all customers: patients, staff, visitors, medical staff, etc.
• The project's consistency with the hospital's mission, values and strategic goals
• Needs and expectations of key constituents (patients, staff, and others)
• Current accepted standards of care/evidence-based practice guidelines/best practices and known benchmarks
- Compatibility with sound business practices
• Incorporates external and internal information regarding safety and potential risks to patients.
• Dimensions of performance:

Efficacy
Continuity
Effectiveness
Appropriateness
Safety
Efficiency
Availability
Respect and Caring
Timeliness

F. Data collection and analysis will include external regulatory requirements and Hospital identified indicators.

G. The assessment process is systematic, interdisciplinary and/or interdepartmental, as appropriate.
Conclusions about need for more intensive measurement will be determined based on:

1. Adverse events (important single event)
2. Major pre/post-operative diagnosis discrepancies
3. Confirmed significant transfusion reactions
4. Significant drug events; ADR's; medication errors
5. Adverse events or patterns of adverse events associated with use of anesthesia
6. Patterns/trends (as determined by significant variance using data over time)
7. Variances (significant deviations from standards of care/expected outcomes/best practices, peer organizations)
8. Competency issues
9. Prioritized proactive issues for risk reduction
10. Root Cause Analysis in response to undesirable occurrences.
11. Potential staffing effectiveness issues
12. Pro active process review for improvement and risk reduction via FMEA
13. Ineffective or inappropriate behavioral management techniques
14. Feedback from patients regarding their perception of safety
15. Ineffective organ procurement

H. Data collected as part of the measurement process are converted to information through assessment and
analysis which can include:
1. Use of statistical tools and techniques as appropriate for assessing variation:
2. Flow Charts (identifying process)
3. Failure Mode Effects Analysis (barriers to success/critical variances)
4. Histograms (graphic summary of variation)
5. Pareto Diagrams (prioritize issues)
6. Run Charts (display summary and comparison data)
7. Aggregate data over time
8. Control Charts (variance and trend identification over time)
    a. Common cause
    b. Special cause

J. Comparison data can be utilized as benchmarks and can include:
1. Reference Data Bases
2. Evidence based Practice Guidelines
3. Relevant Literature/Best Practices
4. Ongoing Internal Process/Outcome Data

IV. **COMMUNICATION**
Vertical and Horizontal communication is critical and an essential component to an effective quality/patient
safety/risk reduction program. All employees are encouraged to share any and all information that will
perpetuate a culture of improvement and safety.

Author: Quality Improvement Department
Original document10/04

KEY PERFORMANCE INDICATORS

Addendum A

The Board of Trustees, management, leadership and clinical and support services believe that monitoring quality indicators is central to the quality improvement/risk reduction process. St. Raphael's leadership has identified a number of organization-wide performance indicators that will be monitored on an ongoing basis. These indicators focus on the key services and functions within the organization. St. Raphael's leadership appreciates that indicators are not direct measures of quality, but instead serves as flags that may suggest areas for potential analysis.

St. Raphael's leadership through the Quality Improvement /Patient Safety Committee, Medical Board, and Quality Committee of the board of Trustees monitor the organization-wide performance indicator data, which are coordinated through the Quality Improvement Department. In addition, these groups determine if the data reveal acceptable statistical means and variation and if the data display any statistically unusual patterns. If any unusual patterns are identified, further investigation is conducted to determine the cause and identify and implement improvements. Improvement efforts might also be initiated to improve the mean and /or amount of variation.

Once areas that require improvement are confirmed, an action plan is developed and implemented. A reassessment is completed to ensure the changes have been successful.

A. Board Indicator Report

a. Transfusion Reaction Rate: Total number of reported transfusion reactions as a percent of total transfusions.
b. Adverse Drug Reaction: Number of patients experiencing untoward event associated with administration of chemical or medicinal substance as a percent of discharges.
c. Needle Stick Injuries: Number of needle stick injuries per 100 occupied beds
d. Medication Variance as a Percent of Discharge
e. Unplanned Readmission Rate: Percent of discharged patients having unplanned readmissions within 30 days.
f. Incomplete Medical Records Rate: Inpatient records lacking required content 30 days after discharge as a percent of discharges
g. In patient Fall Rate: All patient fall per 1000 patient days
h. 3 Day Returns/Admits: Revisits to ED that are admitted within 72 hours of original visit.
i. ED Walk-outs: Patient leaving without being seen or against medical advice as percent of total ED visits.
j. Inpatient Satisfaction: Press Ganey Satisfaction Score for would probably or definitely recommend facility
k. Ambulatory Surgery Satisfaction Report: Press Ganey score for probably or definitely recommend facility.
l. Occupational Health and Illness Incident Rate: Number of injuries and illnesses x 200,000/total hours worked.
m. Continuity and Transition of Care: Percent positive score on quarterly Press Ganey survey relating to discharge for inpatient stay. Employee appraisal Completion Rate: Number of appraisals completed /total number appraisals due.
n. Central Line Associated Bloodstream Infections

B. Publicly reported measures.

1. Acute Myocardial Infarction Indicator
    a. Aspirin at arrival
    b. Aspirin prescribed at discharge
    c. ACEI/ARB for LVSD
    d. Adult smoking cessation advice/counseling
    e. Beta blocker prescribed at discharge
    f. Beta blocker at arrival
    g. Time to PTCA
    h. Inpatient Mortality
2. Pregnancy and Related Conditions Indicator
    a. Vaginal birth after cesarean section (VBAC)
    b. Inpatient neonatal mortality
    c. Third or fourth degree laceration
3. Heart Failure
    a. Left ventricular function assessment
    b. Detailed discharge instructions
    c. Angiotensin-coverting enzyme inhibitors for left ventricular systolic dysfunction
    d. Smoking-cessation advice/counseling

4. Community Acquired Pneumonia

    b. Pneumococcal Screening and Vaccination
    c. Antibiotic Timing
    d. Adult Smoking cessation advice/counseling
    e. Blood Culture Performed in ED prior to Initial Antibiotic Received
    f. Initial Antibiotic Selection in Immunocompetent patients
    g. Influenza vaccination

4. Surgical Care Improvement Project
    a. Proportion of patients who have their antibiotic dose initiated within 1 hour before surgical incision (2 hours for vancomycin or fluoroquinolones)b. Proportion of patients whose prophylactic antibiotics were discontinued within 24 hours of surgery end time (48 hours for cardiac surgery)
    c. Surgical patients who received prophylactic antibiotics consistent with current guidelines.
    d. Surgical Patients with recommended venous thromboembolism prophylaxis ordered during the admission
    e. Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgical incision time to 24 hours after surgery end time.

C. Patient Safety indicators.

Quality Improvement Model
Template

Methodology	Process Description	Planned Project
P **Plan the improvement**	• Review baseline data • Identify who is responsible for coordination • Identify change, goal or target for improvement • How will we know if an improvement occurs? (data to verify success) • Identify actions to be taken • How are we going to do it? (pilot) • Who needs to be involved? • Establish a time frame	
D **Do**	• Implement changes/action plan • Collect data on key indicators	
C **Check**	• Analyze data • Successful or unsuccessful?	
A **Act to hold the gain and continue to improve**	<u>If successful</u> • Build change(s) into process or system • If pilot, plan full scale implementation with PDCA • Change procedure/policies • Educate/train all involved with process • Monitor new process <u>If unsuccessful</u> • Repeat PDCA cycle • Discuss lessons learned	

ADDENDUM A-Definition of terms (Glossary)

Adverse Drug Event (ADE) - An injury, large or small, caused by the use of a drug. It can be as harmless as a drug rash or as serious as death from an overdose. There are two types of ADEs: those caused by errors and those that occur despite proper usage. If an ADE is caused by an error, it is by definition, preventable. Non preventable ADEs (injury but no error) are called adverse drug reactions (ADRs).

Adverse Event - An injury caused by medical treatment, not necessarily due to an error.

Error - An unintended act, or one that fails to achieve its intended outcome.

Failure Mode Effects Analysis (FMEA) - An analytic method that delineates the aspects of a system that has failed and the consequences of these. A fairly structured approach, it is used to understand the types of errors that are occurring in a system in order to remediate the system itself.

Human Factors - The determinants (elements) of a task or process that result from human capacity, including memory, skill, energy, and knowledge.

Medication Error - Any error, large or small, at any point in the medication system from the time the drug is ordered until the patient receives it. This differs from some prior definitions that considered only deviations from the physician's order as errors. Since nearly half of all errors occur in the prescribing stage, these may be included in the definition. A medication error may or may not result in an adverse drug event.

Near Miss - Any process or variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome

Potential Adverse Drug Event (PADE) - A potential ADE is a serious medication error; one that has the potential to cause an ADE, but did not, either by luck (for example, the patient was not allergic to the drug despite a note in the record stating so), or because it was intercepted (for example, the nurse recognized an order for a medication to which the patient is allergic and called the physician to get it changed). Examining ADEs helps identify where the system is failing (the error) and where it is working (the interception).

Process - series of related actions to achieve a defined outcome. Ordering medication or administering medication is processes, as is administering anesthesia.

Protocols - A set of rules governing a process or procedure. A protocol is usually the required procedure in a given circumstance, in contrast to a guideline, which is a recommendation.

System - An interdependent group of processes with a common purpose,

Systems Analysis - Analysis of errors to identify the underlying process failures; not just the components' performance, but also how all the parts of the system fit together, communicate, and function.

Task - A single defined activity such as preparing a medication for administration or setting up an infusion pump. Tasks may also be broken down into component parts, but usually only involve one person.

Hospital of Saint Raphael

Administrative Policies and Procedures

Administrative Policy: Q-20 Hospital of Saint Raphael Patient Safety Plan – FY2009

Reviewed: 11/2003, 10/2004, 9/2005. 12/2006, 10/2008, 4/2009

I. Introduction/Purpose:

The Hospital of Saint Raphael Patient Safety Plan was developed in conjunction with the hospital's **Plan for Excellence in Patient Care.** It is consistent with the organizational mission, values and strategic initiatives, and provides a framework for the following:

- Ensuring a safe patient environment throughout the hospital
- Providing accountability to hospital employees and associates for patient safety
- Incorporating patient safety initiatives into all patient-related care and services
- Integrating and communicating patient safety issues throughout the hospital

A. Scope of the Program and Activities

1. Participating sites, settings, and services

The scope of the patient safety program includes all grounds and facilities that are under the direct management and primary responsibility of the Hospital of Saint Raphael. The emphasis for safety will include all internal and external customers who access our facilities, and encompasses the patient population, visitors, volunteers, students, and staff (including medical staff). The program addresses maintenance and improvement in patient safety issues in every department throughout the facility. There will be an emphasis on important hospital and patient care functions.

The Hospital of Saint Raphael integrates the Patient Safety Program throughout the organization by using multiple educational avenues for patients and staff. Additionally, the hospital incorporates safety practices into patient guidelines and operational policies.

2. Scope of Program Activities relating to Patient Safety

The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, and maintain and improve patient safety. The focus of the program is on improving patient safety systems and processes and relies on a non punitive philosophy as it relates to human factors that may lead to errors. Patient safety variance information from individual patient safety variance reports and from aggregated data reports will be reviewed by the Patient Safety Steering Committee to prioritize organizational patient safety activities and initiatives. Types of patient safety variances or medical/health care errors included, but not limited to, in data analysis are:

a) No Harm or Low Potential for Patient Harm - those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, and that do not result in a physical or psychological negative outcome, or the potential for a negative outcome, for the patient. These could be considered near misses.

b) Patient Harm or Significant Potential for Patient Harm - (Mild-Moderate) those unintended acts, either of omission or commission, or acts that do not achieve their

intended outcome, that result (or have the potential to result) in an identified mild to moderate physical or psychological adverse outcome for the patient.

c) Hazardous Condition - any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome.

d) Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. See Policy S-110 which includes the sentinel event review process and information on The Joint Commission recommended reportable sentinel events.

e) Near Miss - any process variation which did not effect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

II. Structure and Responsibilities

A. Oversight/Management of the Program
The Board of Trustees and executive leadership delegate oversight responsibility for the patient safety program to the Chairman of the Patient Safety Steering Committee, a subcommittee of the Quality Improvement Patient Safety Committee. Reports are submitted to the Quality Improvement/Patient Safety Committee, and the Quality Committee of the Board of Trustees, twice a year or as needed to obtain support, direction or share success.

B. Components (safety-related offices, committees, functions)
Patient Safety Steering Committee or PSSC (Clinical) - Chair of Medicine, acting as Chairman, PSSC, with representation from Medical Staff, Nursing, Pharmacy, Risk Management, Quality Improvement and Information Service Representative

Patient Safety Coordinator - Quality Improvement

Patient Safety Workgroup - subgroups of the PSSC addressing programmatic and operational issues. (Eg. Fall Prevention, CPOE Variance committee, ADE Subcommittee, Medication Variance Review Team, Medication Reconciliation Steering Committee)

Safety Committee (Physical Plant/Employee Safety) - Director of Safety, Chairman

C. Patient Safety Steering Committee

1. Interdisciplinary Membership includes:
Chair of Medicine, acting as Chairman, PSSC
Director, Quality Improvement
Patient Safety Coordinator

Vice President, Patient Services
C.N.S., Department of Nursing
Risk Management Delegate(s)
Director/Assistant Director of Pharmacy
Information Services Representative
Pharmacy representatives as needed
Invited guests: Vice President and Chief Operation Officer

2. Responsibilities

a. Patient Safety Steering Committee members provide reports on a monthly and/or quarterly basis as appropriate.

b. The Patient Safety Workgroup, a subgroup of the Patient Safety Steering Committee, meets on an as needed basis on special projects.

c. Safety Plan and annual goals are reviewed and approved annually.

d. Annual training is conducted regarding patient safety program.

e. Regular reporting of Patient Safety Program activities as depicted in the flow chart of information below.

D. Patient Safety Steering Committee Flow of Information

Board of Trustees
↑
Medical Board
↑
Quality Improvement
Patient Safety
Committee (QIPSC)
↑
Patient Safety Steering
Committee (PSSC)
↑
Aggregate Data From:
• Clinical Variance Reports,
• State Reportable Events,
• Senior Leadership Rounds
↑
Identified Issues
Reported by
Staff/Others
(Concerns may be referred to PSSC for evaluation, prioritization and referral as appropriate.)

III. Activities & functions relating to patient safety

A. Systems for Internal and External Reporting of Safety Variances
All safety variances, including sentinel events, are identified through an anonymous, non-punitive Patient Safety Reporting System, and will be reported internally and externally, per hospital policy and through the channels established by this plan.

1. **As part of the internal reporting process**, hospital staff, medical staff and other members of the hospital community, are expected to report all safety variances including: medical errors, adverse events or sentinel events, near misses or any hazardous condition to Risk Management. These responsibilities are defined in administrative policy, **A Culture of Safety S-120**

   In addition, the details regarding how to report and respond to safety variances can be found in administrative policy, **Safety Variance Reporting A-10**

   Key aspects include:

   - Report all safety variances.
   - Mitigate harm through the provision of care consistent with level of professional responsibility.
   - Seek assistance from immediate manager as needed for assistance in the provision of care.
   - Inform immediate manager of unsafe conditions in need of immediate resolution.
   - Activate the Patient Safety Intervention Policy P-220

1. **As part of the external reporting process**, reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Details of the management of adverse events and sentinel events can be found in the following administrative policies: **Adverse Event Reporting: Statutory Regulations A-90, and the Sentinel Event Policy S-110.**

B. Response to Safety Variances: Responses to safety variances (actual and potential) are collaboratively investigated, analyzed and acted upon among one or several departments, including, but not limited to, Risk Management, Quality Improvement, Pharmacy, Medical Staff, and Nursing. Additional departments may be called upon to assist in the analysis and action plans related to the variances noted.

Mechanisms utilized to assist in this process include (but are not limited to):

1. **Process Flow Sheets** depict the responses to safety variances and the communication that occurs across the organization.

   a. **Safety Variance Process Flowsheet** - used for internal reporting purposes.

   b. **State AE Reporting Process Flow sheet** - for managing adverse events reported externally to the state.

   c. Root Cause Analysis

d. Failure mode effects analysis.

2. Prioritization
The system developed allows categorizing severity of events and responding in a prioritized fashion. Immediate responses to various types of events include RCA (Root Cause Analysis), in response to a sentinel event or a State Reportable event as identified by the Senior Management Review Team (SMRT)

Responses are based upon a prioritization scheme which classifies all events by a SAFE Score 0,1,2,3,4 (for internal reporting purposes), and by a State approved grid of reportable events for external reporting to the state, and also includes responses to near misses (no harm occurrences).

a. Internal Reporting
- **Sentinel Events and/or deaths – Scored as 3 or 4 – require immediate risk assessment/actions taken and are reported monthly to the PSSC.**
- **Patient Harm or significant Potential for Patient Harm – Scored as 2's – require immed investigation and are reported monthly to the PSSC.**
- **No Patient Harm or Low Potential for Patient Harm – Scored as 0 or 1's trended/aggregated**

b. External Reporting – State Adverse Event Reporting
- **Risk Management (RM) submits written reports of State Reportable Events to State within 1 week.**
- **All corrective actions plans for State Adverse Events are coordinated by QI staff and submitted to the state withn 30 days**

C. Prioritization of Improvement activities related to reported safety variances.
Safety improvemtnt projects and teams are prioritized based upon the SAFE Scores (i.e. 0, 1, 2, 3, 4)

D. Proactive risk reduction improvement activities
A proactive approach is used to identify and assess high-risk processes through collection and analysis of aggregate data, utilization of knowledge based information, evaluating information from Sentinel Event Alerts and through benchmarking and use of risk assessment tools.

Proactive risk assessments are conducted annually using Failure Mode, Effects, and Criticality Analysis Tool (FMEA). This tool uses a team approach to study specific procedures/processes to determine where problems might occur, and correct them before they happen.

E. Patient Safety Rounds:
1. Joint Commision Mock Surveys As part of continuous readiness, these are conducted by members of the Continuous Readiness Team and members of the Patient Safety Steering Committee. As part of these rounds, patient safety is addressed.
2. Senior Leadership Patient Safety Rounds. Monthly discussion between Senior Leaders and staff about patient safety concerns.

The information aggregated from these rounds will be shared in Patient Safety Steering Committee and Continuous Readiness Committee. The goal is to promote communication between the front-line clinical staff, unit managers, and senior management regarding opportunities to prevent accidental patient injury. The telling of anecdotal stories of "near misses" is encouraged as a means to proactively address patient safety concerns.

F. Measuring the Culture of Safety
The culture of safety is measured on a regular basis using valid and reliable tools.

G. Communicating with patients about safety
Patient education, related to safety as a priority for the hospital and the vision of the Hospital of Saint Raphael, begins when the patient arrives at the hospital. Patients are provided with information ingluding:

1) **A Guide to Patient Services** booklet provided upon admission **contains** Patient Rights and Responsibilities and encourages patients to speak up and participate in their own safe care .

2) Feedback during **Patient Safety Rounds and Senior Leadership Rounds**

G. Informing patients about their care

An administrative policy of the hospital has been established, **Disclosure of Outcomes,** to provide the patient and their family with information related to clinical care outcomes (see **Disclosure of Outcomes of Care** policy **D: 170**). The hospital will take all reasonable steps to insure that patients and, when appropriate, their families, guardian or representatives are informed about all outcomes of care (anticipated and unanticipated), including sentinel events (Joint Commission reportable and non-reportable) that would impact future health care decisions. The patient's attending physician(s) and hospital leadership should communicate, as needed, to decide the appropriate content, manner, style and timing for informing the patient, and when indicated, the patient's family, about an unanticipated outcome.

H. Staff Education-Safety-related orientation & training

Staff receives safety education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety, including the need and method to report medical/health care errors. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, staff is encouraged to collaborate in the provision of an interdisciplinary approach to patient care and safety.

Desktop screensavers are used to communicate safety concerns and initiatives.

I. Patient/family perceptions of, Staff perceptions of, and suggestions for improving patient safety; staff willingness to report errors.

The Patient Safety Program includes a periodic survey of patients, their families, volunteers and staff (including medical staff). Opinions, needs and perceptions of risks to patients and suggestions for improving patient safety are included in the survey. Patient Satisfaction Survey and Staff perceptions of risks to patient's safety and their willingness to report medical/health care errors are conducted annually.

J. Routine safety-related data collection, analysis, and reporting

A. Safety Variance (Medication and Non-medication related)

Safety Variance Reports are submitted to the PSSC and to QIPSC.

Medication Variance Reports are submitted to P&T, the ADE subgroup, the PSSC, and QIPSC.

B. Facility safety surveillance
Environment of Care/Facility surveillance is reported to the Safety Committee, PSSC, and to the QIPSC.

C. The Joint Commission (TJC) National Patient Safety Goals and Sentinel Event Alerts
The Patient Safety Program includes implementation of the recommendations set forth by The Joint Commission, or identified alternative recommendations defined by this institution, to achieve compliance with TJC established National Patient Safety Goals (NPSG). The Patient Safety Coordinator will coordinate and facilitate the response to these goals, and bring them to the Patient Safety Steering Committee for assignment of responsibility, prior to going to the QIPSC. The selected recommendations will be monitored on a routine basis to evaluate the organization's effectiveness in the implementation of the recommendations in achieving compliance with the identified National Patient Safety Goals.

The Patient Safety Coordinator/designee will also coordinate the distribution, and facilitate the response to Sentinel Event Alerts, and bring the alerts to the Patient Safety Steering Committee for review prior to going to QIPSC.

D. Reporting of results of the Patient Safety Program
1. To all departments

- Risk Management submits trend reports to all departments and nursing units on a monthly basis.

2. To executive leadership and the governing body

- The results of the patient safety program are submitted by the PSSC to the QIPSC biannually, which exists as the oversight committee for the Patient Safety Steering Committee. All data reports and/or meeting minutes (as appropriate) will be forwarded to the QIPSC with all information submitted held under the auspices of the QIPSC.

- Annually in conjunction with the QIPSC, identified patient safety issues are all

reviewed for potential inclusion into sanctioned Quality Organizational Initiatives

- The above patient safety reports are also submitted biannually to the Governing \Body, and include actions taken to improve patient safety, both in response to actual occurrences and proactively.

ADDENDUM A-Definition of terms (Glossary)

Adverse Drug Event (ADE) - An injury, large or small, caused by the use of a drug. It can be as harmless as a drug rash or as serious as death from an overdose. There are two types of ADEs: those caused by errors and those that occur despite proper usage. If an ADE is caused by an error, it is by definition, preventable. Non preventable ADEs (injury but no error) are called adverse drug reactions (ADRs).

Adverse Event - An injury caused by medical treatment, not necessarily due to an error.

Error - An unintended act, or one that fails to achieve its intended outcome.

Failure Mode Effects Analysis (FMEA) - An analytic method that delineates the aspects of a system that has failed and the consequences of these. A fairly structured approach, it is used to understand the types of errors that are occurring in a system in order to remediate the system itself.

Human Factors - The determinants (elements) of a task or process that result from human capacity, including memory, skill, energy, and knowledge.

Medication Error - Any error, large or small, at any point in the medication system from the time the drug is ordered until the patient receives it. This differs from some prior definitions that considered only deviations from the physician's order as errors. Since nearly half of all errors occur in the prescribing stage, these may be included in the definition. A medication error may or may not result in an adverse drug event.

Near Miss - Any process or variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome

Potential Adverse Drug Event (PADE) - A potential ADE is a serious medication error; one that has the potential to cause an ADE, but did not, either by luck (for example, the patient was not allergic to the drug despite a note in the record stating so), or because it was intercepted (for example, the nurse recognized an order for a medication to which the patient is allergic and called the physician to get it changed). Examining ADEs helps identify where the system is failing (the error) and where it is working (the interception).

Process - series of related actions to achieve a defined outcome. Ordering medication or administering medication is processes, as is administering anesthesia.

Protocols - A set of rules governing a process or procedure. A protocol is usually the required procedure in a given circumstance, in contrast to a guideline, which is a recommendation.

System - An interdependent group of processes with a common purpose,

Systems Analysis - Analysis of errors to identify the underlying process failures; not just the components' performance, but also how all the parts of the system fit together, communicate, and function.

Task - A single defined activity such as preparing a medication for administration or setting up an infusion pump. Tasks may also be broken down into component parts, but usually only involve one person.

Reference: Institute of Healthcare Improvement: National Congress of Reducing ADEs, 1998

Other discussed policies:

A Culture of Safety S 120 Administrative Policy Manual

Adverse Event Reporting Statutory Regulations A 90 Administrative Policy Manual

Disclosure of Outcomes of Care.D 170 Administrative Policy Manual

Safety Variance Reporting A 10 Administrative Policy Manual

Sentinel Event Review Process S 110 Administrative Policy Manual

Patient Safety Intervention P-220 Administrative Policy Manual

Attachment IV

HSR's Quality Documents

Quality Improvement and Patient Safety Committee
October 2008 –September 2009
Annual Summary

The Quality Improvement Patient Safety Committee (QIPSC) maintains its commitment to support hospital personnel, medical staff and multidisciplinary teams in their efforts to achieve quality and efficiency in practice and outcomes. QIPSC is supported by the Quality Improvement Department.

Committee Membership FY 2009

Voting Members

Charles Hollander, M.D.	Benedict Fernando, MD	Edward Maloney
James McVeety, M.D.	Scott Helton, M.D.	Elizabeth Conrad
Alan Kliger, M.D.	John Boyce, M.D.	Steve Angelo, M.D.
Joseph Balsamo, M.D.	Sr. Joan Granville	Mary Kuncas, RN
Gary Bloomgarden, M.D.	Ellen Macone, RN	Ronald Thomas, MD
Susan Lipka	Caren Genovese	

Non-Voting Members

David Benfer CEO	Richard Fitzpatrick

Permanent Guests

Janeanne Lubin-Szafranski	Judy Catalano

Support Staff

Susan Carter	Jacqueline Richo	Ellen Macone
Jim Judson	Anna Horne	Deanna Juhasz
Natalie Vinhais-Luysterboroughs		

Activities

- Reviewed and responded to 52 departmental reports on QI/process improvement initiatives. Thirty-six were pulled from the Consent Agenda for further discussion. Focus of the agenda and submitted reports pulled from the agenda included, but was not limited to:
  - Improving levels of patient satisfaction
    - Review of Press-Ganey Patient Satisfaction Scores
    - Public reporting of HCAPS
  - Decreasing central line associated bacteremias. (Strategic Planning Initiative)
    - Implementation of Central Line Bundle
    - Implementation of CUSP program (Comprehensive Unit-based Safety Program) to facilitate implementation of Central Line Bundle.
  - Improving Patient Flow (Strategic Planning Initiative)
    - Improving peri-operative/postoperative episodes of hypothermia
    - Improving Patient Flow in the Emergency Department
    - Decreasing number of patients who Left the Emergency Department

without Being Seen
  - Decreasing Door to Balloon time for the patient who has an ST elevated MI
  - Decreasing ED LOS
  - Decreasing ED LOS for patients who have primary behavioral health needs
  - Improving Department of Pathology (Lab) Turnaround times for Emergency Department Patients.

- Assuring Patient Safety (Operational initiative)
  - Preventing Patient Falls with Injury
  - Preventing hospital acquired pressure ulcers
  - Pain Assessment/Reassessment documentation
  - Housewide implementation of CIWA protocol
  - Medical screening of all outpatient behavioral health patients who are on atypical antipsychotics
  - Decreasing Restraint use
  - Developing policies and procedures related to the use of patient own C-pap/bipap machines
  - Purchasing and initiating of the National Surgical Quality Improvement Project (which will assist us in the review of patient outcomes from admission to 30 days post-operative)
  - Implementing Senior Leadership Safety Rounds
  - Performing a Root Cause Analysis related mislabeled laboratory specimens
  - Analyzing the Agency for Health Care Research's survey related to the culture of safety at the Hospital of Saint Raphael.
  - Monitoring Orthopedic surgical infection rates
  - Developing safe practices related to the use of anticoagulation medications.
  - Assuring safe practices associated with medications that require titration.
  - Developing of a patient safety report card

- Improving levels of compliance with publicly reported measures.

- Provided oversight to the voluntary consent agreements between the Hospital of St. Raphael and the Department of Public Health.

- Continued to address updates as it relates to regulatory compliance and develop mechanisms of implementation.

2010 Quality initiatives and goals:

The following have been identified as new hospital wide Quality Initiatives for 2010.

- Decrease central line associated Bacteremia rates from 2.0 infections per 1000 catheters days to 1.5 infection per 1000 catheter days (Board approved indicator)
- Improve compliance of timely administration of pre-operative antibiotics to a rate of 97% compliance. (Board approved indicator)
- Improve Door to Balloon time for patients who present with ST elevated myocardial infarction to less than 110 minutes (with a stretch goal of less than 90 minutes) (Board approved indicator)
- Decrease orthopedic surgical infection rates
- Decrease readmission rates of patients with a primary diagnosis of congestive heart failure.
- Assure each clinical section has at least one quality improvement initiative related to enhanced patient care by implementing evidence based practices
- Use of quality data to assist in decision-making related to practitioner's reappointment

The following initiatives have been carried over from FY 2009

- Improvement of Patient Satisfaction Scores ("Likelihood to recommend")
- Improvement in processes related to Patient Safety indicators (Patient Fall Prevention, Decreasing medication errors, CIWA protocol implementation)
- Improvement in scores related to publicly reported measures.

Of note, as of October 1, 2009 the following changes have been made to the Committee Membership.

Dr. Alan Kliger, Vice President/Chief Medical Officer/Chief Quality Officer will be the chairperson of the Quality Improvement/Patient Safety Committee replacing Dr. Charles Hollander.

Chris O'Connor as Chief Executive Officer and President replaces David Benfer.

Respectfully Submitted

_____

Jim Judson, RN, CPHQ
Facilitator, Quality Improvement/Patient Safety Committee

Quality Improvement and Patient Safety Committee
October 2009 –September 2010
Annual Summary

The Quality Improvement Patient Safety Committee (QIPSC) maintains its commitment to support hospital personnel, medical staff and multidisciplinary teams in their efforts to achieve quality and efficiency in practice and outcomes. QIPSC is supported by the Quality Improvement Department.

Committee Membership FY 2009

Voting Members

Alan Kliger, M.D.	Benedict Fernando, MD	Edward Maloney
James McVeety, M.D.	Scott Helton, M.D.	Elizabeth Conrad
John Boyce, M.D.	Steve Angelo, M.D.	Joseph Balsamo, M.D.
Sr. Joan Granville	Mary Kuncas, RN	R. Thomas, M.D. (resigned March 2010)
Gary Bloomgarden, M.D.	Ellen Macone, RN	
Susan Lipka	Caren Genovese	

Non-Voting Members

Christopher O'Connor CEO Richard Fitzpatrick

Permanent Guests

Janeanne Lubin-Szafranski Judy Catalano

Support Staff

Susan Carter	Jacqueline Richo	Ellen Macone
Jim Judson	Anna Horne	Deanna Juhasz
Natalie Vinhais-Luysterboroughs		

Activities

- Reviewed and responded to 52 departmental reports on QI/process improvement initiatives. Thirty-six were pulled from the Consent Agenda for further discussion. Focus of the agenda and submitted reports pulled from the agenda included, but was not limited to:
  - Improving levels of patient satisfaction
    - Review of Press-Ganey Patient Satisfaction Scores
    - Public reporting of HCAPS
  - Decreasing central line associated bacteremias. (Strategic Planning Initiative)
    - Implementation of Central Line Bundle
    - Implementation of CUSP program (Comprehensive Unit-based Safety Program) to facilitate implementation of Central Line Bundle.
  - Improving Patient Flow (Strategic Planning Initiative)
    - Improving peri-operative/postoperative episodes of hypothermia
    - Improving Patient Flow in the Emergency Department

  - Decreasing number of patients who Left the Emergency Department without Being Seen
  - Decreasing Door to Balloon time for the patient who has an ST elevated MI
  - Decreasing ED LOS
  - Decreasing ED LOS for patients who have primary behavioral health needs
  - Improving Department of Pathology (Lab) Turnaround times for Emergency Department Patients.

- Assuring Patient Safety (Operational initiative)
  - Preventing Patient Falls with Injury
  - Preventing hospital acquired pressure ulcers
  - Pain Assessment/Reassessment documentation
  - Housewide implementation of CIWA protocol
  - Medical screening of all outpatient behavioral health patients who are on atypical antipsychotics
  - Decreasing Restraint use
  - Developing policies and procedures related to the use of patient own C-pap/bipap machines
  - Purchasing and initiating of the National Surgical Quality Improvement Project (which will assist us in the review of patient outcomes from admission to 30 days post-operative)
  - Implementing Senior Leadership Safety Rounds
  - Performing a Root Cause Analysis related mislabeled laboratory specimens
  - Analyzing the Agency for Health Care Research's survey related to the culture of safety at the Hospital of Saint Raphael.
  - Monitoring Orthopedic surgical infection rates
  - Developing safe practices related to the use of anticoagulation medications.
  - Assuring safe practices associated with medications that require titration.
  - Developing of a patient safety report card

- Improving levels of compliance with publicly reported measures.

- Provided oversight to the voluntary consent agreements between the Hospital of St. Raphael and the Department of Public Health.

- Continued to address updates as it relates to regulatory compliance and develop mechanisms of implementation.

2010 Quality initiatives and goals:

The following have been identified as new hospital wide Quality Initiatives for 2010.

- Decrease central line associated Bacteremia rates from 2.0 infections per 1000 catheters days to 1.5 infection per 1000 catheter days (Board approved indicator)
- Improve compliance of timely administration of pre-operative antibiotics to a rate of 97% compliance. (Board approved indicator)
- Improve Door to Balloon time for patients who present with ST elevated myocardial infarction to less than 110 minutes (with a stretch goal of less than 90 minutes) (Board approved indicator)
- Decrease orthopedic surgical infection rates
- Decrease readmission rates of patients with a primary diagnosis of congestive heart failure.
- Assure each clinical section has at least one quality improvement initiative related to enhanced patient care by implementing evidence based practices
- Use of quality data to assist in decision-making related to practitioner's reappointment

The following initiatives have been carried over from FY 2009

- Improvement of Patient Satisfaction Scores ("Likelihood to recommend")
- Improvement in processes related to Patient Safety indicators (Patient Fall Prevention, Decreasing medication errors, CIWA protocol implementation)
- Improvement in scores related to publicly reported measures.

Of note, as of October 1, 2009 the following changes have been made to the Committee Membership.

Dr. Alan Kliger, Vice President/Chief Medical Officer/Chief Quality Officer will be the chairperson of the Quality Improvement/Patient Safety Committee replacing Dr. Charles Hollander.

Chris O'Connor as Chief Executive Officer and President replaces David Benfer.

Respectfully Submitted

_____

Jim Judson, RN, CPHQ
Facilitator, Quality Improvement/Patient Safety Committee

Quality Improvement and Patient Safety Committee
January 2011 to December 2011
Annual Summary

The Quality Improvement Patient Safety Committee (QIPSC) maintains its commitment to support hospital personnel, medical staff and multidisciplinary teams in their efforts to achieve quality and efficiency in practice and outcomes. QIPSC is chaired by the Vice President, Chief Medical Officer/Chief Quality Officer and is supported by the Quality Improvement Department.

Committee Membership FY 2011

Voting Members

Alan Kliger, M.D.	Ralph DeNatale, MD	L. Pietrosimone
James McVeety, M.D.	G. Kaml, M.D.	Elizabeth Conrad
John Boyce, M.D.	S. Angelo, M.D.	J Balsamo, M.D.
Sr. Joan Granville	Mary Kuncas, RN	R. Braun, M.D.
Chris McLaughlin, MD	Kathleen Quinn	L. Magras, M.D.
Howard Shaw, M.D	Anne Froelich, RN	T. Donohue, MD
H. Birmingham, M.D.	P. Thomas, M.D.	Susan Lipka
Gary Bloomgarden, M.D.	Ellen Macone, RN	Caren Genovese

Non-Voting Members

Christopher O'Connor CEO

Richard Fitzpatrick

Permanent Guests

Janeanne Lubin-Szafranski

Support Staff

Susan Carter	Jacqueline Richo	Ellen Macone
Jim Judson	Anna Horne	Deanna Juhasz
Natalie Vinhais	Jolie Boran	Alison Gaffney
Linda Elgart		

Activities: The following provides a synopsis of the activities within the Quality Improvement Patient Safety Committee for calendar year 2011.

- Reviewed and responded to 49 departmental reports on QI/process improvement initiatives. Forty reports were pulled from the Consent Agenda for further discussion. Focus of the agenda and submitted reports pulled from the agenda included, but was not limited to:
    - The development of the Quality Indicator Dashboard 2011: This document (attached) tracked quality indicators selected by the Board of Trustees and the Quality Improvement Patient Safety Committee.

- Adverse event reporting
  - In calendar year 2011, 20 adverse events were reported to the Department of Public Health. Corrective action plans were also developed in response to each event. The events reported are as follows:
    - 10 patient falls resulting in major injury
    - 3 retained foreign bodies following invasive procedure
    - 3 incidental organ perforations during invasive procedure
    - 2 wrong sided procedures
    - 1 hospital acquired pressure ulcer stage 3
    - 1 surgical injury leading to serious disability

- Department of Health/Center for Medicare/Medicaid Surveys findings and action plans.

- Improving Patient throughput
  - Emergency Department turnaround times related to radiological and laboratory testing
  - Length of Stay in the Emergency Department
  - Discharge planning processes
  - Progression of Care Rounds
  - Implementation of Critical Value Reporting System (Veriphy)

- Infection control
  - Hand Hygiene compliance
  - Central line infection rates
  - Joint Replacement Infection rates

- Cardiology
  - Reducing CHF readmission rates
  - "Door to Balloon" timeliness

- Surgery
  - Participation in the National Surgical Quality Improvement Program
  - Quality Indicators related Bariatric Surgery
  - Quality Indicators related to the Woman's Breast Center of Excellence (as defined by the National Accreditation Program for Breast Centers)
  - Quality Indicators from the Vascular Quality Initiative
  - Quality Indicators related to the Society For Thoracic Surgery (STS)
  - The quest to achieve certification from Joint Commission related to Spinal Surgery. Survey anticipated in 2012.
  - Orthopedic surgery proposed dashboard.

- Patient Safety
  - Critical Value Reporting and implementation of Veriphy (an electronic critical value notification system)
  - Patient fall prevention
  - Implementation of Institute of Healthcare's "trigger tool" to define a "rate of patient harm".
  - Rapid Response Team activities
  - Implementation of the Sepsis Bundle
  - Presentation of 4 root cause analyses related to adverse events
  - Medication reconciliation

- Inpatient Psychiatry Behavioral variances (Elopements and behaviors injurious to self or others)
- Medication errors
- Development of Patient Safety Report Card
- Plan to conduct AHRQ "Culture of Safety Survey" in 2012

- Selection of Quality Indicators for 2012 (see attached)
  - Board Indicators
    - CHF Readmission Rate
    - Timely administration of t-PA to ischemic stroke patients
    - Orthopedic infection rate
    - Compliance with Sepsis bundle related to early recognition and treatment of the patient with Severe Sepsis
      - Lactic acid within 4 hours of admission
      - Initial IV fluid bolus within the first two hours of admission (20cc/kg)
      - Blood Cultures before antibiotics administered
      - Antibiotics given within 3 hours of admission to the Emergency Department
  - Previous Board Focused Indicators
    - Average Door to Balloon time for patients who present with an ST Elevated MI
    - Central line bacterial sepsis rate
    - Timeliness of CT scan for the stroke patient
  - Recently added Quality Indicators for 2012
    - Pneumonia readmission rates (within 30 days)
    - "Rate of patient harm" (IHI Global Trigger tool)
  - Quality Indicators to be maintained for FY 2012.
    - Employee appraisal completion rate
    - Employee injury rate
    - Medical Record Delinquency Rate
    - Inpatient fall rate
    - Inpatient fall rate with injury
    - Hand Hygiene compliance
    - Hospital acquired pressure ulcer prevalence
    - Restraint usage
    - ED "left without being seen rate"
    - ED rate of three day returns requiring in-patient admission

HOSPITAL OF SAINT RAPHAEL
QUALITY INDICATORS
FY 2011

Quality Indicator	Current Performance						Threshold	Target	Maximum
Board Focused Indicators	FY 2010	QTR 1 2011	QTR 2, 2011	QTR 3, 2011	QTR 4 2011	FY 2011			
% of patients Door to CT read equal to or less than 45 minutes (Stroke Patients)	33%	50%	59%	76%	85%	70%	65%	80%	95%
Orthopedic infection rate: (Quarterly) (Hip: Risk Level 0)	1.4	0 (0/60)	2.27% (1/44)	2.32 (1/43)	0 (0/62)	0.96% (2/209)	0.83	0.75	0.67
Orthopedic infection rate: (YTD) (Hip: Risk Level 0)	1.4	0 (0/60)	0.96 (1/104)	1.35% (2/148)	0.96% (2/209)	0.96% (2/209)	0.83	0.75	0.67
Central Line Bacterial Sepsis Rate	2.19	2.2	0	0	0.54	0.60	2.0	1.5	0.1
Patient Satisfaction									
Press Ganey: "Would you recommend "...In patient units.	72	71	74	69	72	71.5	74	77	80
Press Ganey: "Would you recommend" ...ED	61	66.7	62.6	57.3	62.8	62.35	62	63	64
Press Ganey: "Would you recommend": ....Ambulatory Surgery	78	79.1	81.3	82.7	81	81	83	84	85
Overall pain scores for in patient care units. (HCAPS)	66	70	70	70	72	70.5	70	71	72
Human Resource Indicators									
Employee appraisal Completion rate	92.3	93	94.7	92.6%	93%	93.5%	94	95	96
Employee injury rate (The incident rate = total number of osha recordable incidents X (times) 200,000 (divided by) total hours worked)	8.77	8.84	9.22	7.51	8.09	8.42	9.25	8.79	8.20
Medical Staff Indicator									
Medical Record delinquency rate*	20%	<1%	1.24%	1.35%	0.97	1.18%	20%	15%	5%
Patient Care Indicators									
In-patient fall rate	3.1	2.7	3.26	2.79	3.22	3.0	2.8	2.6	2.5
In-patient fall rate with injury	1.06	1.07	1.09	0.84	0.66	0.92	0.95	0.9	0.85
Pressure ulcer prevalence (Facility Acquired)	5.4 *(4th qtr)*	3.18	4.3	4.6	3.9	4.0	4.7 *(2011 Natl . bnchmk)*	3.8	2.8
Restraint episodes per 1000 patient days (Non behavioral health units)	51.99	63.38	52.65	51.41	38.66	51.9	49.4	46.8	44.2
Restraint episodes per 1000 patient visits(Emergency Department)	3.64	5.0	4.7	4.62			3.46	3.3	3.1
Restraint episodes per 1000 patient days (Behavioral Health units)	22.87	30.15	12.65	8.35	13.14	16.85	21.73	20.6	19.4
CHF readmission rate: all payers/all causes within 30 days of discharge	28.4%	21.2%	31.4%				26.8	25.6%	24.14%

HOSPITAL OF SAINT RAPHAEL
QUALITY INDICATORS
FY 2011

Quality Indicator	Current Performance						Threshold	Target	Maximum
Emergency Department Indicators	FY 2010	QTR 1	QTR 2, 2011	QTR 3 2011	QTR 4, 2011	FY 11			
ED: Three day returns requiring in-patient admission	0.8	0.69	0.77	0.70	0.65%	0.7	1%	0.9%	0.8%
ED walk out (LWBS)	2.2	2.2	2.1	2.4%	3.5%	2.6	2.5%	2.0%	1.8%
Infection Control Indicator									
Hand Hygiene compliance: Overall	70%	79.1% (63.3/94.9)	27.9%** (9.8%/55.1%)	40.6***			75%	80%	85%
Core Measure Indicators	All core measure data is from 3rd QTR 2010						Goal is established from CT Hospitals		Maximum rate is based on Top Hospital Data
Myocardial Infarction	**Qtr 4, 10**	**Qtr 1, 11**	**QTR 2, 11**	**QTR 3 11**					
ASA at arrival	100%	95.2%	100	98%			98%	99%	100%
ASA at discharge	100%	97.2%	100	100%			97%	98%	100%
ACEI or ARB for LVSD	100%	87.5%	100	100%			90%	95%	100%
Adult Smoking Advice. Counseling	100%	100%	100	100%			98%	99%	100%
Beta Blocker at Discharge	97.1%	100%	97.7	100%			98%	99%	100%
PCI received within 90 minutes of hospital arrival (VBP)	85.7%	80%	100	75%			85%	92%	100%
Congestive Heart Failure									
Discharge Instructions (VBP)	96.2%	96.7%	94.3	100%			82%	91%	100%
LVF assessment	100%	100%	98.8	100%			97%	99%	100%
ACEI or ARB for LVSD	91.7%	95.7%	94.7	94%			91%	95%	100%
Adult smoking cessation or counseling	100%	100%	100	100%			95%	98%	100%

(VBP: VALUE BASED PURCHASING INDICATOR) **BASE 'JNE ***AUDIT BEING DONE BY TRAINED OBSERVER USING WHO CRITERIA.

HOSPITAL OF SAINT RAPHAEL
QUALITY INDICATORS
FY 2011

Quality Indicator	QTR 4 2010	QTR 1 2011	QTR 2, 2011	QTR 3, 2011	QTR 4, 2011	Threshold	Target	Maximum
Community Acquired Pneumonia								
Pneumococcal Screening/Vaccination	91.8%	91.7%	95.1%	91%		91%	95%	100%
Blood Culture Prior to Antibiotic (VBP)	91.3%	95.9%	93.9%	100%		94%	97%	100%
Adults smoking cessation	100%	100%	100%	100%		95%	97%	100%
Antibiotic timing	87.7	91.5%	96.2%	98%		93%	97%	100%
Initial antibiotic selection for CAP Immuno-competent patients (VBP)	87.5%	94.3%	77.8%	75%		92%	95%	99%
Influenza vaccine	Not collected	87%	88.6%	NC		88%	94%	100%
SCIP Infection Prevention								
Timely administration of antibiotics (VBP)	97%	99%	98%	99%		96%	98%	100%
Appropriate selection of antibiotics (VBP)	93%	97%	95%	96%		98%	99%	100%
Discontinuation of antibiotics within 24 hours (48 hrs post cardiac surgery) (VBP)	95%	97%	93%	97%		94%	97%	99%
Cardiac surgery patients with controlled 6 am glucose (VBP)	82%	90%	79%	94%		94%	97%	99%
Appropriate hair removal	99%	98%	98%	99%		99%	99.5%	100%
Urinary Catheter Removed on POD1 or POD2*	92%	94%	91%	90%				
Perioperative Temperature Management*	99%	96%	99%	100%				
Surgery patients on beta blocker during the perioperative period (VBP)	96%	83%	84%	93%		93%	96%	100%
Surgery patients with recommended VTE prophylaxis ordered during admission(VBP)	94%	100%	100%	100%		95%	97%	100%
Surgery patients who receive appropriate VTE prophylaxis within 24 hours prior to surgical incision to 24 hours after surgery end time. (VBP)	94%	100%	100%	100%		94%	97%	100%
Timing of Antibiotic for surgical outpatients	90%	90%	83%	95%		90%	95%	100%
Appropriate selection of antibiotics for surgical outpatients	96%	84%	77%	81%		93%	97%	100%

(VBP: VALUE BASED PURCHASING INDICATOR)

Hospital of Saint Raphael
Board Quality Indicator Report
FY 03 - 09

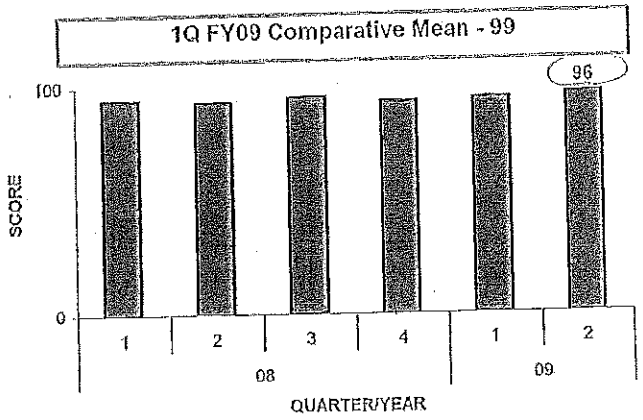
Date: July 2009

1. Inpatient Satisfaction

Definition: HCAHPS question would probably or definitely recommend hospital

Comparison: Press Ganey Custom Peer Group mean

Comment: Rate below comparative mean (unfavorable).

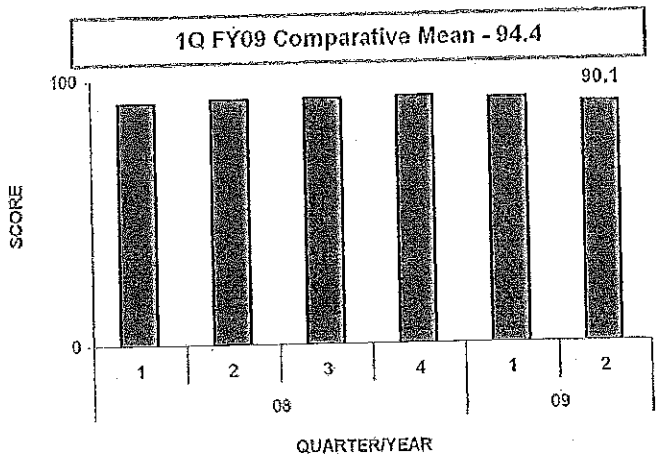


2. Ambulatory Surgery Satisfaction

Definition: Press-Ganey question likelihood of recommending facility

Comparison: Press Ganey Custom Peer Group mean

Comment: Rate below comparative mean (unfavorable).

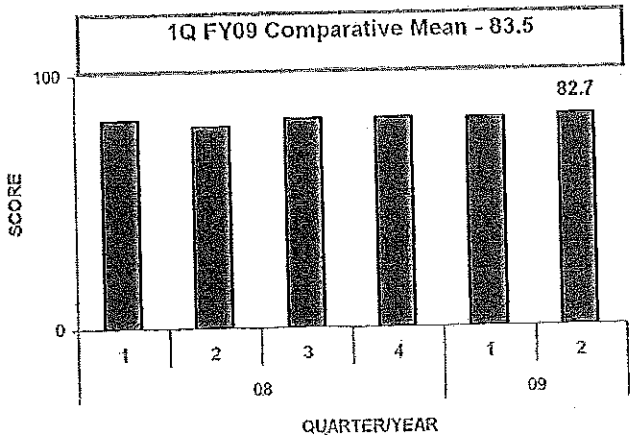


3. Continuity and Transition of Care

Definition: Percent positive score on quarterly Press Ganey survey relating to discharge for inpatient stay.

Comparison: Press Ganey Custom peer group mean

Comment: Rate below comparative mean (unfavorable).



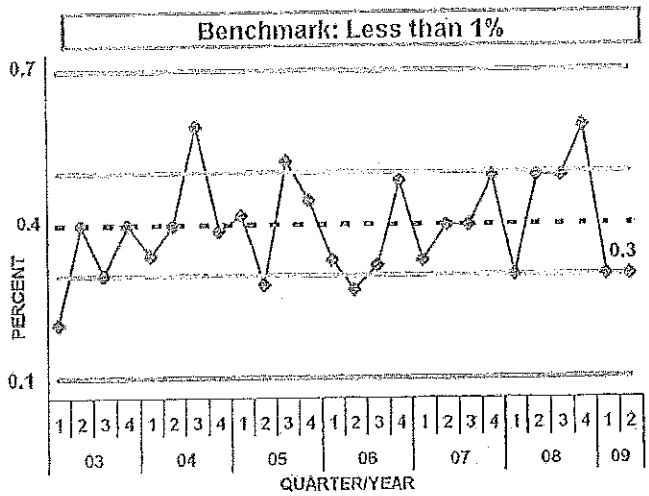
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

4. Transfusion Reaction Rate

Definition: Total number of reported transfusion reactions as a percent of total transfusions.

Comparison Group: Less than 1%
(American Association of Blood Banks)

Comment: Rate stable this quarter and is below benchmark. (favorable)

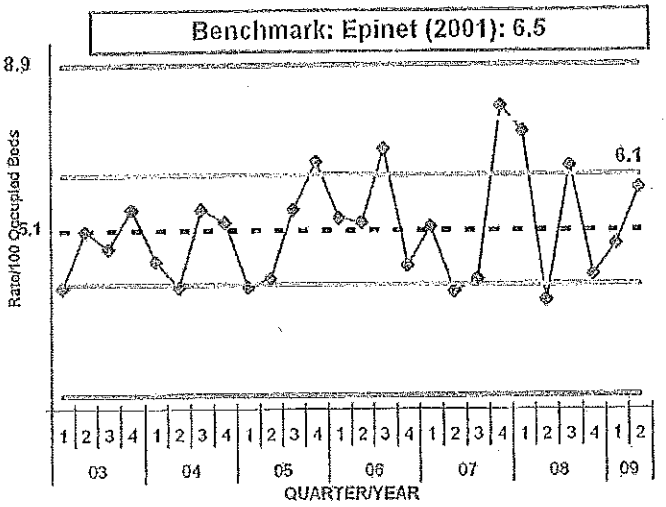


5. Needlestick Injuries
Definition: # of needlestick injuries per 100 occupied beds

$$\frac{\text{\# needlstick injuries in defined quarter}}{\text{Average Daily Census for quarter}} \times 100$$

Comparison: New EpiNet benchmark (2001 - Teaching Hospitals) 26 Injuries per 100 occupied beds per year. (Note: equivalent to 6.5 injuries per 100 occupied beds per quarter)

Comment: Rate increased slightly this quarter, but annual rate is more meaningful.

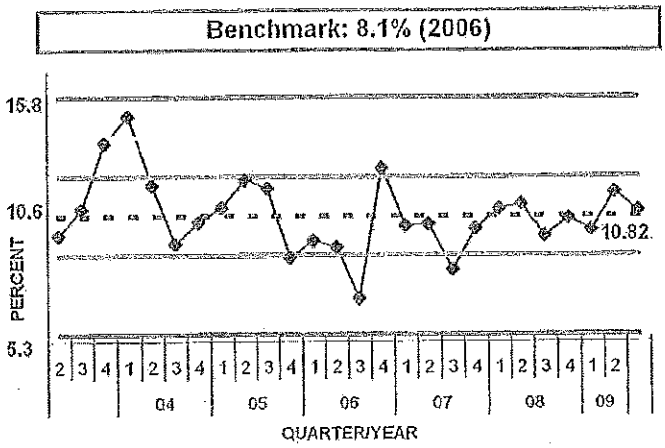


6. Occupational Health and Illness Incident Rate

Definition: Number of injuries and illnesses x 200,000/total hours worked (includes overtime hours)

Comparison: Bureau of Labor Statistics for Hospitals (2006)

Comment: Decrease noted for 2nd quarter. Rate minus exposures is 6.9%.



This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

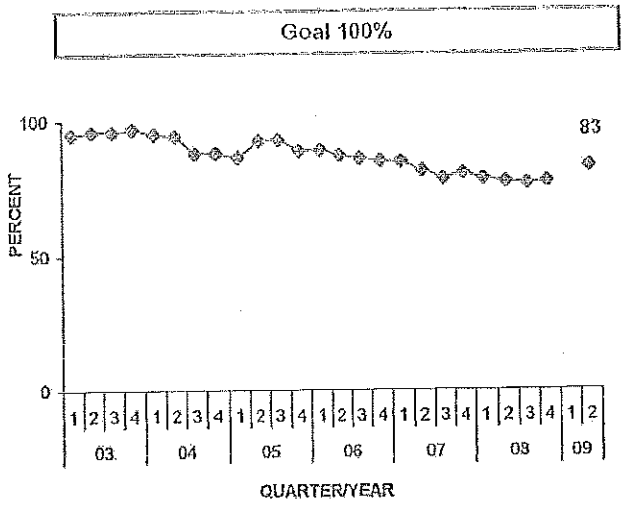
7. Employee Appraisal Completion Rate

Definition: # Performance Appraisals Completed*
Total # Performance Appraisals Due*

*Excluding per diem employees and physicians
Completion - done within 30 days of due date

Goal: 100%

Comment: Rate has shown an improvement this quarter based on corrective action plan developed by HR.

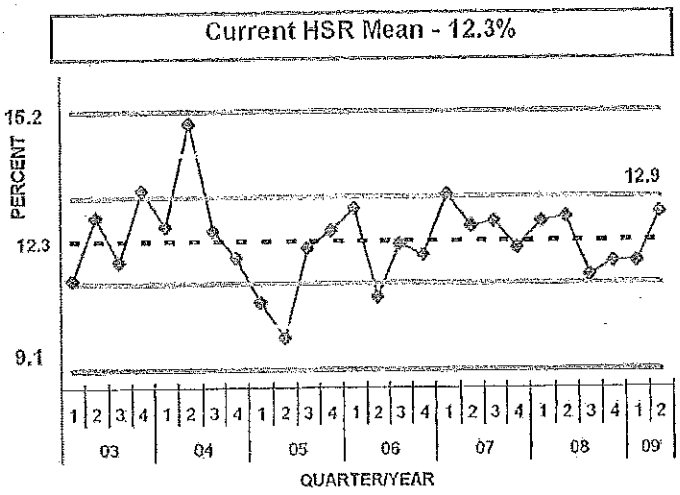


8. Unplanned Readmission Rate

Definition: Percent of discharged patients having unplanned readmission within 30 days

Comparison: 17.6 (2005) Medicare Payment Advisory Commission Report, June 2007

Comment: Rate shows unfavorable increase this quarter but remains close to mean.

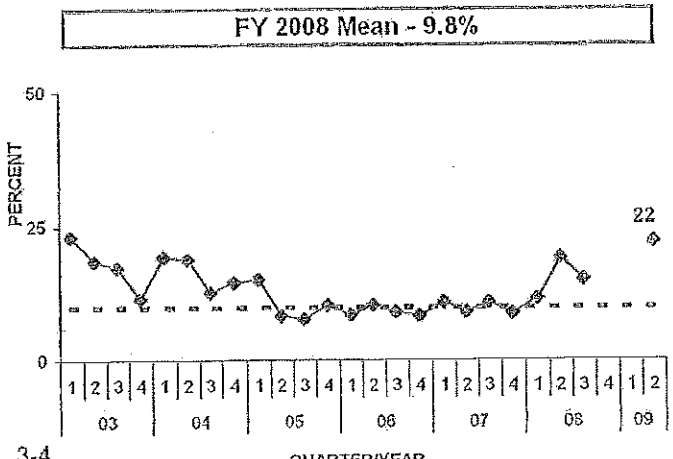


9. Incomplete Medical Records Rate

Definition: Inpatient records lacking required content 30 days after discharge as a percent of discharges.

Goal: 0% Incomplete

Comment: Changes made to way rate is calculated. New process put into placed to help increase compliance with timely record completion.



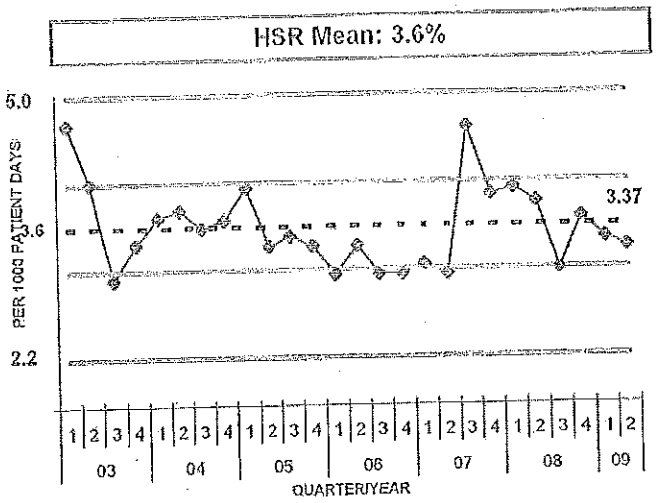
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

10. Inpatient Fall Rate

Definition: All patient falls per 1000 patient days

Comparison: Previous HSR rates

Comment: Decrease noted again this quarter. Rate compares favorably against the mean.

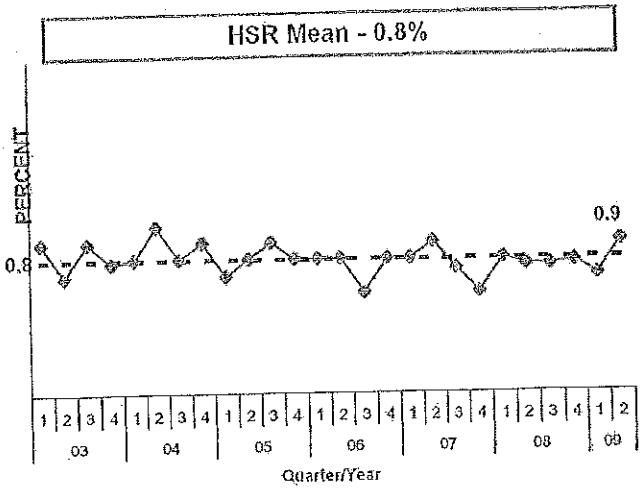


11. Three Day Return Admits

Definition: Returns to ED within 72 hours and admitted, as percent of total ED visits.

Comparison: Previous HSR rates.

Comment: 2nd quarter of FY 09 is consistent with overall mean.



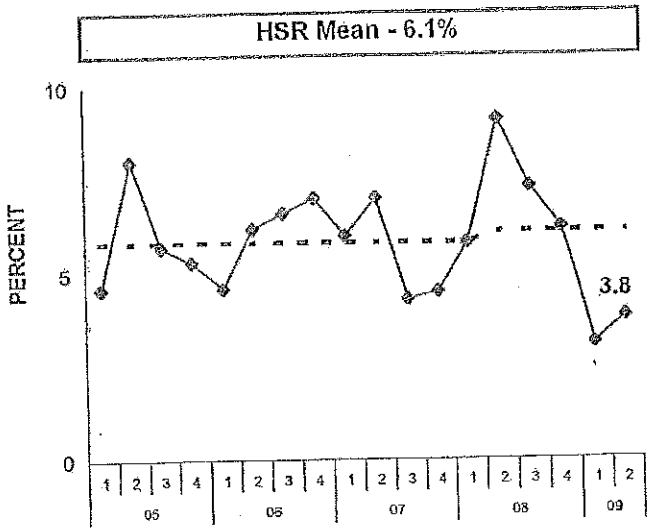
12. ED Walk-outs

Definition: Patient leaving without being seen as percent of total ED visits.

Data Source: Data Warehouse

Goal: $\leq 3\%$

Comment: Slight increase noted this quarter (unfavorable). Will continue to monitor.

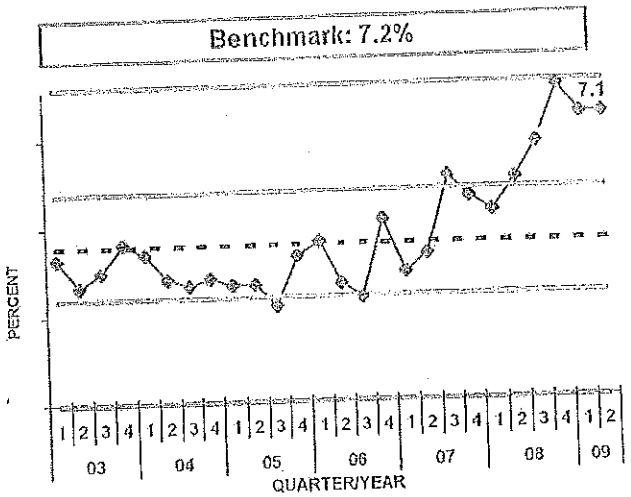


This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

13. Medication Variance Rate

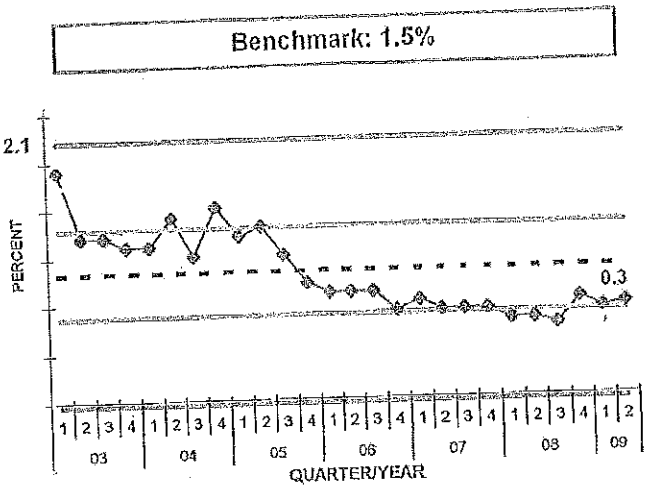
Definition: # Medication Variances Reported x 100
# of Patient Discharges

Medication variance is any variance at any point in the medication system from the time the drug is ordered until the patient receives it. (Note: a medication variance may or may not result in an injury to the patient)
Comparison: 7.2% (Leape, et al. JAMA 1995, 35-43.)
Comment: Rate consistent with comparison rate. Will continue to monitor.



14. Adverse Drug Reaction

Definition: Number of patients experiencing untoward event associated with administration of chemical or medicinal substance in usual fashion as a percent of discharges.
Comparison: Benchmark: 1.5% (Set by P&T Sub-committee)
Comment: Rate remains steady this quarter.

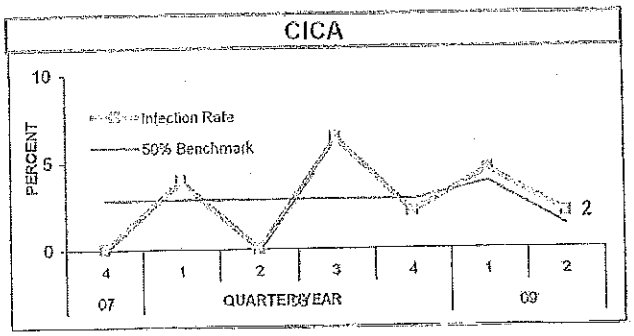


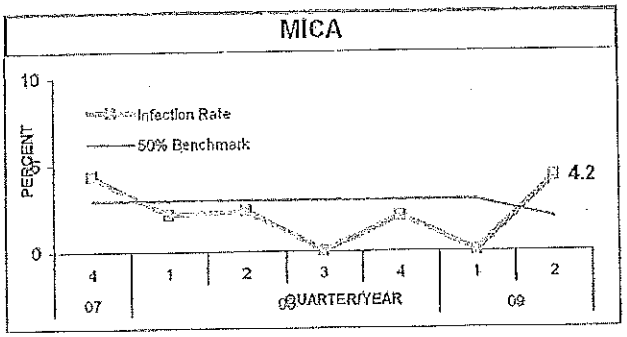
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

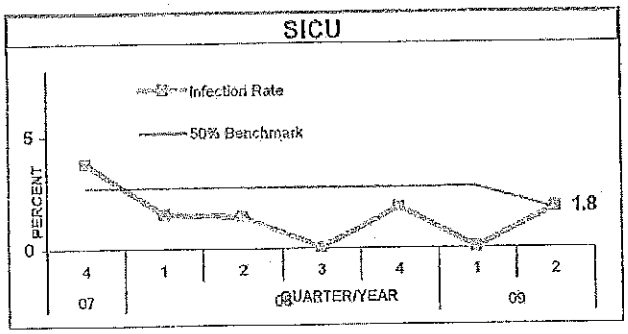
15 a-d. Central Line Associated Bloodstream Infection

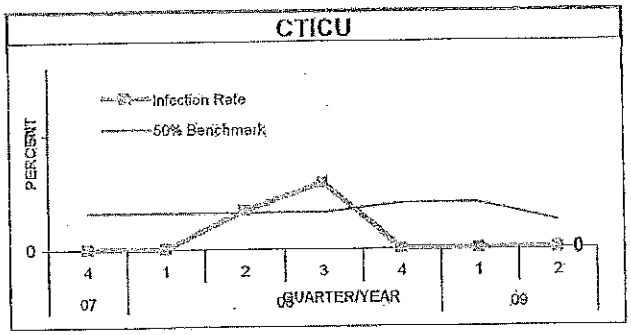
Definition:
Total number of central line associated bloodstream infection cases in the identified intensive care units per 1000 catheter days.

Comparison Group: National Healthcare Safety Network (NHSN) Outcomes Monitoring Project with the CDC, Report for 2006, AJIC June 2007, Vol. 35, No. 5









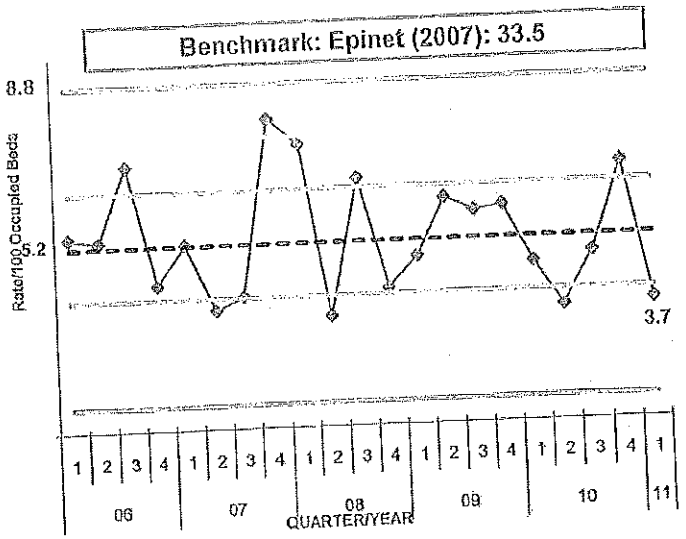
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

1. Needlestick Injuries
Definition: # of needlestick injuries per 100 occupied beds

$$\frac{\text{\# needlstick injuries in defined quarter}}{\text{Average Daily Census for quarter}} \times 100$$

Comparison: EpiNet benchmark (2007) - Teaching Hospitals 33.5 Injuries per 100 occupied beds per year.

Comment: Rate considerably lower than past two quarters, how annual rate is more meaningful for the purpose of comparsion.

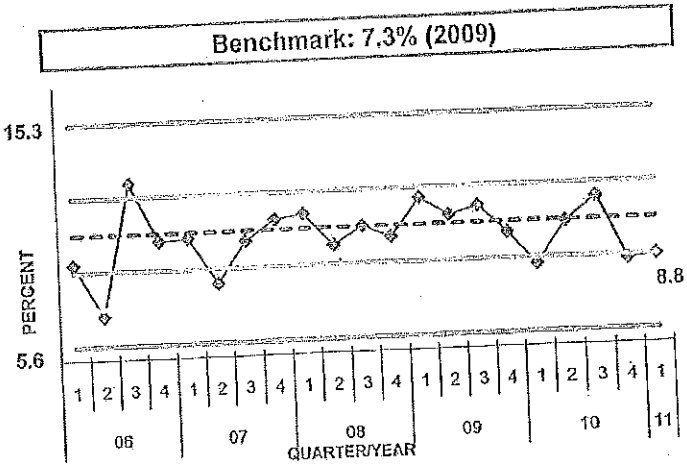


2. Occupational Health and Illness Incident Rate

Definition: Number of injuries and illnesses x 200,000/total hours worked (includes overtime hours)

Comparison: Bureau of Labor Statistics: 2009 7.3 for Hospitals (Conn OSHA 8.5)

Comment: Rate consistent with last quarter. Of note: exposures total 38% of 1Q rate. 1Q rate minus exposures equals 5.45.



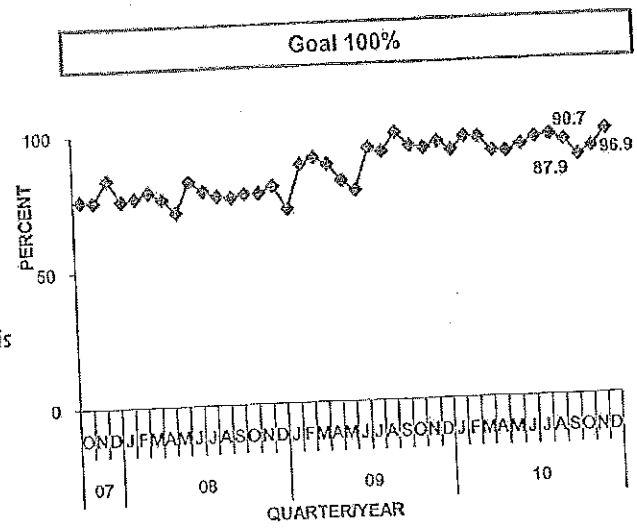
3. Employee Appraisal Completion Rate

Definition: $\frac{\text{\# Performance Appraisals Completed*}}{\text{Total \# Performance Appraisals Due*}}$

*Excluding per diem employees and physicians
Completion - done within 30 days of due date

Goal: 100%

Comment: Rate rose over the past three months and is at it's highest point in over a year.



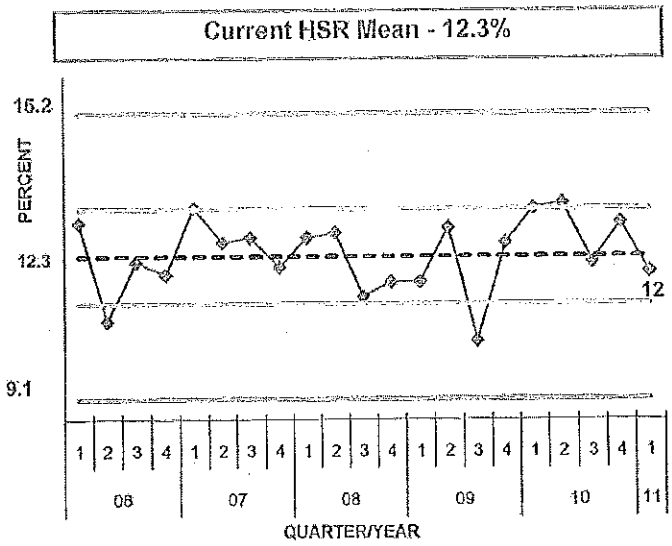
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

4. Unplanned Readmission Rate

Definition: Percent of discharged patients having unplanned readmission within 30 days

Comparison: 17.6 (2005) Medicare Payment Advisory Commission Report, June 2007

Comment: Rate displays favorable decline this quarter, but remains consistent with overall mean.

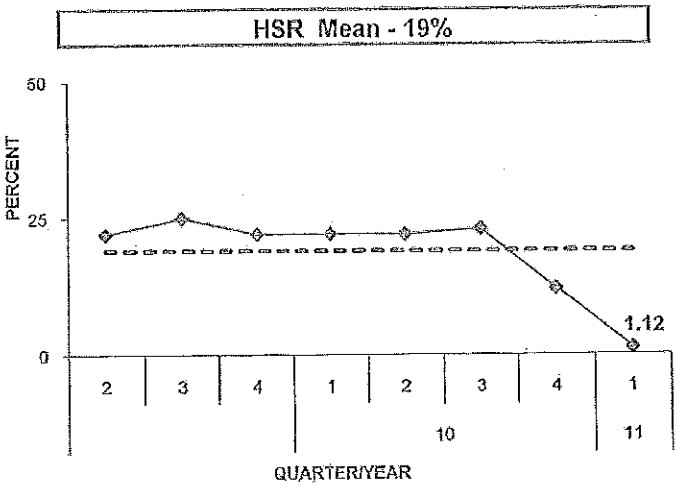


5. Incomplete Medical Records Rate

Definition: Inpatient records lacking required content 30 days after discharge as a percent of discharges.

Goal: 0% Incomplete

Comment: A campaign to heighten awareness of medical record completion timeframes was initiated during the fall of 2010 and maybe the prime contributer to the significant decrease in this rate.

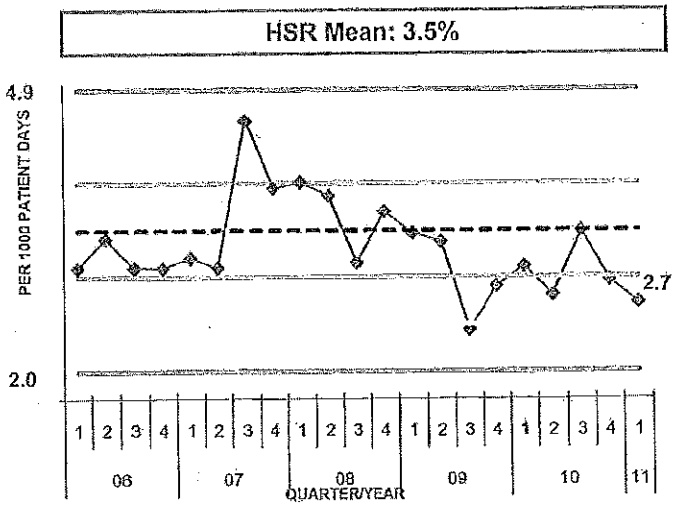


6. Inpatient Fall Rate

Definition: All patient falls per 1000 patient days

Comparison: Previous HSR rates

Comment: Decrease noted this quarter and rate compares favorably against the mean. There were 3 major injury with falls.



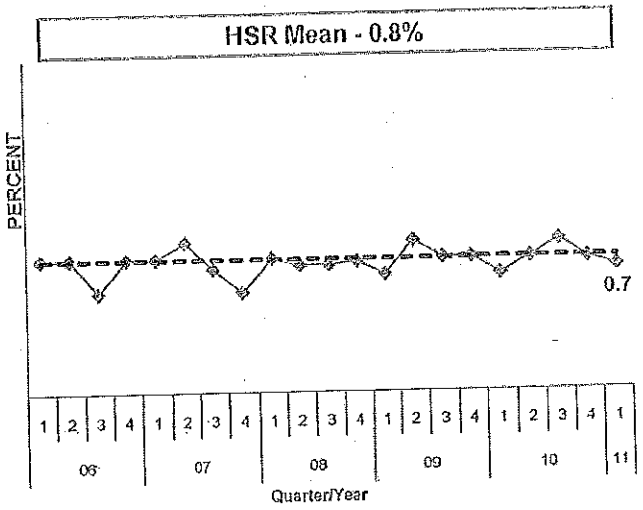
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

7. Three Day Return Admits

Definition: Returns to ED within 72 hours and admitted, as percent of total ED visits.

Comparison: Previous HSR rates.

Comment: Annual rate consistent with overall mean.



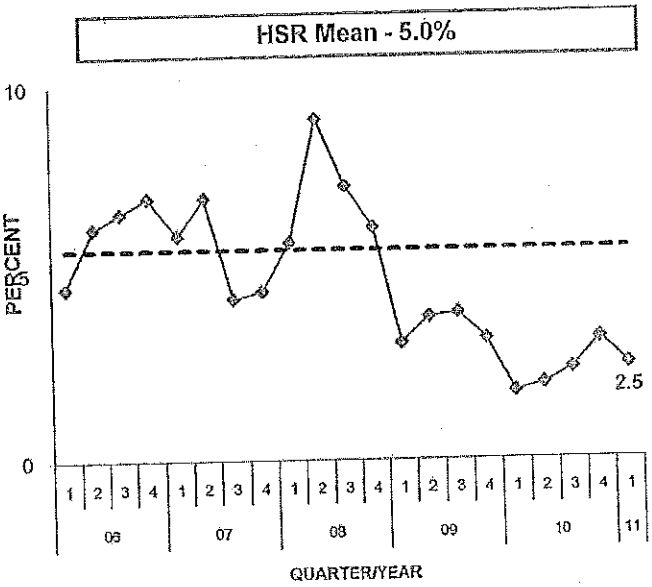
8. ED Walk-outs

Definition: Patient leaving without being seen as percent of total ED visits.

Data Source: Data Warehouse

Goal: $\leq$ 3%

Comment: Rate has shown a favorable decrease this quarter and is below goal.



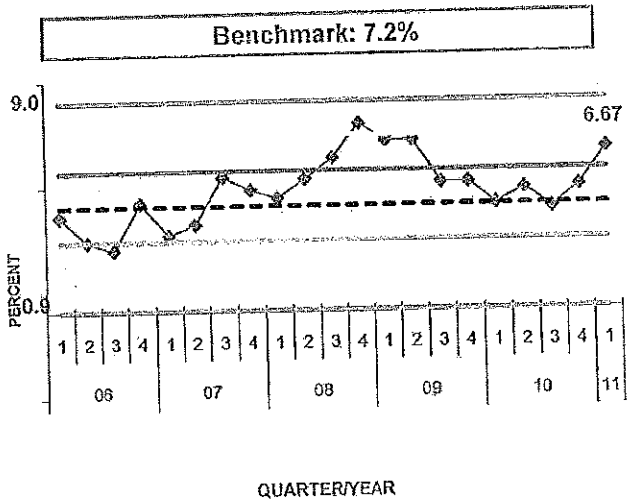
9. Medication Variance Rate

Definition: $\frac{\text{\# Medication Variances Reported}}{\text{\# of Patient Discharges}} \times 100$

Medication variance is any variance at any point in the medication system from the time the drug is ordered until the patient receives it. (Note: a medication variance may or may not result in an injury to the patient)

Comparison: 7.2% (Leape, et al. JAMA 1995, 35-43.)

Comment: Education to help heighten awareness of the value of variance reporting was conducted in the Department of Nursing during the fall of 2010. This may have lead to the rate increase for 1Q FY 11.



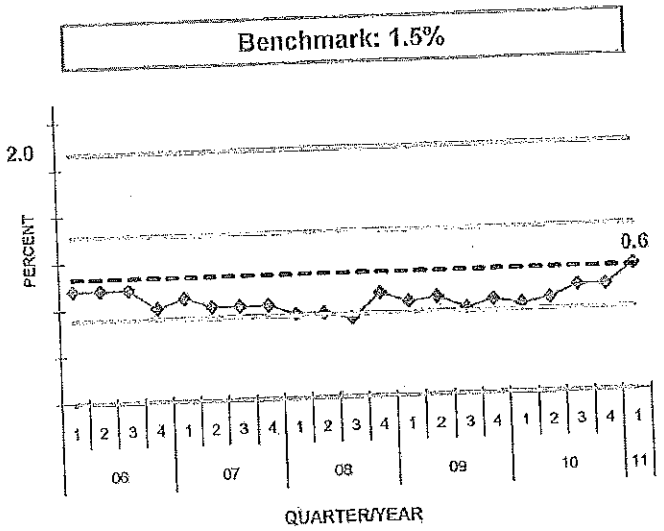
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

10. Adverse Drug Reaction

Definition: Number of patients experiencing untoward event associated with administration of chemical or medicinal substance in usual fashion as a percent of discharges.

Comparison: Benchmark: 1.5% (Set by P&T Sub-committee)

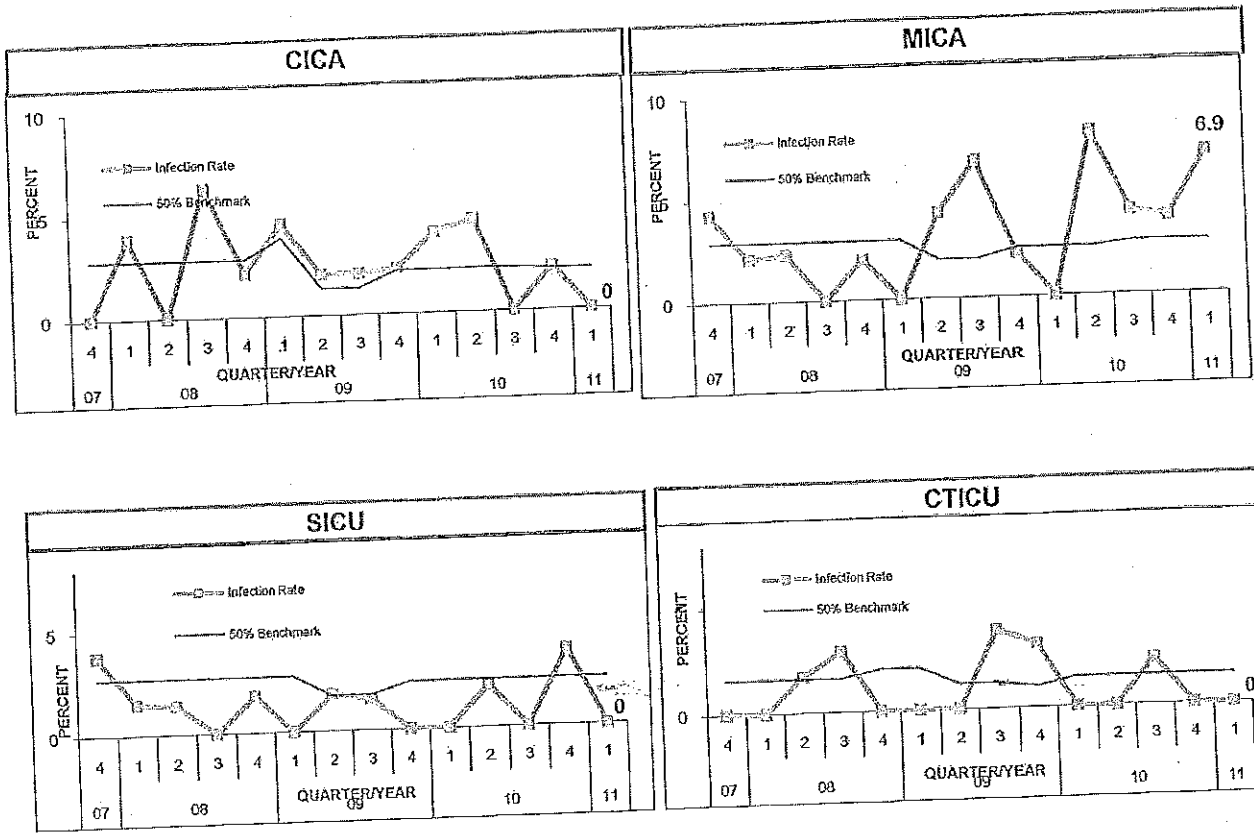
Comment: Slight increase note, but remains well below benchmark.



11 a-d. Central Line Associated Bloodstream Infection

Definition:
Total number of central line associated bloodstream infection cases in the identified intensive care units per 1000 catheter days.

Comparison Group: National Healthcare Safety Network (NHSN) Outcomes Monitoring Project with the CDC, Report for 2006, AJIC June 2007, Vol. 35, No. 5



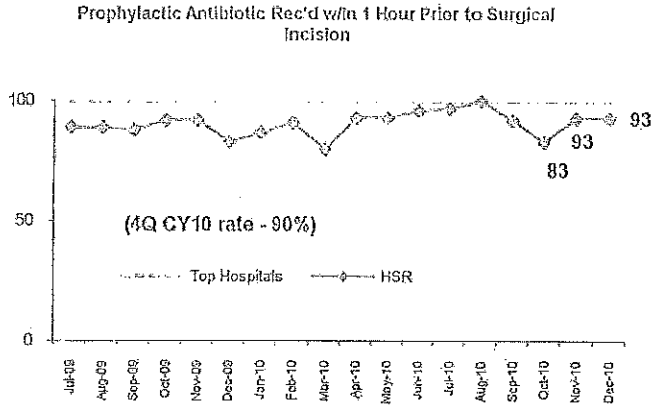
This material is confidential and protected under Peer Review pursuant to Connecticut State Statute 19a-17b.

Measures/Hospital Quality Alliance (HQA)
Outpatient Surgical Quality Measures
Jul 09 - Dec 10

OP-6 Timing of Antibiotic Prophylaxis

Description: Ambulatory surgical patients who received prophylactic antibiotics within one hour prior to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics administered within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.

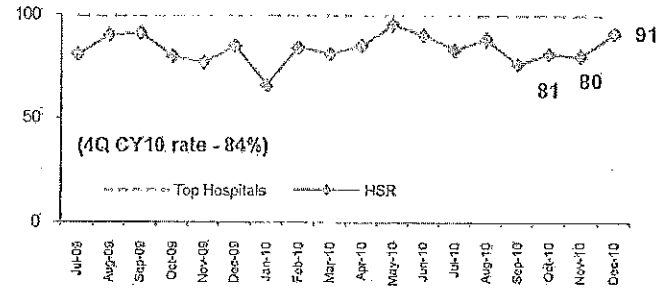
Comparison rates: Jul 09 - Mar 10
HSR - 88% (1% decrease from last quarter)
State - 91% (1% decrease from last quarter)
Top Hospitals - 100% (same as last quarter)



OP-7 Prophylactic Antibiotic Selection for Surgical Patients

Description: Ambulatory surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).

Comparison rates: Jul 09 - Mar 10
HSR - 83% (1% decrease from last quarter)
State - 92% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



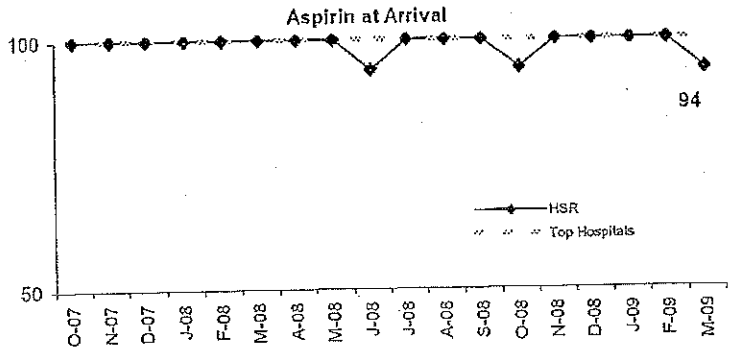
Data collected by: Deanna Juhasz
Report prepared by: Jacqueline Richo, Sr. QI Coordinator Apr 2011
Benchmark rate source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Acute Myocardial Infarction (AMI)
Oct. 07 - Mar 09

Aspirin at Arrival (AMI-1)

Acute Myocardial Infarction (AMI) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival.

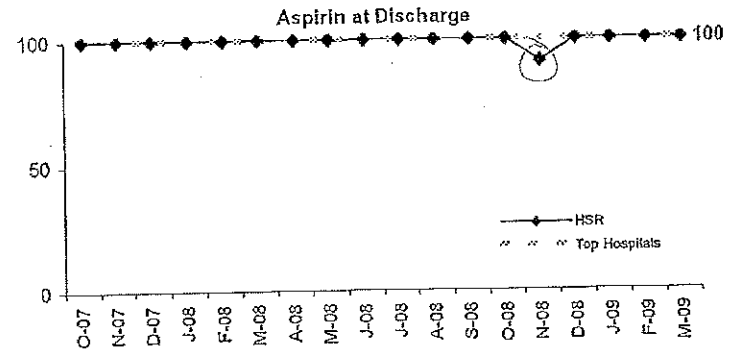
Comparison rates: Jul 07 to Jun 2008
HSR - 99% (1% decrease from last quarter)
State - 98% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



Aspirin at Discharge (AMI-2)

Acute Myocardial Infarction (AMI) patients without aspirin contraindications who were prescribed aspirin at discharge

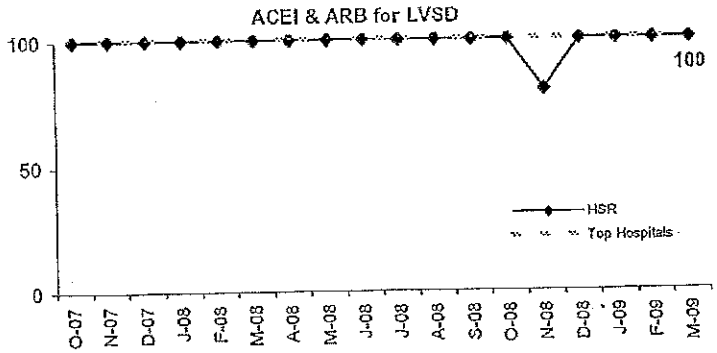
Comparison rates: Jul 07 to Jun 2008
HSR - 100% (same as last quarter)
State - 97% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



ACEI & ARB's for LVSD (AMI-3)

Acute Myocardial Infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) without both ACEI and ARB, contraindications who are prescribed an ACEI or ARB at hospital discharge. LVSD is defined as chart documentation of left ventricular function (LVF) < 40% or a narrative description of LVF consistent with moderate or severe systolic dysfunction.

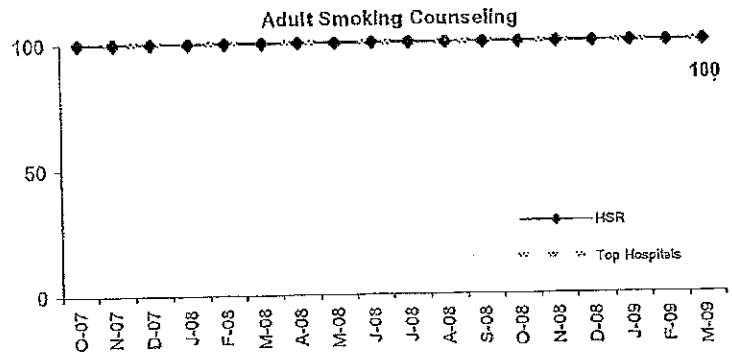
Comparison rates: Jul 07 to Jun 2008
HSR - 100% (same as last quarter)
State - 93% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Adult Smoking Advice/Counseling (AMI-4)

AMI patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For the purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Jul 07 to Jun 2008
HSR - 100% (same as last quarter)
State - 95% (3% increase from last quarter
Top Hospitals - 100% (same as last quarter)

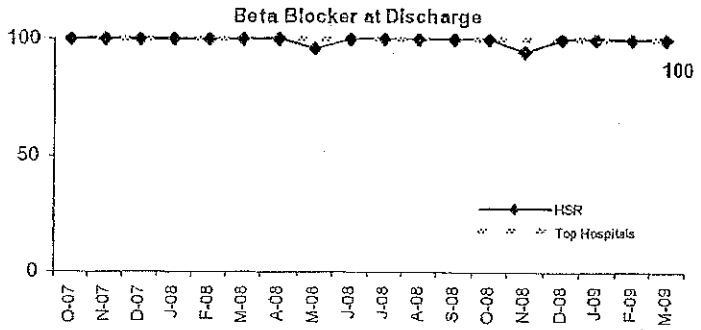


Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Jul 09
Comparison Rate Source: 03/24/09

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Acute Myocardial Infarction (AMI)
Oct 07 - Mar 09

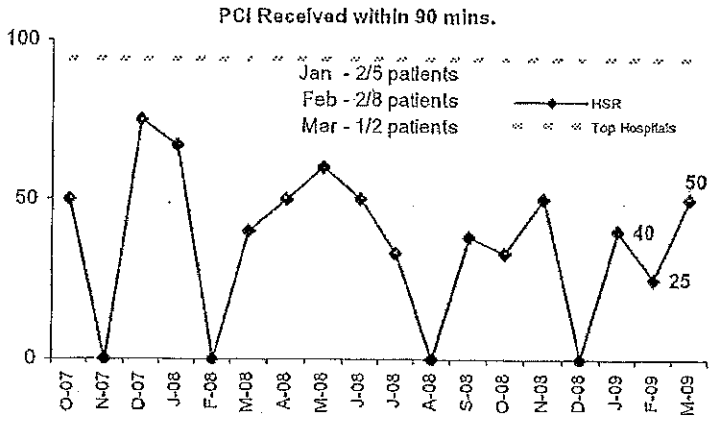
Beta Blocker at Discharge (AMI-5)
Acute Myocardial Infarction (AMI) patients without beta blocker contraindications who were prescribed a beta blocker at discharge

Comparison rates: Jul 07 to Jun 2008
HSR - 100% (same as last quarter)
State - 98% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



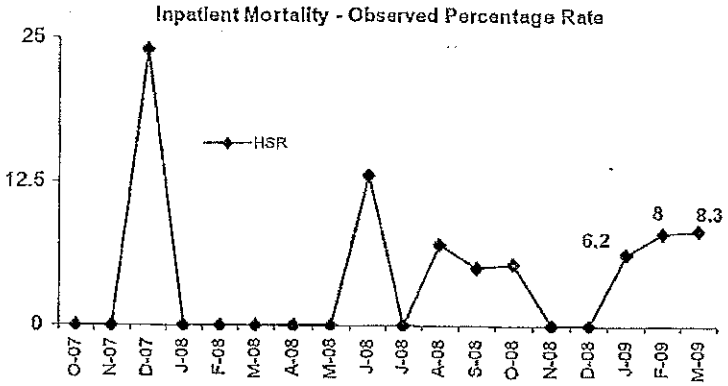
PCI Received Within 90 Minutes of Hospital Arrival (AMI-8a)
AMI patients receiving percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.

Comparison rates: Jul 07 to Jun 2008
HSR - 50 (4% decrease from last quarter)
State - 67% (1% decrease from last quarter)
Top Hospitals - 94% (1% increase from last quarter)



Inpatient Mortality (AMI-9)
AMI patients who expired during hospital stay.
Note: This measure does not include deaths that occurred in the Emergency Department.

No benchmark data currently available.



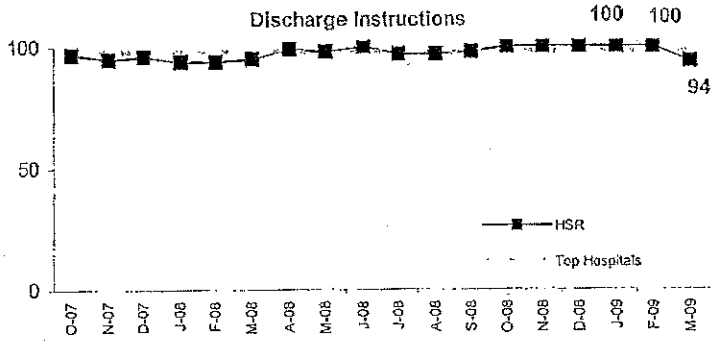
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Jul 09
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 03/24/09

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Congestive Heart Failure
Oct 07 - Mar 09

Discharge Instructions (HF-1)

Heart failure patients discharged home with written instructions given to patient/caregiver addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring and what to do if symptoms worsen.

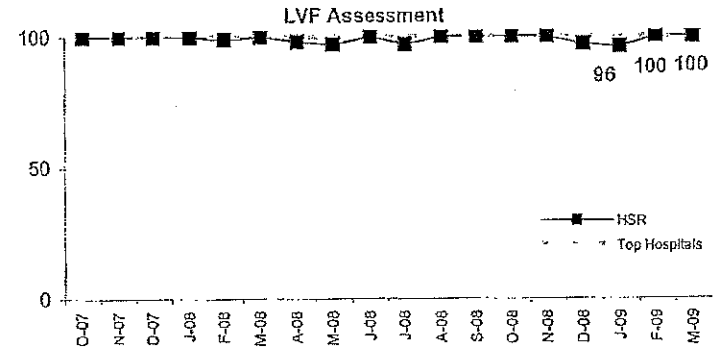
Comparison rates: Apr 07 to Mar 2008
HSR - 95% (same as last quarter)
State - 76% (4% increase from last quarter)
Top Hospitals - 98% (1% increase from last quarter)



LVF Assessment (HF-2)

Heart failure patients with documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge.

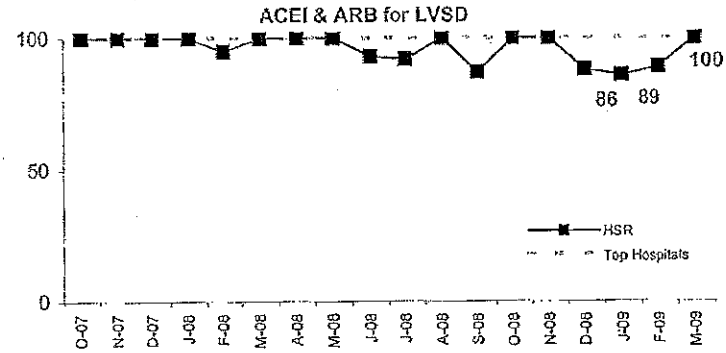
Comparison rates: Apr 07 to Mar 2008
HSR - 99% (1% decrease from last quarter)
State - 96% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



ACEI & ARB for LVSD (HF-3)

Heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) contraindications who are prescribed an ACEI at hospital discharge.

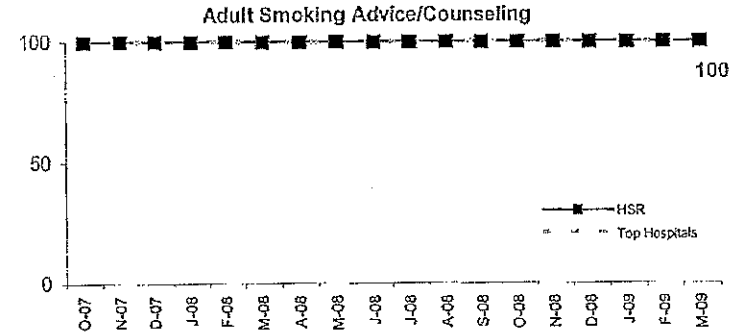
Comparison rates: Apr 07 to Mar 2008
HSR - 99% (1% decrease from last quarter)
State - 93% (2% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Adult Smoking Advice/Counseling (HF-4)

Heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For the purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Apr 07 to Mar 2008
HSR - 100% (same as last quarter)
State - 94% (3% decrease from last quarter)
Top Hospitals - 100% (same as last quarter)



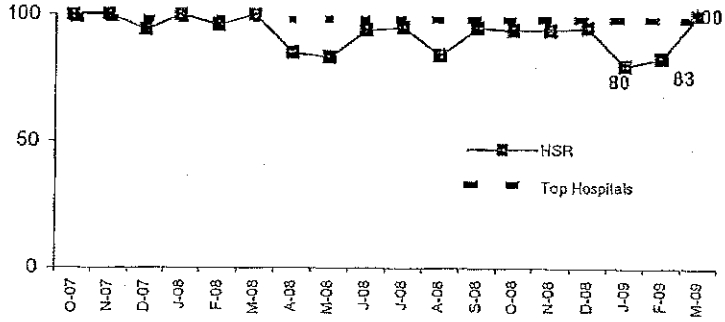
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Jul 09
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 03/24/09

Public Reporting Initiative
JCAHO Core Measure/Hospital Quality Alliance (HQA)
Pneumonia
Oct 07 - Mar 09

neumococcal Screening and/or Vaccination (PN-2)

Number of pneumonia inpatients who were screened for vaccine status and were not vaccinated due to refusal or contraindications, or needed vaccine and received it prior to discharge.

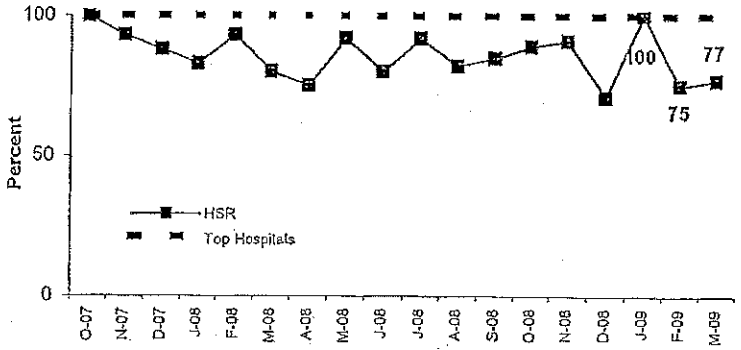
Comparison rates: Jul 07 to Jun 08
HSR - 96% (2% decrease from last quarter)
State - 86% (1% increase from last quarter)
Top Hospitals - 98% (1% increase from last quarter)



Blood Culture Performed in the ED Prior to Initial Antibiotic Received in Hospital (PN-3b)

Pneumonia patients whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics.

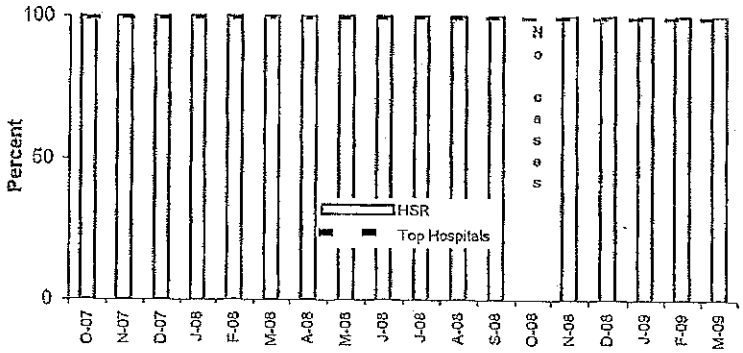
Comparison rates: Jul 07 to Jun 08
HSR - 86% (same as last quarter)
State - 90% (same as last quarter)
Top Hospitals - 100% (1% increase from last quarter)



Adult Smoking Cessation Advice/Counseling (PN-4)

Pneumonia patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For the purpose of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Jul 07 to Jun 08
HSR - 100% (same as last quarter)
State - 91% (2% decrease from last quarter)
Top Hospitals - 100% (same as last quarter)



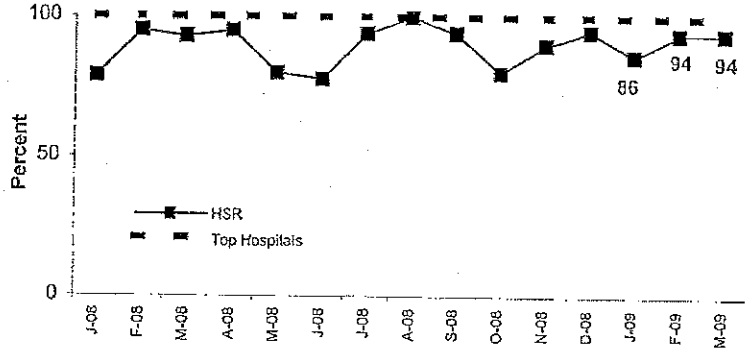
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Jul 09
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 03/24/09

Public Reporting Initiative
JCAHO Core Measure/Hospital Quality Alliance (HQA)*
Pneumonia
Oct 07 - Mar 09

ntibiotic Timing (PN-5c)

The time from hospital arrival to administration of first antibiotic for inpatients with pneumonia. (Compliance with measure is time of less than 360 minutes.)

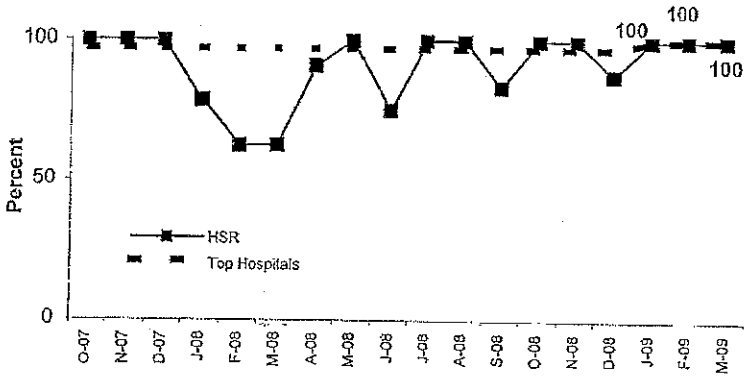
Comparison rates: Jul 07 to Jun 08
HSR - 91% (1% decrease from last quarter)
State - 94% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Initial Antibiotic Selection for Community Acquired Pneumonia (CAP) in Immunocompetent Patients (PN-6)

Immunocompetent patients with Community Acquired Pneumonia whoc receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines. This measure includes both ICU and non-ICU patients.

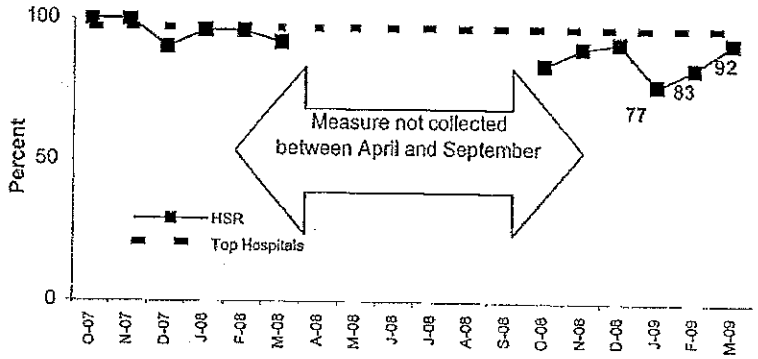
omparison rates: Jul 07 to Jun 08
HSR - 87% (2% increase from last quarter)
State - 88% (same as last quarter)
Top Hospitals - 97% (same as last quarter)



Influenza Vaccination (PN-7)

Pneumonia patients age 50 years and older, hospitalized during October, November, December, January, February or March who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated.

Comparison rates: Jul 07 to Jun 08
HSR - 96% (same as last quarter)
State - 81% (same as last quarter)
Top Hospitals - 97% (same as last quarter)

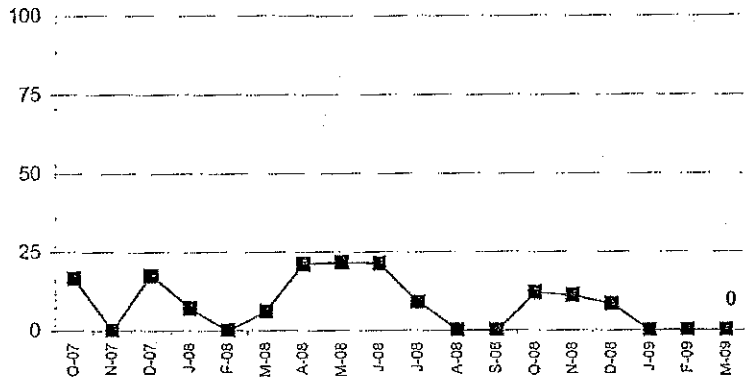


Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Jul 09
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 03/24/09

Public Reporting Initiative
JCAHO Core Measures
Pregnancy and Other Related Conditions
Oct 07 - Mar 09

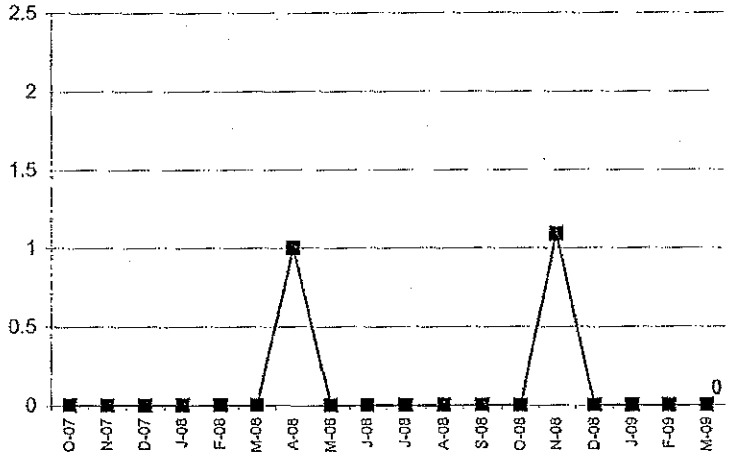
Vaginal Birth After Cesarean Section (VBAC)
Patients with vaginal birth after cesarean section.

Comparison Rates: Jan - Mar 09
HSR - 0%
State (TEIC Hospitals) - 5.9%
JCAHO - 11.16%



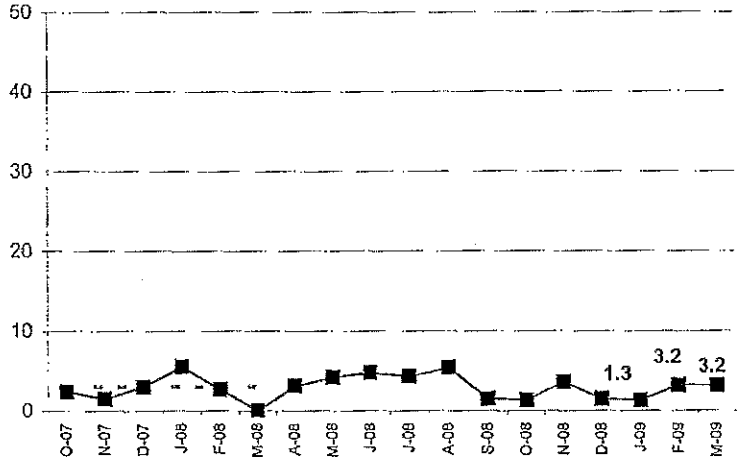
Inpatient Neonatal Mortality
All neonates who expire at the facility within 28 days of birth.

Comparison Rates: Jan - Mar 09
HSR - 0%
State (TEIC Hospitals) - 0%
ICAHO - .36%
(a lower rate is more favorable)



Third or Fourth Degree Lacerations
All patients with third or fourth degree perineal laceration during a vaginal delivery.

Comparison Rates: Jan - Mar 09
HSR - 2.5%
State (TEIC Hospitals) - 2.3%
JCAHO - 3.2%
(a lower rate is more favorable)

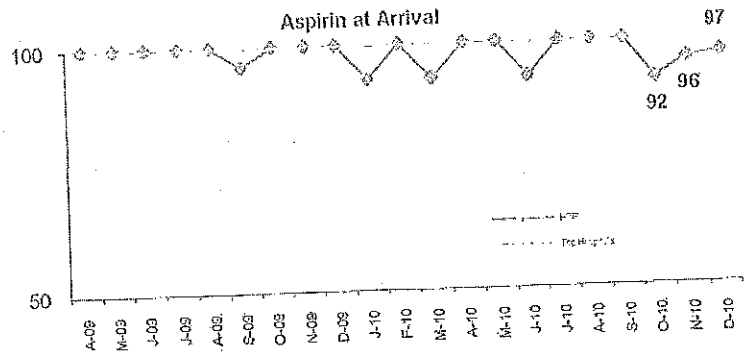


Prepared by: Jacqueline Richo, Sr. QI Coordinator
Report Date: Jul 2009
TEIC Hospitals include: Danbury, Day Kimball, and The Hospital of Saint Raphael

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Acute Myocardial Infarction (AMI)
Apr 09 - Dec 10

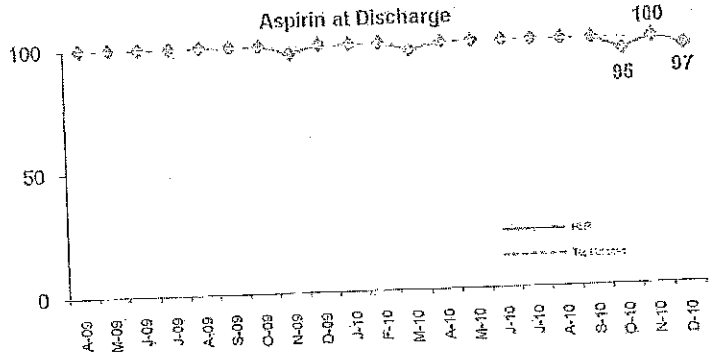
Aspirin at Arrival (AMI-1)
Acute Myocardial Infarction (AMI) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival.

Comparison rates: Apr 09 - Mar 10
HSR - 98% (1% decrease from last quarter)
State - 99% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



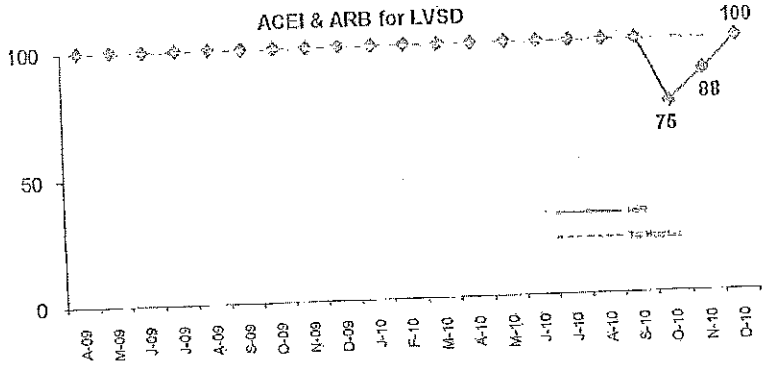
Aspirin at Discharge (AMI-2)
Acute Myocardial Infarction (AMI) patients without aspirin contraindications who were prescribed aspirin at discharge

Comparison rates: Apr 09 - Mar 10
HSR - 99% (1% decrease from last quarter)
State - 99% (2% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



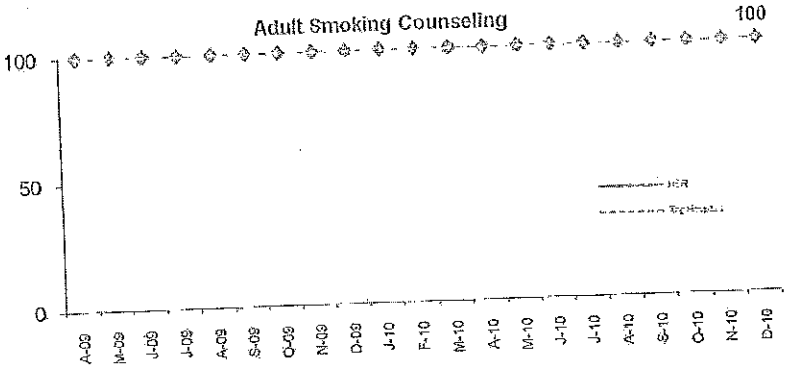
ACEI & ARB's for LVSD (AMI-3)
Acute Myocardial Infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) without both ACEI and ARB contraindications who are prescribed an ACEI or ARB at hospital discharge. LVSD is defined as chart documentation of left ventricular function (LVF) < 40% or a narrative description of LVF consistent with moderate or severe systolic dysfunction.

Comparison rates: Apr 09 - Mar 10
HSR - 100% (same as last quarter)
State - 94% (4% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Adult Smoking Advice/Counseling (AMI-4)
AMI patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For the purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Apr 09 - Mar 10
HSR - 100% (same as last quarter)
State - 99% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)

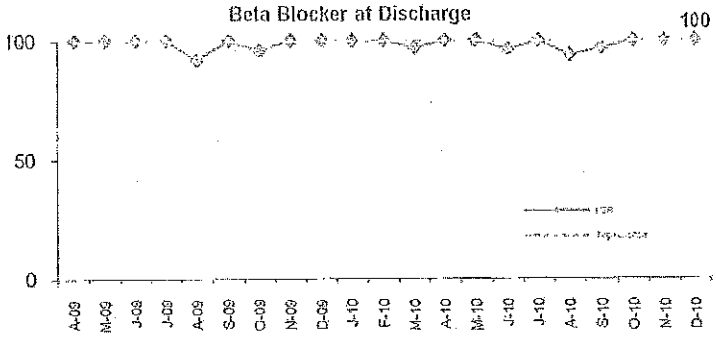


Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator Apr 2011
Comparison Rate Source: hospital compare.hhs.gov Updated 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Acute Myocardial Infarction (AMI)
Apr 09 - Dec 10

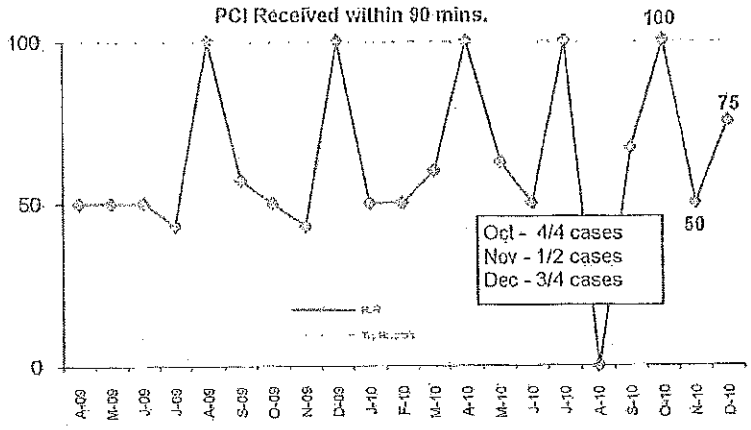
Beta Blocker at Discharge (AMI-5)
Acute Myocardial Infarction (AMI) patients without beta blocker contraindications who were prescribed a beta blocker at discharge

Comparison rates: Apr 09 - Mar 10
HSR - 98% (1% decrease from last quarter)
State - 98% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



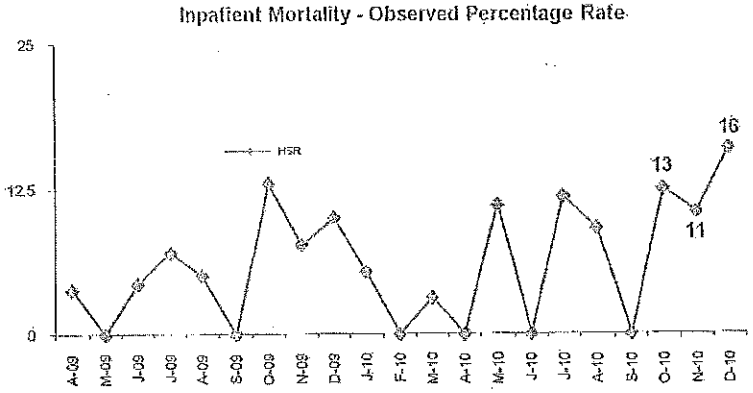
PCI Received Within 90 Minutes of Hospital Arrival (AMI-8a)
AMI patients receiving percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.

Comparison rates: Apr 09 - Mar 10
HSR - 56% (6% increase from last quarter)
State - 87% (2% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Inpatient Mortality (AMI-9)
AMI patients who expired during hospital stay.
Note: This measure does not include deaths that occurred in the Emergency Department.

No benchmark data currently available.



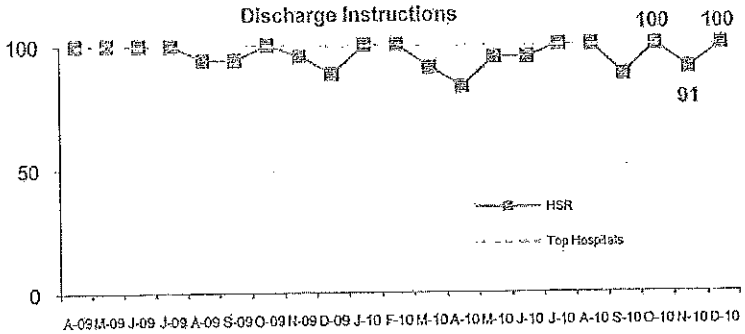
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Congestive Heart Failure
Apr 09 - Dec 10

Discharge Instructions (HF-1)

Heart failure patients discharged home with written instructions given to patient/caregiver addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring and what to do if symptoms worsen.

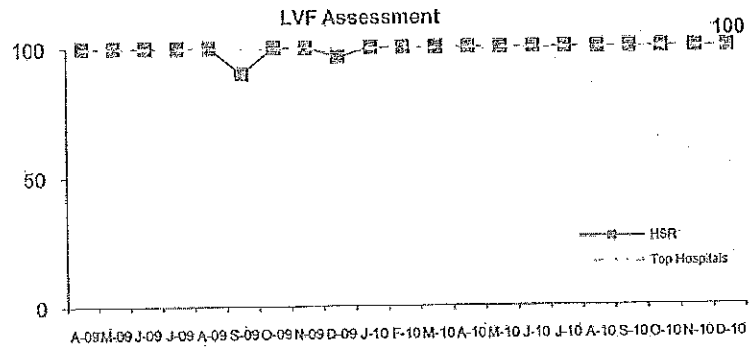
Comparison rates: Apr 09 - Mar 10
HSR - 97% (same as last quarter)
State - 84% (2% increase from last quarter)
Top Hospitals - 100% (1% increase from last quarter)



LVF Assessment (HF-2)

Heart failure patients with documentation in the hospital record that left ventricular function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge.

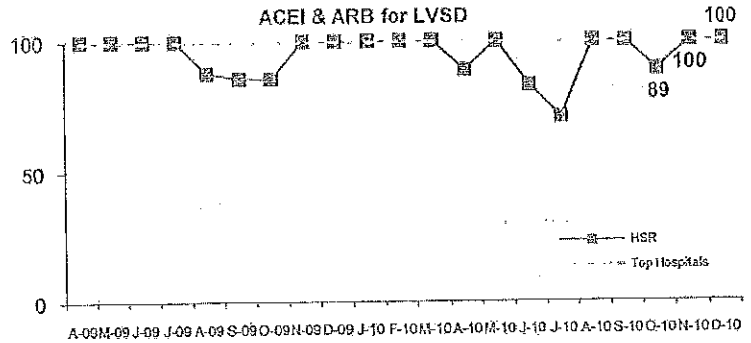
Comparison rates: Apr 09 - Mar 10
HSR - 99% (same as last quarter)
State - 99% (2% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



ACEI & ARB for LVSD (HF-3)

Heart failure patients with left ventricular systolic dysfunction (LVSD) and without angiotensin converting enzyme inhibitor (ACEI) contraindications who are prescribed an ACEI at hospital discharge.

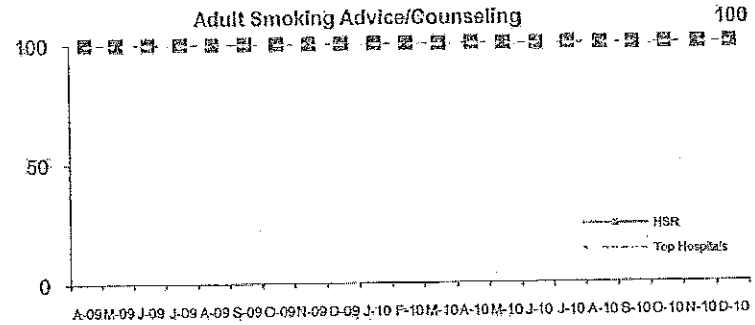
Comparison rates: Apr 09 - Mar 10
HSR - 96% (2% increase from last quarter)
State - 92% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Adult Smoking Advice/Counseling (HF-4)

Heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For the purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Apr 09 - Mar 10
HSR - 100% (same as last quarter)
State - 98% (3% increase from last quarter)
Top Hospitals - 100% (same as last quarter)

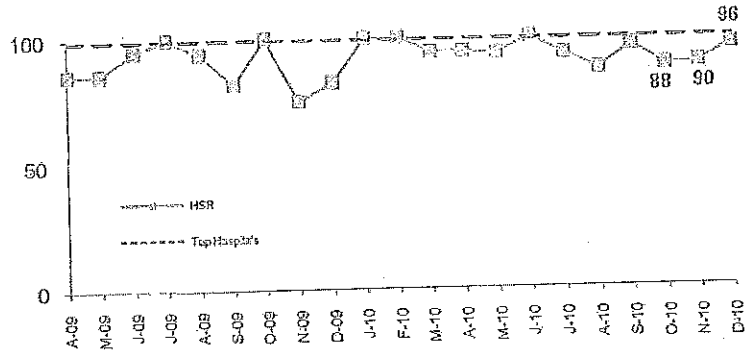


Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measure/Hospital Quality Alliance (HQA)
Pneumonia
Apr 09 - Dec 10

eumococcal Screening and/or Vaccination (PN-2)
Number of pneumonia inpatients who were screened for vaccine status and were not vaccinated due to refusal or contraindications, or needed vaccine and received it prior to discharge.

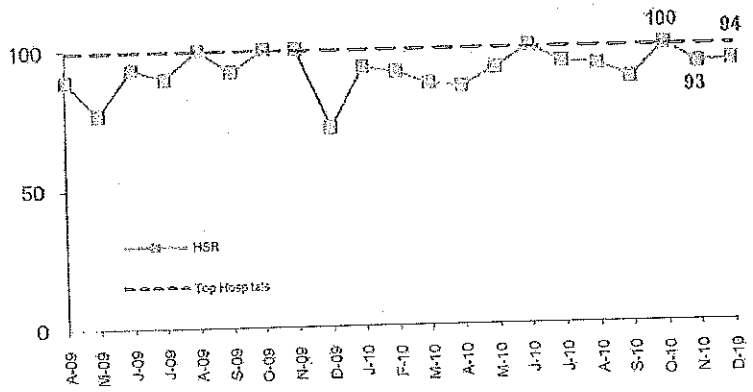
Comparison rates: Apr 09 - Mar 10
HSR - 93% (3% increase from last quarter)
State - 93% (2% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Blood Culture Performed in the ED Prior to Initial Antibiotic Received in Hospital (PN-3b)

Pneumonia patients whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics.

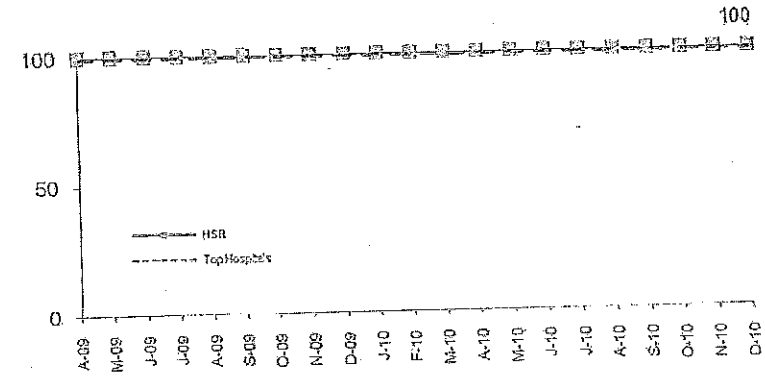
Comparison rates: Apr 09 - Mar 10
HSR - 89% (1% increase from last quarter)
State - 95% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Adult Smoking Cessation Advice/Counseling (PN-4)

Pneumonia patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For the purpose of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Comparison rates: Apr 09 - Mar 10
HSR - 100% (same as last quarter)
State - 98% (3% increase last quarter)
Top Hospitals - 100% (same as last quarter)



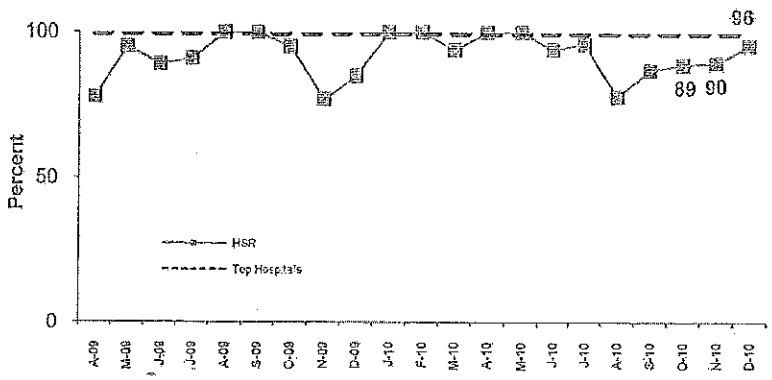
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measure/Hospital Quality Alliance (HQA)*
Pneumonia
Apr 09 - Dec 10

ıtibiotic Timing (PN-5c)

The time from hospital arrival to administration of firs antibiotic for inpatients with pneumonia. (Compliance with measure is time of less than 360 minutes.)

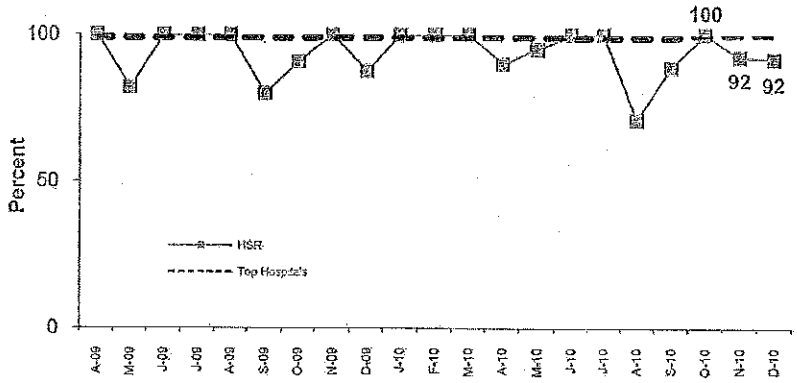
Comparison rates: Apr 09 - Mar 10
HSR - 92% (2% increase from last quarter)
State - 96% (3% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



Initial Antibiotic Selection for Community Acquired Pneumonia (CAP) in Immunocompetent Patients (PN-6)

Immunocompetent patients with Community Acquired Pneumonia whoc receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines. This measure includes both ICU and non-ICU patients.

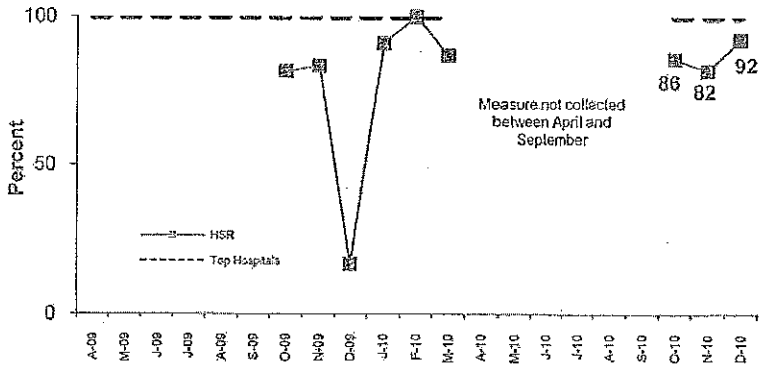
omparison rates: Apr 09 - Mar 10
HSR - 96% (1% increase fromlast quarter)
State - 93% (1% increase from last quarter)
Top Hospitals - 100% (1% increase from last quarter)



Influenza Vaccination (PN-7)

Pneumonia patients age 50 years and older, hospitalized during October, November, December, January, February or March who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated.

Comparison rates: Apr 09 - Mar 10
HSR - 85% (10% increase from last quarter)
State - 91% (3% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



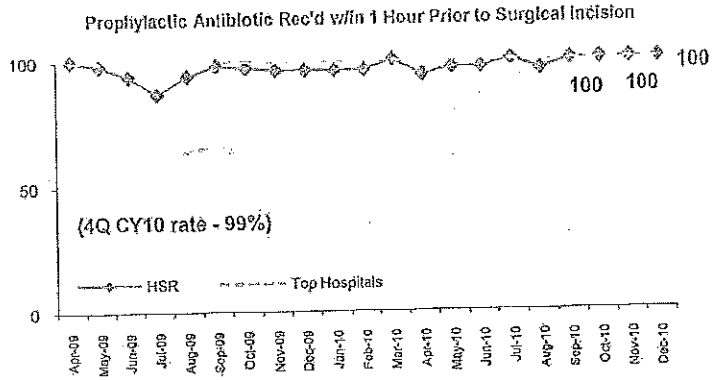
Data collected by Deanna Juhasz, Outcomes Coordinator
Report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Comparison Rate Source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)*
Surgical Care Improvement Project
Apr 09 - Dec 10

CIP-Inf - 1

Surgical patients who received prophylactic antibiotics within one hour prior to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics administered within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.

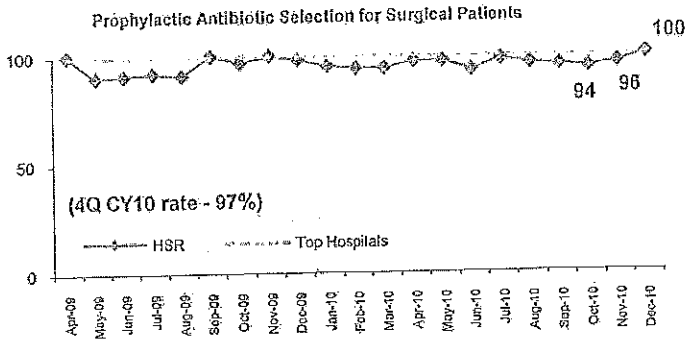
Comparison rates: Apr 09 - Mar 10
HSR - 96% (1% increase from last quarter)
State - 96% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



SCIP-Inf - 2

Description: Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).

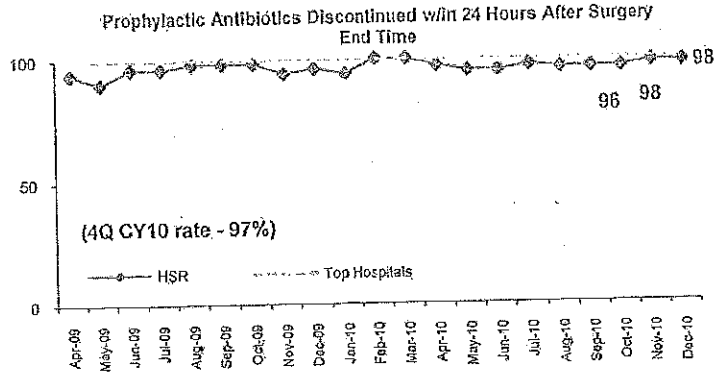
Comparison rates: Apr 09 - Mar 10
HSR - 95% (same as last quarter)
State - 97% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



SCIP-Inf - 3

Description: Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after surgery end time and with 48 hours for cardiac surgery as recommended by The Society of Thoracic Surgeons (STS) Practice Guidelines for Antibiotic Prophylaxis in Cardiac Surgery.

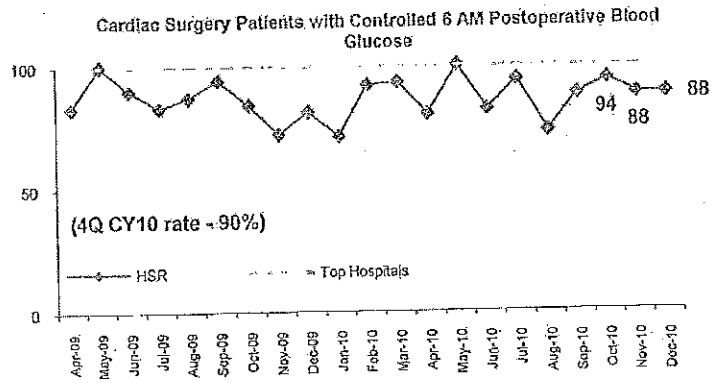
Comparison rates: Apr 09 - Mar 10
HSR - 96% (2% increase from last quarter)
State - 94% (2% decrease from last quarter)
Top Hospitals - 100% (same as last quarter)



SCIP-Inf-4

Description: Cardiac surgery patients with controlled 6 AM blood glucose (<200 mg/dL) on postoperative day one and postoperative day two.

Comparison rates: Apr 09 - Mar 10
HSR - 86% (3% decrease from last quarter)
State - 92% (2% decrease from last quarter)
Top Hospitals - 99% (same as last quarter)



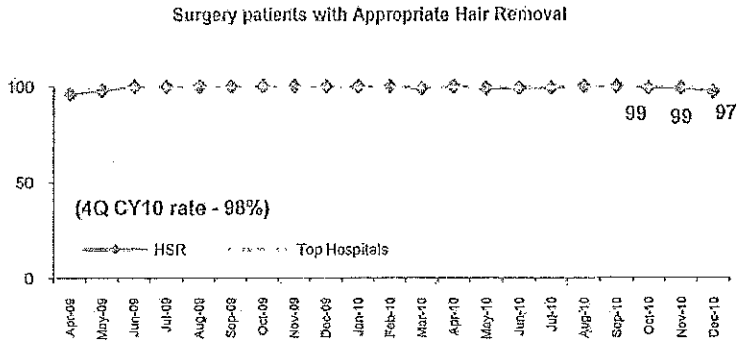
Data collected and report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Benchmark rate source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Surgical Care Improvement Project
Apr 09 - Dec 10

SCIP-Inf-6

Description: Surgery patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered appropriate. Shaving is considered inappropriate.

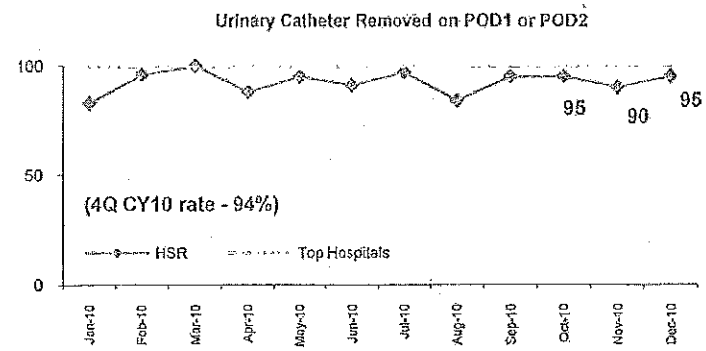
Comparison rates: Apr 09 - Mar 10
HSR - 99% (same as last quarter)
State - 99% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



SCIP-9

Description: Surgical patients with urinary catheter removed on postoperative day one or postoperative day two with day of surgery being day zero.

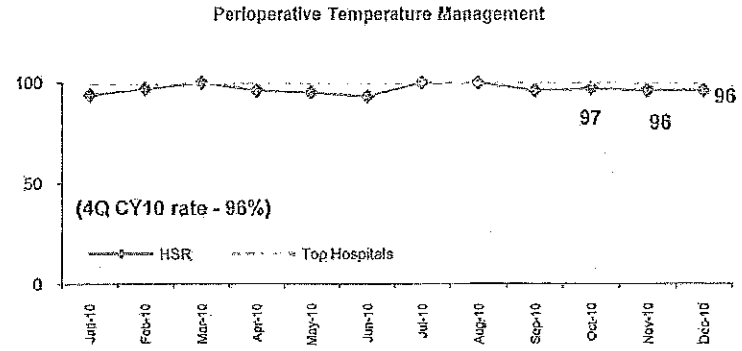
Comparison rates: Jan 10 - Mar 10
HSR - 92%
State - 89%
Top Hospitals - 100%



SCIP-10

Description: Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal or greater than 96.8 F/36 C recorded within the 30 minutes immediately prior to or the 15minutes immediately after Anesthesia End Time.

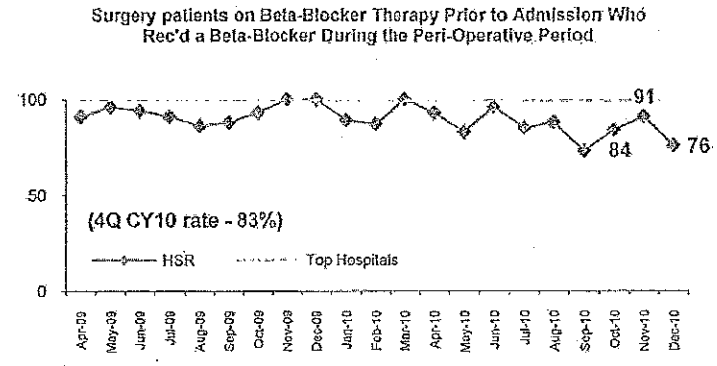
Comparison rates: None currently available



SCIP-Card-2

Description: Surgery patients on beta-blocker therapy prior to admission who received a beta-blocker during the peri-operative period. The peri-operative period is defined as 24 hours prior to surgery through discharge from post-anesthesia care.

Comparison rates: Apr 09 - Mar 10
HSR - 93% (1% decrease from last quarter)
State - 93% (same as last quarter)
Top Hospitals - 100% (same as last quarter)

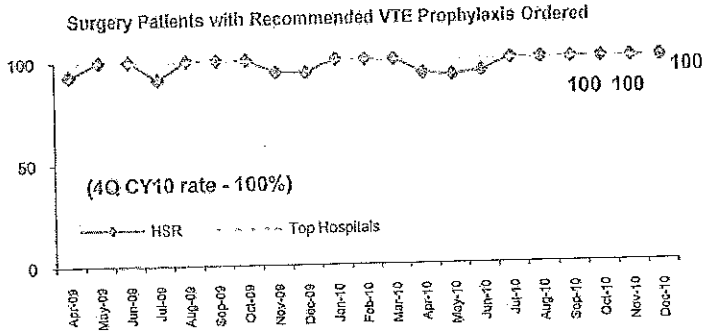


Data collected and report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Benchmark rate source: hospitalcompare.hhs.gov Updated: 12/11/10

Public Reporting Initiative
JCAHO Core Measures/Hospital Quality Alliance (HQA)
Surgical Care Improvement Project
Apr 09 - Dec 10

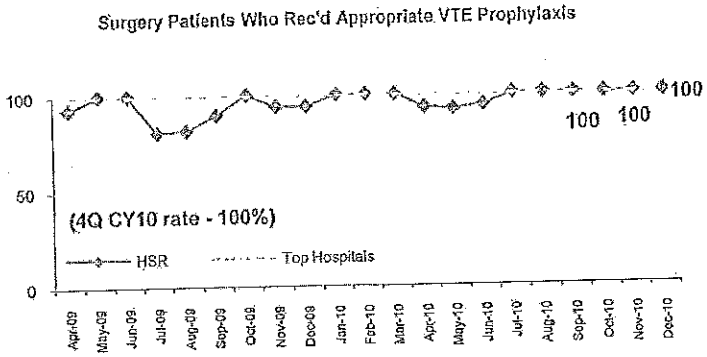
SCIP-VTE-1
Description: Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered during the admission.

Comparison rates: Apr 09 - Mar 10
HSR - 98% (1% increase from last quarter)
State - 96% (1% increase from last quarter)
Top Hospitals - 100% (same as last quarter)



SCIP-VTE-2
Description: Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to surgical incision time to 24 hours after surgery end time.

Comparison rates: Apr 09 - Mar 10
HSR - 98% (1% decrease from last quarter)
State - 94% (same as last quarter)
Top Hospitals - 100% (same as last quarter)



Data collected and report prepared by: Jacqueline Richo, Sr. QI Coordinator
Apr 2011
Benchmark rate source: hospitalcompare.hhs.gov Updated: 12/11/10

Attachment V

Connecticut Hospitals – Capital Spending as a Percentage of Depreciation (from DPH data)

Comparison of Connecticut Hospitals' Capital Expenditures and Related Measures
2010

	Hospital	Located In Combined Service Area	Net Patient Services Revenue	Capital Expenditure	Capital Expenditure as a Percent of: Depreciation	Total Assets	Total Property, Plant & Equipment Less Depreciation	Gross Patient Services Revenue	Net Patient Services Revenue	Total Operating Revenue
[1]	Yale-New Haven Hospital	X	$1,318,578,000	$146,487,000	283.6%	8.3%	17.1%	3.8%	11.1%	10.7%
[2]	Hartford Hospital		$800,993,375	$58,788,362	137.4%	5.4%	19.7%	3.1%	7.3%	6.3%
[3]	Saint Francis Hospital and Medical Center		$598,146,639	$104,091,813	394.7%	13.1%	24.3%	7.2%	17.4%	16.0%
[4]	Danbury Hospital	X	$473,298,383	$37,988,325	147.8%	6.0%	20.7%	3.6%	8.0%	7.8%
[5]	Hospital of Saint Raphael	X	$471,037,000	$8,692,000	59.5%	2.9%	9.2%	0.7%	1.8%	1.8%
[6]	Stamford Hospital	X	$429,754,000	$21,774,000	79.5%	4.7%	9.1%	1.7%	5.1%	4.7%
[7]	St. Vincent's Medical Center	X	$371,617,000	$31,462,000	141.9%	5.5%	14.8%	3.4%	8.5%	8.2%
[8]	Hospital of Central Connecticut	X	$368,946,837	$18,695,139	107.2%	5.1%	14.9%	2.3%	5.1%	4.9%
[9]	Bridgeport Hospital	X	$359,062,000	$14,280,000	80.3%	4.8%	12.7%	1.2%	4.0%	3.9%
[10]	Middlesex Hospital	X	$326,682,000	$22,763,000	107.2%	5.8%	14.3%	2.4%	7.0%	6.8%
[11]	Norwalk Hospital	X	$326,580,262	$15,014,858	75.1%	5.7%	13.5%	2.0%	4.6%	4.3%
[12]	Lawrence & Memorial Hospital	X	$314,168,301	$19,933,142	119.2%	5.9%	18.3%	3.1%	6.3%	6.1%
[13]	Greenwich Hospital		$279,086,000	$18,814,000	91.8%	3.9%	7.7%	2.1%	6.7%	6.2%
[14]	William W. Backus Hospital	X	$270,048,715	$12,056,041	69.0%	3.6%	12.2%	2.1%	4.5%	4.4%
[15]	Waterbury Hospital	X	$254,787,935	$5,488,470	57.2%	3.4%	12.7%	0.6%	2.2%	2.1%
[16]	University of Connecticut Health Center - John Dempsey Hospital		$246,155,547	$5,723,019	54.1%	5.3%	10.5%	1.1%	2.3%	2.3%
[17]	St. Mary's Hospital	X	$243,847,000	$7,021,000	80.8%	3.8%	12.9%	1.2%	2.9%	2.8%
[18]	Connecticut Children's Medical Center and Subsidiaries		$223,198,671	$6,722,903	65.8%	2.0%	7.2%	1.5%	3.0%	2.7%
[19]	MidState Medical Center	X	$182,022,152	$27,849,402	244.2%	11.5%	20.7%	7.4%	15.3%	13.0%
[20]	Manchester Memorial Hospital		$166,310,748	$5,887,334	76.8%	3.9%	11.4%	1.4%	3.5%	3.3%
[21]	Bristol Hospital	X	$128,018,896	$7,025,485	134.0%	7.2%	19.0%	1.9%	5.5%	5.3%
[22]	Griffin Hospital	X	$120,786,185	$5,728,839	87.6%	4.7%	8.9%	1.5%	4.7%	4.6%
[23]	Day Kimball Healthcare		$107,034,385	$10,934,250	240.5%	14.1%	34.2%	6.2%	10.2%	9.9%
[24]	Charlotte Hungerford Hospital	X	$103,758,285	$1,606,967	26.0%	1.4%	3.9%	0.9%	1.5%	1.5%
[25]	New Milford Hospital	X	$91,604,813	$6,604,081	120.3%	9.6%	20.0%	2.7%	7.2%	6.9%
[26]	Windham Community Memorial Hospital		$88,942,706	$4,396,613	97.2%	6.5%	12.1%	2.3%	5.1%	4.9%
[27]	Milford Hospital	X	$78,615,925	$767,576	21.5%	1.1%	2.9%	0.4%	1.0%	1.0%
[28]	Johnson Memorial Hospital		$65,622,834	$2,353,889	74.0%	4.9%	9.9%	1.5%	3.6%	3.6%
[29]	Rockville General Hospital		$64,174,022	$1,470,713	38.5%	1.6%	4.5%	1.0%	2.3%	2.1%
[30]	Essent Healthcare of Connecticut		$54,034,467	$1,997,641	60.8%	3.5%	5.1%	1.6%	3.7%	3.7%
	Unweighted Hospital Average				112.4%	5.5%	13.5%	2.4%	5.7%	5.4%
	Minimum				21.5%	1.1%	2.9%	0.4%	1.0%	1.0%
	Maximum				394.7%	14.1%	34.2%	7.4%	17.4%	16.0%
	# of CT Hospitals Lower than HSR				5	4	8	2	2	2
	% of CT Hospitals Lower than HSR				16.7%	13.3%	26.7%	6.7%	6.7%	6.7%

Notes:

1. Combined lease expenses are often available in the notes but did not specify payments on capital lease obligations. In these cases, the lease expenses were not included in the Capital Expenditure total.
2. Figures highlighted in red are lower than the same figure for Hospital of Saint Raphael.

Source:

1. State of Connecticut Department of Public Health, Audited Financial Statements 2010. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=484044 (Accessed on 11/10/2011).

Attachment VI

HSR - Additional Capital Needs

	ADDITIONAL CAPITAL NEEDS	Total
1	2012 Deferred Capital Equipment and Requests (See worksheet below)	17,247,408
2	OB/Gyn LDRP	14,000,000
3	Radiology Renovation and Modernization	10,000,000
4	OR Consolidation and Modernization	10,000,000
5	Renovate 596-598 George St,1389 Chapel, 301 Orchard Sy, 11 Sherman Ave, 84 Main St Branford	9,600,000
6	Other Locations: Real Estate	9,600,000
7	Nursing Call, Monitoring, Pumps, Case Cart System	6,500,000
8	Adult Psych Private/Main	5,000,000
9	MICU Acute Care	3,500,000
10	CCU Renovation	3,500,000
11	CTICU Renovation	3,500,000
12	Elev Upgrades (10 Elev banks req upgrade)	3,000,000
13	Parking Garage Repairs GSG / OSG	2,750,000
14	Private/Main Building Window Replacement/Masonry	2,750,000
15	Upgrading the second MRI magnet	2,500,000
16	ATS Replacement	2,500,000
17	Replace Verdi AHU, HVAC Coils	2,180,000
18	Case Cart System for OR	2,000,000
19	1 Chiller Replacement	2,000,000
20	Bring AC to Main and Private	2,000,000
21	Replacement of Roofs	2,000,000
22	2 Boiler Replacements	1,900,000
23	Renovate Verdi Cores (3 Flrs)	1,800,000
24	Main ED Triage	1,750,000
25	Parking Garage Repairs OSG	1,750,000
26	Replace Electrical Generators	1,600,000
27	Spine Unit Renovations	1,600,000
28	Expanded space for breast imaging adjacent to breast center	1,500,000
29	Celentano 1st Floor	1,370,000
30	Replacement of 5 RTU's	1,000,000
31	Scranton Building AHU / Roof	500,000
32	Renovate 1441 Chapel St.	300,000
33	Waterproof SLA	250,000
34	Waterproof CEL	250,000
35	Repair Verdi Windows/Bldg. Envelope	175,000
36	Orchard Surgical Services Renovations Bariatric Service Line	52,215
37	Cardiovascular LifeNet wireless EKG technology	50,000
38	Diagnostic Services PICSPlus Software	50,000
	Total Deferred Strategic Projects & Repairs	**132,024,623**

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total
1	Facility	Ortho/Spine Unit			3,500,000
3	Information Services	Meaningful Use: Sunquest Upgrade $150K, QuadraMed $850K, and Ambulatory EMR $600K	The Meaningful Use line item is a contingency capital item. We will need to spend these funds only if the YNHH deal is not approved or the approval process is extended.		1,600,000
4	Radiology/PET Scan	Replacement PET/CT. Quality of imaging, extremely profitable discipline in imaging	Quality of imaging, extremely profitable discipline in imaging		1,550,000
5	Dept of Surgery	Integrated Anesthesia Gas and Physiologic Monitors*			1,086,173
6	Information Services	Payroll and Personnel System for 4000 employees. Note: Capital Request 73 or 74	Replacement of Payroll and Personnel System --4000 employees. Implement an outsourced arrangement for payroll and an implementation of an HRIS system. We are currently looking at 2 vendors for this - ADP and Ceridian. Year 1: $700K Proposal, hardware, interfaces, Year 2: $600K		1,000,000
7	Facility	Verdi 5E Project			875,000
8	CCU	Phillips Monitoring Equipment	New technology to replace 12-15 year old central and bedside monitoring equipment. Present system unable to meet the needs of the critical care monitoring and diagnosis necessary in the care of our patients. Present system has periods of freezing and screen blackouts	Replacement	826,192
9	Facility	ED Psych Renovations (DOH & ECRI Recommended)			500,000
10	Radiology	Radiographic DR Unit Rm 3. Patient throughput and quality	Patient throughput and quality		500,000
11	Information Services	Kronos Clocks Upgrade/? Badge system Note: Capital Request 73 or 74	Kronos, time and attendance system. Clocks are at end of life and no longer supported. HSR will not be able to upgrade the Kronos software in the future without upgrading our clocks. This expenditure is necessary only if we do not proceed with the new HRIS/Payroll system.		400,000
12	Psychiatry	Renovations to Celentano 1	By changing the bedroom configuration and adding a bathroom we can improve patient throughput and the quality of the environment (no 3-bedroom). We will also change the location of the activity room and staff room. Only downsize is the loss of some storage space on the unity which we need to address. Need to incorporate recommendations from ECRI report related to adverse event. Current nursing station is not functional.	Regulatory/Quality; Safety/Infection Control	395,000

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
13	Engineering	Elevators 19 & 24 Replacement	These elevators present regular recurring problematic issues of breakdowns and entrapments. #19 used for delivery of supplies from loading dock to hospital. #24 street side of the GSG.		330,000	
15	Engineering	SLA/CEL Building Façade Repairs	Repair façade of SLA/Celentano buildings. Leaking windows result in having to relocate patients due to safely and environmental conditions. Also revenue loss when rooms cannot be occupied during high census. Construction $258K and Design/Project Monitoring $33K.		290,800	
17	Dept of Surgery	Neuro Microscope			258,000	
18	Information Services	Vocera Housewide			250,000	
19	Facility	Correct Water Infiltration (SLA & CEL)			250,000	
20	Labs	Beckmen Coulter Hematology analyzers			250,000	
21	Facility	Verdi 4N Facelift			200,000	
24	Labs	Coagulation analyzers			150,000	
25	Nursing	Rauland Responder Patient Call System	Rauland Responder System. Timely response to patient requests. Ability to answer call light immediately from a central console and find appropriate assistance for the patient.	Regulatory/Quality; Safety/Infection control; Customer service	145,000	
26	ED	Phillips Intelliview Monitors	Needed to equip rooms 22-27 in the ED. This will allow all ED to be equipped with the same patient monitors. Currently using monitors that are no longer supported by the vendor.	Replacement; Regulatory/Quality; Accreditation Reqmt; Licensure/Code reqmt; Safety/Infection control	144,000	
27	FPP Surgery	Renovations	Renovations to MOB 205 for Bariatric Service line	Clinical Business Plan Strategic Initiative	141,840	
28	Labs	Advance Bar Code & Tracking	Allows positive patient identification through multiple transfers of specimen from receipt, gross dictation, processing, micrometry, histologic review and final report.	Patient Safety	141,000	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
29	Food & Nutrition	Dishwasher	Current dishwasher >15 years old, constantly serviced/ repaired. Last repair 8/6/11. Prior to this, the dishwasher was out of service for 1 week while we were waiting for the new part to be delivered. All meals were delivered on disposable ware, negatively affecting food temperature and quality. Total charges for repair/maintenance of dishwasher from 1/2011 to present: $19K . Hobart (vendor) estimated cost for total overall service/replacement of current machine to good working condition estimated to be $15,000-$20,000. Request range for new dishwasher 130,000 to 150,000.	Replacement; Safety/Infection Control	140,000	
30	Mammography	Mammography Reporting System. Physician and technologist efficiency, regulatory requirement for reporting	Physician and technologist efficiency, regulatory requirement for reporting		130,000	
31	Dept of Surgery	Super Dimensions Electromagnetic Navigation Bronchoscopy (ENB) Buyout			123,000	
32	Information Services	SQL Connect---this includes the shadow server/training/software	Enhanced report writing capabilities/queries to support hospital/clinical operations		110,000	
33	Dept of Surgery	Urology Lasers			110,000	
34	Information Services	Centralized Video Monitoring/Maint	Centralization of ED, OR, Café, IS Data Centers/Ops areas/Inpatient Psych and Inpatient Child Psych cameras. Approx 63 cameras that will feed to Security office and their operational status will be monitored (alarm notification if not functioning) certain clinical video will not be displayed due to privacy concerns. Server will be located in Data Center		100,000	
35	Engineering	Cast Iron Waste Lines	Replacement of cast iron waste lines in basement levels of multiple buildings. The 36 to 25 year old cast iron waste lines in Verdi, SLA and Celentano building are breaking down and deteriorating, causing sanitary leaks. They need to be systematically replaced with new cast iron pip before actually causing major sanitation leaks		100,000	
36	Dept of Surgery	ENT Microscopes/Laser			85,000	
37	Dept of Surgery	Hercules Electric OR Table			84,000	
38	Dept of Surgery	Jackson Spine Table			82,000	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
41	Engineering	CPES Wall Protection	Installation of new wall protection in the C.P.E.S. Patient Rooms. Due to the weekly damage by in-patients within the C.P.E.S. Nursing Unit on the Celentano Bldg fifth floor, there is a need to provide a sturdy wall protection to prevent the in-patient population from endangering themselves from harm due to the exposing of internal wall components of electrical wiring, insulation and other hazardous in-wall components. This damage occurs on a weekly basis that is documented with thousands of dollars of material and labor costs within the past year. Repairs must be immediate in nature and takes away from scheduled projects and maintenance tasks of the various trades within Engineering and Maintenance. During any one instance of a patient being injured within a wall cavity that is breeched by that or another patient, the subsequent regulatory review and/or legal litigation would pay for this one time investment/protection expenditure. During the week of 8/8/11, electrical wiring was being pulled from damaged/opened up wall cavity!		75,000	
42	Nursing	Pulse Oximetry Monitoring	Philips central pulse oximetry monitoring for post-op patients O2 and CO2 according to Anesthesia (ASA) guidelines	Regulatory/Quality; Safety/Infection Control; New equipment	74,523	
43	Facility	Main Campus Chiller Repair			70,000	
44	Information Services	McKesson Upgrade to 15.0---Note: In discussion for whether or not OR wants to pursue	Additional enhancements to support nursing documentation within the OR. 6-9 month project to upgrade the McKesson OR system		65,000	
45	Dept of Surgery	OR Light Upgrades			64,000	
46	OMS	Panoramic X-Ray Sirona XG & 3D upgrade module	Upgrade module and labor to become current with AMOS standards of care	Regulatory/Quality; Accreditation Reqmt; Increase revenue; Customer service	60,000	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total
48	Engineering	Overhead Page System	Replacement and upgrade of hospital wide system. 36 year old system is failing. Complete system outages have occurred, system components are obsolete and replacement parts scarce.		60,000
49	Dept of Surgery	20 Syringe Pumps for Anesthesia			52,000
51	Dept of Surgery	Electrosurgical Units /w Smoke Evac.			50,000
52	Labs	PICS Plus Imaging	Allows for the capture of requisition slips, gross images, microscopic images and reference reports. Images attached to specimens as permanent record. Eliminates transcription of reference reports	Patient Safety/ Support; Outreach Initiatives	48,400
53	Well Baby Nursery	Infant Free Standing Warmers	Request for 3 Warmers, currently have 3 warmers, they are 16, 24, and 26 yrs old. They are used to warm babies for baths, procedures, exams, and evaluations. Cost: $15000 ea.		45,000
54	Dept of Surgery	Ultrasound for Vascular			42,000
55	NICU	Giraffe Omnibed needed for premature babies; have 2 given volume need a 3rd.	Equipment used for premature babies. Last 3 FYs 150-180/yr NICU admissions; 80-90/yr are premature.		40,000
57	Radiology Admin	Film Digitizer. Replacement of current film digitizer - not compatible with PACS	Replacement of current film digitizer - not compatible with PACS		32,652
58	Adult Primary Care Clinic	Renovations and floor replacement	Currently in OSHA violation (Per maintenance dept)	Replacement; Regulatory/Quality	32,000
59	Nursing	Room Window Shades	Patients upset that no means to filter early morning light	Replacement; Customer service	30,744
60	Information Services	Replace the GEAC Fixed Asset module.	This is a residual replacement from the Mediclick replacement that occurred in September of 2010.		30,000
61	Parking	Orchard St. Garage: Repair stairwell towers	Significant weathering over the years resulting in damaged looking property.	Customer Satisfaction - Appearance	30,000
62	Radiology Admin	PACS Control Tower Workflow. QI ability for radiologists and technical personnel	QI ability for radiologists and technical personnel		29,488
63	FPP Surgery	Renovations	Renovation of exam rooms for Bariatrics. Carry over from prior year approved capital budget	Replacement; Safety/Infection control; Increase revenue and volume	28,785

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
64	Security	ED Lot Security Gate	Install Security Gate to Lockdown Lot. Sometime challenging to keep disorderly crowd away from the ED; physical barrier needed to maintain a safe environment. Current procedure: Manpower form a line & contact police.	Regulatory/Quality /Safety	26,000	
65	Dept of Surgery	New Luxtec Xenon Headlights (5)			25,000	
66	Dept of Surgery	Intraoperative Ultrasound Probes Vascular			24,000	
67	Engineering	OR Corridor Wall Protection	Installation of new wall protection in the remaining OR Corridors that have not been completed. Due to the ongoing damage by stretchers, beds and other equipment within the OR corridors in the Verdi Bldg second floor, there is a need to provide a sturdy wall protection to prevent the ongoing damage of walls that is both an infection control issue and the ongoing scrutiny of the State DPH and CMS regulatory inspections. This damage occurs on a regular basis was a documented citation by CMS this past year.		24,000	
68	Parking	Orchard St. Garage: Replace Cashier Booth	Current booth is 26 yrs old. Leaking and electrical problems.	Safety	20,000	
69	Engineering	Boiler Feed Water Pump	Replacement of a boiler Feedwater Pump. Due to the failure of a boiler feed water pump that cannot be rebuilt, a new replacement is required in ordered to back-up an older, well used boiler feed water pump. Without either of these pumps in the event of double failure, the use of one boiler would be lost. The ability to provide heat in winter and cooling in summer would be severely jeopardized.		19,200	
70	Dept of Surgery	Video Mediastinascope (Storz)			18,154	
71	Dept of Surgery	Intraoperative Ultrasound Probes Trans-Rectal			18,000	
72	Facility	OSG Sidewalk and OSG Garage Exterior Repairs	Replacement of a portion of the concrete sidewalk in front of OSG. Broken and Deteriorated sidewalk is a safety hazard. West corner of the garage is deteriorating and concrete is dropping to the sidewalk.		18,000	
73	Labs	CoPath Order Entry Interface	Allows anatomic pathology tests to be ordered in HIS which will facilitate verification of receipt and access by physicians to report status.	Patient Safety	17,000	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
74	Well Baby Nursery	Infant Over Bassinet Warmer	Qty: 2 - Replacement current old, outdated warmers (17 and 14 yrs old); difficult for nursing staff to use.		16,380	
75	FPP Women	Renovations to Accommodate Pyxis Machine	To enable the capture of current unbilled revenue or force cost avoidance of improper prescriptions e.g. marena devices	Increase revenue; cost reduction; new equipment	16,000	
76	Nursing	Suction Regulators	Replacement of broken and missing suction regulators in patient rooms-5 per cost center	Regulatory/Quality; Safety/Infection Control	16,000	
77		Bladder Scanner	Bladder scanner is used as a diagnostic tool for many GYN patients. A bladder scanner is borrowed from another unit as needed. Patients are inconvenienced by the delay and physicians are not happy when their patients' discharge or treatments are delayed due to unavailability of scanner.	New equipment	13,500	
78	Labs	Embedding Station	Second embedding station never replaced - no redundancy of critical equipment for processing histologic slides.	Maintain Operations	13,000	
79	FPP G&A	Waiting Room chairs and exam room furniture	Replace medical group broken furniture in various waiting and exam rooms	Replacement; Customer service	12,000	
80	Nursing	Dinemap VS Monitors	Improve efficiencies. Replace old, undependable equipment	Regulatory/Quality; Safety/Infection Control; New equipment	11,088	
81	Pedi Primary Care Shelton and Hamden	Two transcutaneous biliometers	It will allow the provider to check newborn infants billirubin levels in the clinics faster, without needing a needle and without the wait time required of a blood sample result; this also means less time for a newborn infant to sit in the waiting room of the lab and clinic where there is a possibility of coming in contact with sick children. Monitoring billirubin levels in young infants can help prevent kernicterus, a serious condition that is the result of high billirubin levels that can result in seizures and severe developmental delay.	New Business; Increase revenue; new equipment	10,800	
83	Security	George St. Garage: Add'l Security Camera Coverage	Add'l security cameras in GSG on levels 2A, 4A, 5A, 6A, 7A. $2,000/camera	Regulatory/Quality /Safety	10,000	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
84	OMS	Front desk renovation	Only able to register and speak with one patient at a time, approx. 4-6 pt.'s in line at any given time, no privacy	Replacement; Regulatory/Quality; Accreditation Reqmt.; Customer service	9,865	
85	Psychiatry	Replace Air Conditioning at 646 George St., 3rd Fl.	Air conditioning replacement for 646 George St. to support 3rd fl where new program will be. New system is required to support the building size. New furnace and new 5 ton AC system.	Replacement; Regulatory/Quality; Clinical Business Plan; Increase revenue and volume; New service; New staff; Support space	8,800	
86	Engineering	Water Treatment System Replacement	Replacement of the potable water chlorination/disinfection system. The automatic, secondary water chlorination/disinfection system analyzer has failed and is we are manually adjusting the chemical feed rate. The 25 year plus, potable water disinfection system needs urgent replacement with a new technology, automatic system to prevent legionella and other bacterial contamination of the potable water system in the Verdi Building.		8,500	
87	Surgical Specialty Clinic	EKG and PFT equipment	Current EKG and PFT equipment is near obsolete	Replacement; Regulatory/Quality	8,000	
88	Haelen Center	Colposcope	Equipment needed to perform anoscopes in the Haelen Center clinic for patients with abnormal anal paps. 600 cases to be done per Dr. Virata	New Business; Increase revenue and volume; New equipment	8,000	
89	CT ICU	Automatic Doors	Replace doors with automatic doors. Our current doors have to manually held open to transport patients through them on stretchers and wheelchairs. *Itemized cost: doors-$4,000; operators-$2,080; Honeywell fire alarm-$1.214	Replacement; Safety/Infection Control; Customer Service	7,294	
90	NICU	Neonatal Ventilators compatible with MRI Unit	Babies on ventilators requiring an MRI are transferred and remain at YNHH.		7,197	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

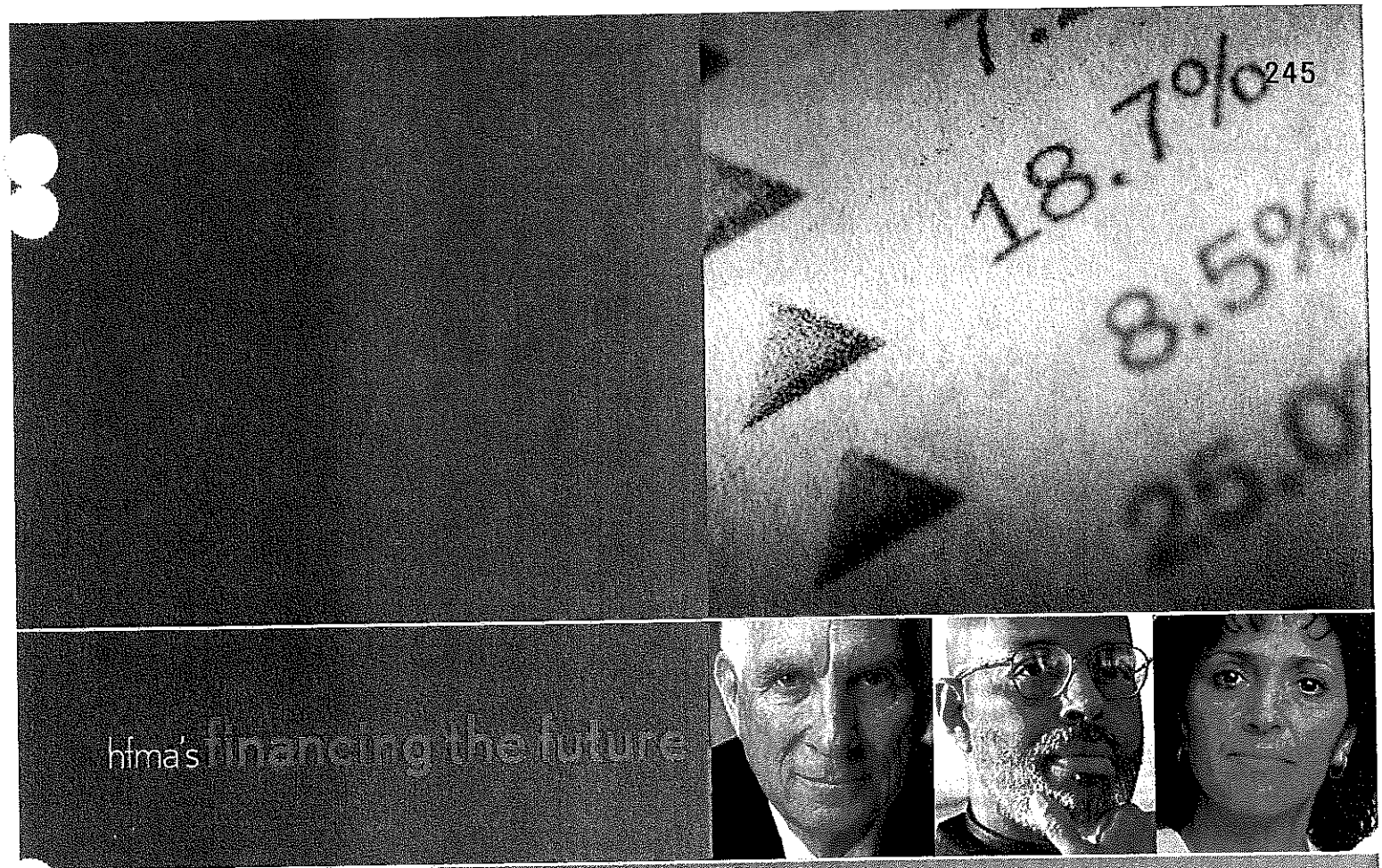
	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
91	CT ICU	Intermit. Suction Regulator	Need to replace 16 intermittent suction regulators with fittings. Currently do not have enough to keep patient rooms ready and set up. The nurses have to move regulators from room to room to set up for admissions-depending on the type of procedure the patient has had.	Replacement; Regulatory/Quality; Safety/Infection control	6,488	
92	Well Baby Nursery	Scale-Tronix Infant Scale	Request for 2 scales, currently have 4 scales we have are 15, 22, 24, and 28 yrs old. 2 of the 4 are out of service waiting for spare parts to be found, vendor no longer services the scales. Cost: $3100 ea.		6,200	
93	Well Baby Nursery	Medfusion Syringe Pumps	Request for 2 pumps, currently have 4 pumps, they are 14, 15, 16, and 16 yrs old; they are no longer serviced by the vendor. Cost: $3000 ea.		6,000	
94	SLA3	Vital Sign Machines	Patient vital sign machines require 2 machines. Move to V5 East increased census. The current machines have aging of equipment, obsolete, reliability. They are repaired with increased frequency.	Replacement; New service	5,815	
95	Pedi Primary Care New Haven	One Transcutaneous billiometer	It will allow the provider to check newborn infants billirubin levels in the clinics faster, without needing a needle and without the wait time required of a blood sample result; this also means less time for a newborn infant to sit in the waiting room of the lab and clinic where there is a possibility of coming in contact with sick children. Monitoring billirubin levels in young infants can help prevent kernicterus, a serious condition that is the result of high billirubin levels that can result in seizures and severe developmental delay.	New Business; increase revenue; new equipment	5,400	
96	V3E	Blinds	Roller shades are required in the patient rooms. We can no longer replace the current curtains that hang in the patient rooms.	Replacement	5,035	
97	OMS	Tuttnauer EZ10 Autoclave	Current autoclave not able to be repaired. Have been renting for $85/mo.	Replacement; Safety/Infection control	5,002	
98	NICU	NeoBlue Phototherapy Light needed for premature babies; have 3 given volume need a 4th.	Equipment used for premature babies. Last 3 FYs 150-180/yr NICU admissions; 80-90/yr are premature. Phototherapy lights are used in almost all preemies any many term infants.		5,000	
99	SLA3	Meditherm III Hypo/hyperthermia unit base model	Machine to cool patient's body temperature or warm patient's body temperature. Current machine is 20 years old.	Replacement	4,200	

Hospital of Saint Raphael
2012 Deferred Capital Equipment and Requests

	Department	Deferred Capital Equipment and Requests	Description	Request Justification	Request Total	
100	CT ICU	Stance Recliners	2 Stance Recliners ($1,799 ea.). We received 6 recliners this year and have 4 older ones (for a 16 bed unit). Concerned that with wear and tear on the older ones, we will not have enough chairs to ensure that we are properly mobilizing our patients. We have already experienced times when the census has been up and patients have had to wait for a recliner to get out of bed.	Replacement; Safety/Infection control	3,598	
101	V3E	Stand-on scale	...handles for the patient to hold on to so they are at risk for falling or to have an accurate weight done.	Replacement; Safety/Infection control	2,295	
103						
104						
106		**Total Deferred Capital Equipment and Requests**			**17,247,408**	

Attachment VII

HFMA Report 6: The Outlook for Capital Access and Spending



hfma's financing the future

Financing the Future II

Report 6: The Outlook for Capital Access and Spending

In partnership with

GE Healthcare Financial Services and Kaufman

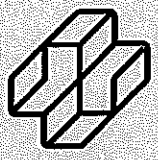
hfma
healthcare financial management association

Financing the Future II
Report 6:
The Outlook for Capital Access and Spending

Copyright 2006
Healthcare Financial Management Association
All rights reserved.

Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154-5700
www.hfma.org
www.financingthefuture.org

Correspondence: megflan@hfma.org



hfma™
healthcare financial management association

In partnership with

GE
Healthcare Financial Services

and

KaufmanHall

August 2006

Table of Contents

Financing the Future II

Report 6:

The Outlook for Capital Access and Spending

Introduction ii

What Big-Picture Trends Should Hospitals Be Most Attentive To in Their Strategic, Financial, and Capital Planning? 1

Competition 1

Payment 1

Technology 2

How Is Access to Capital Likely to Change in the Next Five to 10 Years? 2

Access Categories 2

Access by Geography 4

Financial Performance 4

The Performance-Access Link 5

How Should Hospitals Determine Where to Focus Their Capital Spending? 7

The Process 7

The Tools 7

Capital Spending Priorities 8

Are Hospitals Spending Enough to Meet Competitive and Consumer Needs? 8

Spending Levels 8

Spending Adequacy 10

What Should Hospitals Do to Close the Gap Between Capital Need and Spending? 11

The Performance Improvement Mandate 11

Alternative Funding Sources 11

Scenarios for Struggling or Unsuccessful Hospitals 12

Closing Comment 14

References 15

Introduction

The first *Financing the Future* series, published from November 2003 through September 2004, brought together key stakeholders to share knowledge about and produce solid empirical evidence of healthcare capital needs, availability, and factors associated with access. Led by HFMA in partnership with GE Healthcare Financial Services and with research conducted by HFMA and PricewaterhouseCoopers, the series continues to be cited and used extensively in the healthcare industry.

The bedrock tenet of the information provided in the six reports in the first *Financing the Future* series was that solid financial performance is a prerequisite for capital market access. The series thus began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital.

Financing the Future II, developed by HFMA in partnership with GE Healthcare Financial Services and Kaufman, Hall & Associates, Inc., and published from May 2005 through August 2006, continues this process. Its cornerstone principle, carried through in each of its six reports, is this: Adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance.

To obtain capital at an affordable cost, hospitals must show rating agencies, bond insurers, investors, and other capital market constituents a track record of solid financial results. Organizations arrive at such outcomes through implementation of consistent, high-quality planning processes and thorough monitoring and revision of plans, as appropriate. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second *Financing the Future* series seeks to help healthcare organizations of all sizes "raise the bar" on financial performance.

The first three reports in *Financing the Future II* illustrate how actual hospitals and healthcare systems have applied the seven principles of best practice financial management to achieve successful performance and capital access. The fourth report focuses on how healthcare leaders can pursue joint venture opportunities within a corporate finance-based framework that aligns the joint venture with the organization's long-range strategic, financial, and operating plans. The fifth report addresses strategies for financially distressed hospitals.

Report 6: The Outlook for Capital Access and Spending provides updated healthcare industry data and thoughts from leaders in the field about the future of healthcare spending and capital access. Panelists include **Martin Arrick**, managing director, Not-for-Profit Healthcare, Standard & Poor's; **Richard L. Clarke**, DHA, FHFMA, president and CEO, Healthcare Financial Management Association; **Randy Fuller**, manager, Market Intelligence, GE Healthcare Financial Services; **Paul B. Ginsburg**, PhD, president, Center for Studying Health System Change; **Lisa Goldstein**, senior vice president/team manager, Health Care Ratings, Moody's Investors Service; and **Kenneth Kaufman**, managing partner, Kaufman, Hall & Associates.

We asked these leaders such questions as: What are the trends hospitals should be most attentive to in their strategic, financial, and capital planning? How should hospitals determine where to focus their capital spending? How is access to capital likely to change in the next five to 10 years? Their responses, which appear with updated industry statistics, frame this report.

What Big-Picture Trends Should Hospitals Be Most Attentive To in Their Strategic, Financial, and Capital Planning?

Strategic, financial, and capital planning by hospitals begins with an assessment of the environment in which they operate. Described fully in Report 3 of the second *Financing the Future* series, this industry evaluation identifies trends affecting or likely to affect the organization now and into the future. As mentioned by Martin Arrick, one of our panelists, "Leaders assessing their environment must think globally about their business and about the forces that could impact the organization at multiple levels."

Change has been and will likely continue to be ever-present in the healthcare industry. Although the "jury was out" with our panelists on whether such current trends as consumer-directed health care and pay for performance will persist into the future, the opinion was unanimous that three big-picture issues warrant ongoing focus from hospital leaders: competition, payment, and technology.

Competition

The competitive landscape for not-for-profit hospitals and healthcare systems has altered dramatically in the past decade. Although the intensity of competition varies by location, many organizations are facing significant threats—particularly in relation to highly profitable services, such as orthopedics and cardiology—from physicians, regional healthcare providers, and for-profit companies. Demographic growth occurring in some local or regional markets may support new nontraditional providers, but more often than not, general hospitals are feeling intense competitive heat in key service areas.

Paul Ginsburg: "The most important trend for hospitals, and one that probably creates more planning uncertainty than any other factor, is hospitals' changing relationship with their physicians. An increasing portion of lucrative outpatient services offered by hospitals is subject to competition from physician-owned facilities, including physician practices. Some hospitals are much more vulnerable to competitive challenges from physicians than others.

"Research indicates that population aging is not as large a factor as many in the hospital industry have imagined, but local population trends can also be extremely important to hospital planning efforts. For example, consider how fast hospitals in the Phoenix area need to expand just to keep up with population growth."

Payment

Payment constraints are hardly new news, having been a major environmental factor for hospitals and healthcare systems since Medicare's prospective payment system in 1983 and the Balanced Budget Act of 1997. The mounting federal budget deficit since 2002, however, has greatly exacerbated an already tough situation and makes government-based payment a particularly hot-button issue.

Lisa Goldstein: "Medicare payment will be the first and foremost issue that drives hospital financial and capital planning. Medicare accounts on average for 50 percent of a hospital's revenue base. Although rates are favorable and the outlook stable for 2006, the rate of Medicare payment is likely to slow in the next couple of years."

Martin Arrick: "Key issues on the horizon and likely to emerge within a couple of years include whether the federal government can continue to fund Medicare at the current levels plus an increased percentage each year, and whether states can afford Medicaid healthcare expenditures that exceed growth in overall state revenues each year."

Dick Clarke: "Healthcare financial managers should take into account the federal budget deficit as they develop their longer-term financial plans. The obvious method by which the government deals with funding shortfalls is to limit payment, so, as part of their

projections, managers need to consider likely reductions in the rate of payment increases, and potentially even a rate of overall payment reduction. Operating plans must reflect the imperative to drive down costs and/or strategic plans must reflect consideration of different scenarios for diversification into new markets with new revenue and payer streams.

"Price inflexibility will present hospitals with a significant challenge. In addition to Medicare constraints on pricing, consumer price sensitivity is expected to be a key issue in the next decade. Consumers and payers will require price transparency. As consumers become more responsible for making their healthcare purchasing decisions, they will shop for prices that are 'in line' with market rates."

Technology

During the past 20 years, advances in technology related to patient diagnosis and treatment have made possible increasingly complex inpatient procedures and shifted the provision of many less complex services from acute care settings to outpatient facilities. Healthcare IT is helping hospitals improve clinical quality, patient safety, and physician recruitment.

Randy Fuller: "During the next decade, hospitals will continue to struggle in defining and selecting the 'right' portfolio of high-tech equipment. New technologies are evolving very quickly and increasingly enabling new services, and thus are generating top-line growth. These technologies can support the growth goals of hospitals and help to enhance a hospital's position in increasingly competitive markets. Hospitals should be attentive in their future planning to how they will support technology-related capital expenditures."

Lisa Goldstein: "Hospitals need to be attentive to developments in technology. Electronic health records, quality/outcomes tracking, clinical decision support, revenue/cost management systems, and other IT applications will be 'the enabler' for managing hospital issues coming down the pike. IT will help decide to what degree an organization is able to address current trends, whether managing or tracking pay for performance, consumer-directed health care, or demographic changes."

How Is Access to Capital Likely to Change in the Next Five to 10 Years?

The first *Financing the Future* series addressed such questions as: What is the profile of a hospital with broad access to capital and a hospital with limited access to capital? Do they share certain performance characteristics? Are the percentages of such hospitals increasing or decreasing? Are such hospitals found in specific areas of the country?

Access Categories

Hospitals defined in the first series as having *broad (or "wide") access* to capital met certain criteria related to profitability, liquidity, and debt burden. These hospitals would be able to fund their own capital needs or would be considered excellent credit risks to the capital markets.

Hospitals defined as having *limited (or "constrained") access* to capital met a second set of criteria, which was representative of organizations under significant financial strain—not profitable, not liquid, and with significant debt burden. Access to capital may be possible for these hospitals, but it would come from a more limited number of sources and at a higher cost than hospitals with stronger financial performance.

The first *Financing the Future* series described a gap that exists between U.S. hospitals that have capital to invest strategically and those that no longer produce operating margins sufficient to access capital and support their capital needs. With constrained capital access, these "have-not" hospitals are falling behind in the market.

The first series noted that the gap separating "have" from "have-not" hospitals was widening. Between 1997 and 2001, the percentage of hospitals with wide access to capital declined from 42 percent to 36 percent, and the percentage of hospitals with constrained access to

Exhibit 1

Thresholds for Categorizing Hospitals by Ability to Access Capital

	Wide Access	Constrained Access
Operating margin	more than 2.0%	less than 0.0%
Debt service coverage ratio	more than 3.50	less than 1.25
Days cash on hand	more than 150	less than 15
Current ratio	more than 2.0	less than 1.0
Debt to capitalization ratio	0% to 35%	less than 0% or more than 70%

Notes: Data reflect updates to those presented in *Financing the Future I, Report 1: Access to Capital in Health Care Today*. PricewaterhouseCoopers defined the original methodology and conducted analysis related to identifying hospitals by capital-access category.

The updated scoring allocates a +.5 for each wide access criterion and a –.5 for each constrained access criterion met. Operating margin is weighted as 1 point and each remaining criterion is weighted as 1 point (to allow equal weighting for profitability, liquidity, and capital structure). A hospital score greater than 1 is considered wide access and less than –1 is considered constrained access. Scores between 1 and –1 are moderate access.

Source: HFMA analysis. Medicare cost report data provided by www.ahd.com. Analysis excluded reporting variations and other data quality concerns.

capital rose even more sharply, nearly doubling from 11 percent to 19 percent.

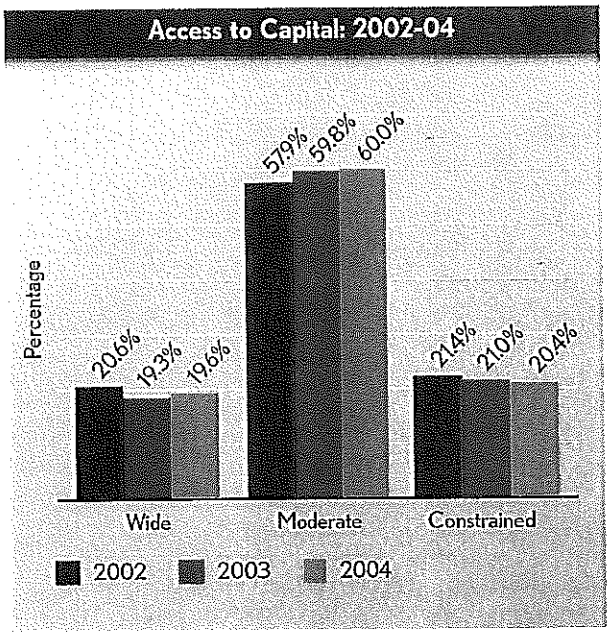
Exhibit 1 defines the criteria used to classify hospitals with wide and constrained access to capital. Exhibit 2 provides most recent data related to the capital access gap, reflecting years 2002 through 2004. The following observations can be made:

- More than half of U.S. hospitals (60 percent) currently have moderate access to capital. This proportion has remained relatively constant during the past three years.
- The gap between hospitals with wide access (19.6 percent) and those with constrained access (20.4 percent) appears to be narrowing modestly. (This is most likely due to the more stable payment environment experienced by hospitals in the past few years which is expected to turn unfavorably in the near future.)

When looking at this information, it is important to note that an apples-to-apples comparison with earlier data is not possible because criteria for and weighting of access categories have changed.

Data also indicate that constrained access was a higher 25.1 percent for hospitals not affiliated with a system over a three-year period, so it would appear that being part of a system positively influences capital access for some hospitals. Researchers also noted that more rural hospitals are included in the constrained access category (22.3 percent) than hospitals as a whole (20.9 percent).

Exhibit 2



Source: *Financing the Future I*, Report 1 (Exhibit 4) based on Solucient data. Updated.

Given the critical nature of reinvestment and the relative needs of most hospitals, Fitch expects the financial gaps between credits at both ends of the rating scale to continue to widen in 2006.

Fitch Ratings: *2006 Nonprofit Hospitals and Health Care Systems Outlook*, New York, Jan 12.

Access by Geography

Exhibits 3-5 indicate that geography continues to be a key differentiator between wide and constrained capital access for hospitals. This finding likely relates to state-specific issues, such as certificate-of-need laws and Medicaid payment. Exhibit 3 shows the top 10 states in percentage of hospitals falling within wide-access and constrained-access categories. Key findings include:

- None of the top 10 states in terms of percentage of wide-access hospitals is in the top 10 for percentage of constrained-access hospitals.
- New York ranks first in the percentage of hospitals designated as having constrained access to capital.
- Indiana, Wisconsin, and Nebraska have the highest proportion of hospitals with wide capital access.

Exhibit 4 shows the proportion of hospitals within each state defined as having constrained capital access; Exhibit 5 shows the proportion of hospitals defined as having wide access.

Exhibit 3

Top 10 States by Hospitals within Capital Access Category

Rank	Wide	Constrained
1	Indiana	New York
2	Wisconsin	Hawaii
3	Nebraska	Washington, DC
4	New Hampshire	Pennsylvania
5	Vermont	West Virginia
6	Minnesota	New Jersey
7	Ohio	North Dakota
8	Virginia	Massachusetts
9	Arizona	California
10	Tennessee	Connecticut

Source: Based on Solucient data. Updated.

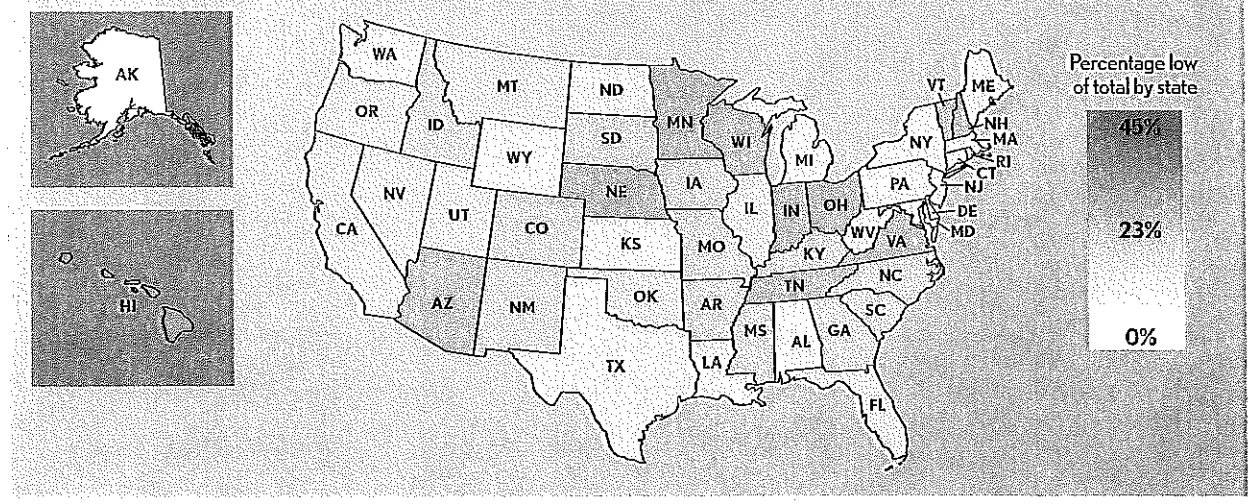
Financial Performance

The performance gap between high-performing and low-performing hospitals, as measured by total margin, widened significantly in the 2002-04 period (Exhibit 6). Although median total margin increased modestly, total margins for high-performing hospitals spiked to more than 8 percent, while total margins for low-performing hospitals dipped into the red, dropping below -2 percent.

Creditworthiness based on financial performance and credit ratings are inextricably linked. Exhibit 7 illustrates a parallel widening disparity of credit quality. In 1990, 5 percent of the credits rated by Moody's Investors Service were Aa rated, 65 percent were A rated, and 27 percent were Baa rated. In 2005, the curve has flattened with 16 percent Aa rated, 44 percent A rated, and a larger 30 percent Baa rated.

Exhibit 4

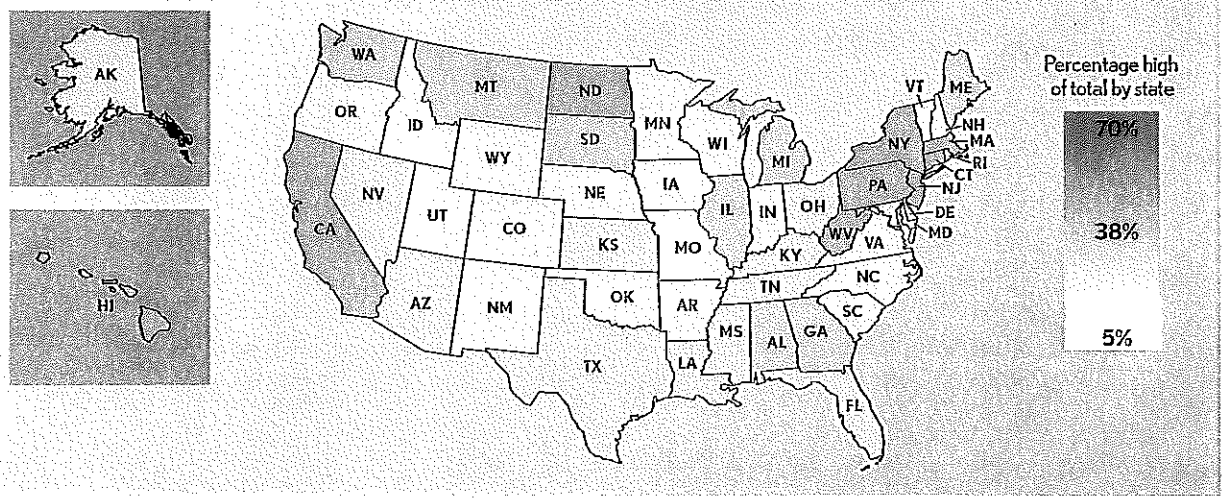
Proportion of Hospitals with Constrained Access to Capital by State



Source: HFMA analysis. Medicare cost report data by www.ahd.com. Analysis excluded reporting variations and other data quality concerns.

Exhibit 5

Proportion of Hospitals with Wide Access to Capital by State



Source: HFMA analysis. Medicare cost report data by www.ahd.com. Analysis excluded reporting variations and other data quality concerns.

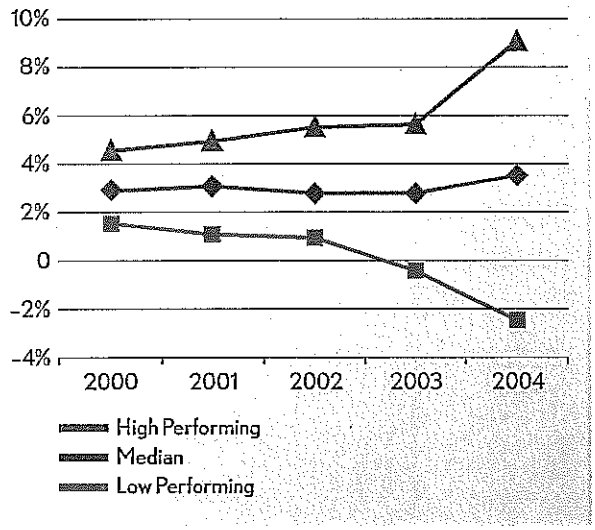
Bond insurance is on the rise, due in part to the re-entry of additional bond insurers into the healthcare space and improved overall industry performance in recent years. In 2005, slightly more than 50 percent of total healthcare debt was insured, up from approximately 40 percent in 2004.

The Performance-Access Link

The first *Financing the Future* series concluded that the cost of capital will be higher for the have-not hospitals, pushing them further and further behind. This conclusion remains valid today and in all likelihood into the future. Hospitals and healthcare systems with lower credit ratings will pay higher interest rates for capital

Exhibit 6

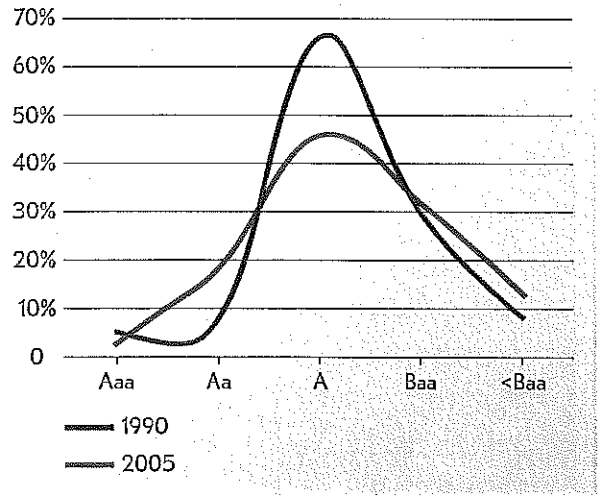
Total Hospital Margins: Widening Performance Gap



Source: Ingenix: *Almanac of Hospital Financial and Operating Indicators,* Jan. 2006. Reprinted with permission.

Exhibit 7

A Widening Disparity in Credit Quality



Source: Moody's Investors Service: *Not-for Profit Healthcare Sector: 2006 Industry Outlook,* Jan. 2006. Reprinted with permission.

than hospitals with better credit ratings. Our panel of experts offered the following comments about future capital access and cost:

Ken Kaufman: "Access to capital is entirely dependent on whether a hospital achieves the financial performance required to meet its long-term financial goals. As described at the beginning of this series, every hospital or health system has a defined level of profitability and financial success necessary to meet its strategic financial requirements. A hospital is or is not meeting those requirements and as a result, will either have or not have access to low-cost capital.

"Large organizations, growing larger, *have* capital access and are borrowing more through much larger debt offerings. Use of bond insurance, available to strong credits, with just a few exceptions, is increasing and lowering the cost of capital for hospitals that can access insurance.

"For hospitals and health systems with declining creditworthiness, as reflected in declining financial performance, access to the capital markets is increasingly limited and will continue to be so. A single notch drop in a bond rating can mean a significant difference in the price of capital. A slightly higher interest rate can amount to significant dollars over the lifetime of the typical 30-year bond issue. The implications for certain healthcare borrowers could be serious and significant.

"Healthcare industry credit ratings have been heading downward for almost a decade. Between 1998 and 2004, bond downgrades significantly outpaced upgrades. 2005 represents the first time in many years that the proportion of upgrades exceeded downgrades by two of the three rating agencies."

Lisa Goldstein: "If you subscribe to the notion of the strong getting stronger and the weak getting weaker, hospitals whose financial performance or credit profile is weakening are likely in the next decade to incur a higher cost of capital and may not have access to bond insurance; hospitals with strong financial performance and a solid credit profile are likely to have good access both to low-cost capital and bond insurance.

"Will the gap widen between stronger and weaker credits? The healthcare industry has changed rapidly in some ways and at a glacially slow place in other ways. Depending upon local market conditions, the bifurcation between the strong and the weak has mostly been a slow one, but may be accelerated by quality as a differentiation strategy. The gap between hospitals that don't have or don't choose to invest capital in the IT and personnel required for quality initiatives, such as achieving Magnet status and high ratings in metrics-based scoring systems, and those that do invest in quality initiatives may widen the performance gap between hospitals in the next decade. Higher-rated hospitals with more resources to dedicate to quality initiatives may achieve growth in volumes and market share, improved payer arrangements, and cost reductions. Hospitals that cannot differentiate themselves in fragmented markets may fall further behind."

Randy Fuller: "Liquidity, bond market access, and hospital credit quality are currently quite healthy, so overall capital access is likely to be robust for the next few years. This situation could change rapidly with modification of federal or local payment. Hospitals that currently do not have a healthy financial picture are likely to continue struggling over the next few years. Without access to affordable capital, turning around a distressed facility is very difficult and calls for a clear view of market position and trends and a crystal clear strategic plan. This is very difficult to achieve while dealing with problematic day-to-day issues."

Martin Arrick: "The past two or three years have been good years for many hospitals, and in some sense, a rising tide lifts all boats. In the future, hospitals 'at the top' with exceptional performance will continue to have unlimited and unfettered access to capital. Hospitals in the middle tier will continue to have good access even if their margins drop a bit. However, the hospitals in the bottom tier are going to have a tougher time as their margins drop to a negative level."

Dick Clarke: "A hospital's continuing access to capital will reflect its ability to respond to market and environmental changes. Organizations that are relatively nimble and, which in fact, can seize emerging opportunities, will continue to have fairly broad access to capital. Organizations at the other end of the spectrum, which have had difficulties responding to marketplace and industry challenges, are not going to have capital access. Organizations in the middle of the spectrum, with moderate capital access, will need to identify their areas of distinctive competence and focus their capital spending on these areas."

How Should Hospitals Determine Where to Focus Their Capital Spending?

The three capital spending priorities most frequently cited in the first *Financing the Future* series—digital radiology systems, computerized physician order entry systems, and other major IT—were all technology-centered. Spending on facility construction was increasing during the 1997-2001 period as a total dollar amount industrywide, but decreasing as a percentage of total healthcare spending.

A number of trends are accelerating capital spending and necessitate sound planning practices, including:

- Continued aging of facilities, which although leveling off, was at a historic high point of 9.8 in 2004, up from 7.9 in 1990
- Continued rapid development of new equipment and technology
- National focus on safety and the benefits that can be achieved with electronic health records, CPOE, and other IT systems
- Industry trends, such as consumer-driven health care, pay for performance, pricing transparency, and clinical decision support—all of which are driving increased IT expenditures

Technologies represent a significant portion of hospitals' planned capital spending, which is estimated to be approximately $12 billion to $15 billion in 2006.[1] Electronic medical records, bar coded medication management, and CPOE currently are the three IT applications most frequently cited as priorities by healthcare leaders.[2]

Our panel of experts addressed the process hospitals should use to allocate capital, the required tools, and the areas requiring significant future capital spending.

The Process

Randy Fuller: "Decisions about where to focus capital spending should be based on a sound strategic plan, which is itself based on sound data and information about what customers need and want, where the market is going, and a full understanding of the payment environment. The capital allocation decision-making process should be multidisciplinary, involving medical directors, CFOs and finance staff, and strategy/business development leaders."

Dick Clarke: "The organization's overall strategic plan, which is linked to a financial and capital plan, should guide capital allocation. The strategic plan reflects an internal and external assessment of market conditions—it essentially is a SWOT (strengths, weaknesses, opportunities, and threats) analysis, which identifies the organization's strategic priorities. The capital plan defines the investments needed to support those priorities within the organization's financial abilities and how the required capital will be obtained."

Ken Kaufman: "Healthcare executives should be making capital spending decisions based on strategic-financial analyses of what they need to do to keep their organizations strong and competitive into the future. This is determined through the development of strategic, financial, and capital plans that identify strategic and financial goals and the debt, cash, capital, and profitability required to meet those goals. Through implementation of the integrated planning process described in earlier *Financing the Future* reports, hospitals invest in a portfolio of initiatives that provides a positive contribution to the strategic financial position of the organization."

The Tools

Dick Clarke: "Hospitals must have comprehensive and cohesive strategic plans that make sense for the organizations and their markets, and which position the organizations to meet their missions. Textbooks, educational programs, consultants, and other sources described in this series provide guidance in developing high-quality strategic plans. Capital planning and allocation tools must have capabilities that include sensitivity analyses so that hospitals can test a variety of assumptions about strategies pursued, payers, volume by payer, underlying cost structures, and other factors."

Randy Fuller: "Hospitals should ensure that they have sound decision-support systems that allow them to fully understand their markets, customers, costs, and

revenues. Also important are capital support or asset tracking systems that allow hospitals to identify age and life cycle issues related to equipment and other assets."

Ken Kaufman: "Hospitals should use rigorous calendar management to guide an integrated strategic, financial, and capital planning process; best practice capital management to achieve the right capital structure and a solid balance sheet; consistent processes and templates to evaluate capital investment opportunities; and monitoring and controls to track strategic and financial performance."

Lisa Goldstein: "Hospitals that perform the best, whether measured strategically, financially, operationally, or through quality measures, are characterized by a key enabling tool. This tool is the unflagging commitment by governance to support the hospital's strategic financial planning process, embrace its strategies as long-term ones, and provide the expertise and approve the resources needed to carry out the strategies."

Capital Spending Priorities

Martin Arrick: "Hospitals need to focus on IT spending, but this will continue to be tricky. Spending on IT doesn't ensure that a hospital will get what it expects or wants in terms of capabilities. These IT 'black holes' may be one of the reasons why some organizations, especially smaller hospitals, are still reluctant to make the needed IT investment.

"Consumerism and service-line profitability will also drive capital spending. Plush specialty centers and convenient outpatient facilities with plenty of parking are being designed to meet consumer expectations. Intent on sustaining the organization over time, hospitals are investing money in service lines that make money. They are not building new psychiatric facilities, for example, but instead, are investing in new cardiac and oncology centers."

Lisa Goldstein: "Hospitals need to focus spending on their facilities, as evidenced by climbing national age-of-plant averages. Years of thin or deferred capital spending can place hospitals at a significant competitive disadvantage with patients, payers, physicians, and employees. IT requires sustained capital spending to meet strategic, clinical, operational, quality, and financial goals. Hospitals must embrace IT as a long-term strategy because IT touches every aspect of an organization's operations."

Paul Ginsburg: "Hospitals should devote planning efforts to identifying major new technology-based procedures and services and to developing the capacity to deliver such services. In recent years, many hospitals have paid particular attention to expanding services that are most profitable. CMS recently proposed a rule to address the inadvertent differences in profitability of inpatient services that come from the reimbursement structure—an approach likely to be broadened to outpatient services in the future—so incentives are about to change dramatically. Hospitals should be tracking this closely."

Are Hospitals Spending Enough to Meet Competitive and Consumer Needs?

The first *Financing the Future* series reported that despite a double-digit increase in utilization, hospitals' aggregate capital spending increased only about 1 percent between 1997 and 2001, in large measure attributable to the financial effects of the Balanced Budget Act of 1997. However, 72 percent of CFOs surveyed in 2001 expected their hospitals' capital spending to increase at a rate of 14 percent per year during the 2001 to 2006 period.

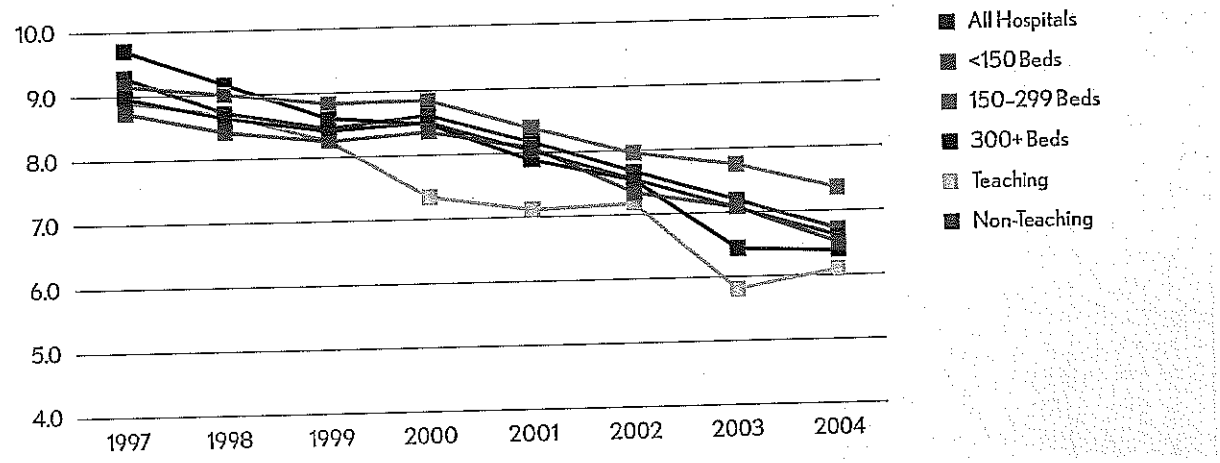
Spending Levels

In general, capital spending levels don't appear to be keeping up and needs for capital are expected to continue to accelerate. That said, it should be noted that data related to aggregate capital spending levels are difficult to obtain and sometimes paint different pictures.

Total capital spending as a percentage of total operating expense has declined steadily during the 1997 to

Exhibit 8

Average Capital Costs as a Percentage of Total Operating Expense



Source: Solucient: *The Health of Our Nation's Hospitals*, 1997–2004, Dec. 2005. Reprinted with permission.

2004 period, and fell to an average of below 7 percent for all hospitals in 2004, according to healthcare information source Solucient.[3] (Exhibit 8)

Moody's Investors Service indicates that capital spending levels since 2001 have been increasing both in the aggregate and as a percentage of depreciation—the ratio most commonly used to assess capital spending levels.[4]

The *capital spending ratio*, defined as capital expenditures as a percentage of depreciation expense,[5] is used extensively in addition to *average age of plant*, the traditional measure of the level of organizational investment.

Median capital spending ratios by rating category are similar by rating agency, but there is a wide discrepancy in spending between hospitals with high credit ratings ("have" hospitals) and those with lower credit ratings ("have-not" hospitals).

Exhibit 9 provides 2005 median capital spending ratios by rating category. Higher-rated credits tend to spend more capital in relation to depreciation expense than lower-rated credits. The higher cash flow generation and/or stronger liquidity in organizations with higher ratings provide increased resources and debt capacity that enable these organizations to spend more.[6]

The effect of spending levels by rating category on the age of physical facilities is significant. Although average age of plant is levelling off after its decade-long ascent, wide discrepancy exists in median plant age by rating category, ranging from 9 years for Aa-rated hospitals to 14.5 years for hospitals rated below Baa (Exhibit 10).

Exhibit 9

Median Capital Spending Ratios by Rating Category, 2004

	AA	A	BBB	Below Investment Grade
Fitch Ratings	154%	139%	128%	101%
Moody's Investors Service	150%	140%	120%	70%
Standard & Poor's	181%	141%	124%	72%

Sources: Fitch Ratings: *2005 Median Ratios for Nonprofit Hospitals and Health Care Systems*, August 2005; Moody's Investors Service: *Not-for-Profit Healthcare: 2005 Outlook and Medians*, August 2005; Standard & Poor's: *U.S. Not-for-Profit Health Care 2005 Median Ratios*, July, 2005.

This trend provides further evidence that hospitals with the financial performance needed to achieve higher ratings can access and are spending capital to replace and refurbish facilities; hospitals without sufficient capital access are falling further and further behind in their ability keep their facilities up to date. In a short three-year period, median age of plant increased from 11 percent to 14.5 percent for hospitals with below-investment-grade ratings.

Industry sources of healthcare bond issuance data show a strong recent increase in "new money" projects—likely to be primarily major construction—and in the overall volume of healthcare bonds, which has nearly doubled over the past five years.

Spending Adequacy

Our panel offered the following comments about whether capital spending is adequate now and will be adequate into the next decade:

Martin Arrick: "Ten or 15 years ago, A-rated hospitals typically spent 100 percent of depreciation. Now the weak BBB credits are spending 100 percent of depreciation and the AA-rated credits are spending almost two times depreciation year in and year out. Spending equal to depreciation has become a kind of floor, not a target. This is related to consumer expectations and the need for hospitals to remain competitive in their marketplaces."

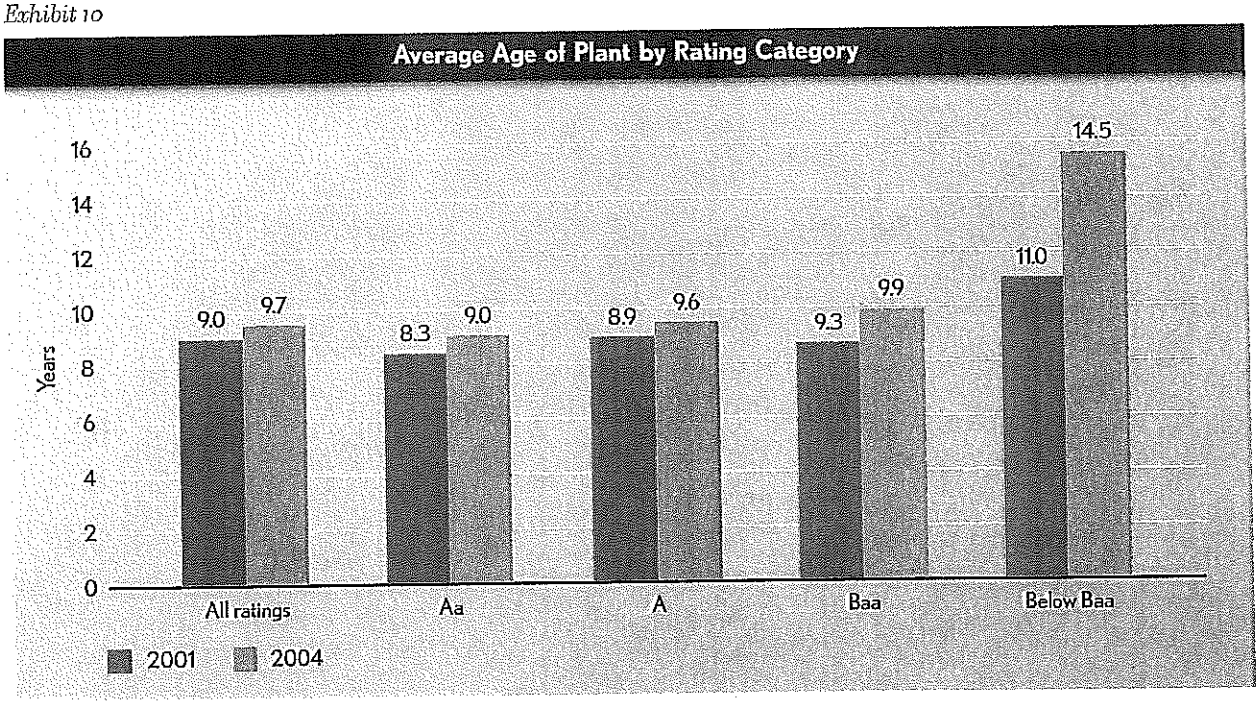
Dick Clarke: "Hospitals with wide access to capital will be able to spend at the level needed to meet their strategic goals. They may not be able to do everything they want to do, but they will have enough capital to support their strategic direction. Hospitals in the middle, moderate-access category will need to be very careful about how much they spend and the initiatives they choose to invest in."

Ten or 15 years ago, A-rated hospitals typically spent 100 percent of depreciation. Now the weak BBB credits are spending 100 percent of depreciation and the AA-rated credits are spending almost two times depreciation year in and year out. Spending equal to depreciation has become a kind of floor, not a target.

Martin Arrick, managing director,
Not-for-Profit Healthcare, Standard and Poor's

Lisa Goldstein: "Spending is likely to be adequate according to the measures we use to assess spending levels, but whether or not spending will be enough to meet consumer and competitive needs remains to be seen. Hospitals with strong performance that operate in states with certificate-of-need regulation and/or with strong population growth are more likely able to maintain a competitive position, while those hospitals without adequate performance and reserves in states without certificate-of-need regulation and in highly competitive local markets may fall further behind. Future capital spending adequacy will be very market specific."

Exhibit 10



Source: Moody's Investors Service: *Not-For-Profit Healthcare: 2005 Outlook and Medians*, August 2005. Reprinted with permission.

What Should Hospitals Do to Close the Gap Between Capital Need and Spending?

What are the likely scenarios for struggling and/or ultimately unsuccessful hospitals? As noted by Jason Sussman of Kaufman Hall in the third report of *Financing the Future II*: "Few healthcare organizations have sufficient capital capacity to meet their comprehensive strategic capital requirements. The organization must set priorities among, and allocate resources to, the most important strategies with the highest potential return as a portfolio of opportunities." Continued borrowing for and spending on projects that do not generate acceptable financial returns can have devastating and potentially fatal long-term consequences.

Two key gap-closing strategies are improvement of financial performance and pursuit of alternative funding sources. Our panel comments about these strategies and the likely scenarios unsuccessful hospitals may experience in the years to come.

The Performance Improvement Mandate

Martin Arrick: "The answer is really very simple: hospitals must improve cash flow and overall operating performance by doing a better job, day in and day out."

Lisa Goldstein: "Although our audits indicate that 2005 was a record year of strong financial performance by the credits we rate, all organizations should focus on improving financial performance. Now is the time for hospitals to build reserves, in essence, to stockpile for the rainy days when they need to enter into a heavy capital spending mode."

Randy Fuller: "Hospitals should shore up their financial position. This may involve taking a hard look at their mission and their portfolio of services. If some services are marginal in terms of financial performance and in helping them meet their mission, they should think critically about whether they can continue these services and adjust their portfolio accordingly."

Paul Ginsburg: "Capital need is not an objective or measurable concept. A number of hospitals have shown that they can make very useful adjustments when access to capital is limited. For example, some hospitals have been revamping their operations to increase efficiency, which in turn enables them to serve more patients with their existing facilities. The pressure to use capital more efficiently is healthy for the healthcare system."

Alternative Funding Sources

Philanthropy and leasing represent two options for capital access.

Philanthropy. Forty-five percent of CFOs surveyed for the first *Financing the Future* series indicated that they were going to rely more on philanthropy in the future.

During recent years, however, philanthropy in U.S. hospitals has increased only modestly. After experiencing a significant drop from $8.01 billion in 2001 to $5.53 billion in 2002, attributed largely to the economy, fundraising increased to $6.1 billion in 2004.

Forecasting the possibility of unprecedented challenges to community hospital philanthropy for decades 2010 through 2030, the Association for Healthcare Philanthropy reports record numbers of professional hospital fundraisers and the growing involvement of CEOs in fundraising.[7] "Yet, the proportion of philanthropic income to total hospital income remains a minimal amount, largely an unchanged percentage for decades," notes the AHP.

In a recent article, *Unleashing the Untapped Potential of Hospital Philanthropy*, one fundraising executive notes that fundraising is becoming a strategic imperative, particularly for not-for-profit community hospitals: "More institutions are incorporating explicit expectations of fundraising into their financial planning and now consider fundraising a 'must' for survival."[8]

Another strategist comments that trends, such as growing commercialization of not-for-profit hospitals, continuing civic disengagement, increasing demographic diversity, and challenges to tax-exempt status, could diminish returns on hospital fundraising and result in a much less robust future than predicted for hospital philanthropy, especially for community hospitals.[9]

The future impact of philanthropy as an alternative capital source is unclear.

Lisa Goldstein: "During the past 10 years, there's been a lot of interest in different types of debt vehicles, such as subordinate debt and various forms of off balance sheet debt. However, beyond operating leases, we haven't seen the healthcare industry actually adopt new vehicles or structures to any material degree. Traditional tax-exempt bonds continue to be the primary vehicle for capital.

"Capital vehicles and sources may change during the next five to 10 years. Hospitals are just now awakening to fundraising as an untapped source of capital. Philanthropy is likely to increase nationwide. Certain hospitals, particularly children's hospitals and some academic medical centers, have been extremely successful in their philanthropic efforts, which are ingrained in their culture."

Leasing. The U.S. healthcare equipment leasing market, which continues to grow at an average annual rate of 7 percent, is projected to reach $7.5 billion in new volume in 2006 and $8 billion by 2007.[10] Although leasing dollars have increased, lease financing penetration is low (Exhibit 11 on page 13).

Randy Fuller: "Leasing as an alternative financing solution can enable hospitals to expand their capital expenditure capacity. Financing companies can help hospitals obtain needed equipment and match up equipment payments with payment streams flowing from the equipment."

Scenarios for Struggling or Unsuccessful Hospitals

Report 5: Strategies for Financially Distressed Hospitals in *Financing the Future II* described hospitals that are experiencing severe financial stress. Performance at this level may leave such hospitals in need of a turnaround to ensure survival as an ongoing independent entity or to position the organization for purchase or merger with another entity. For the hospitals highlighted in the report, development and successful execution and monitoring of an improvement plan that addressed strategic, clinical, operational, and financial performance was key to turnaround success.

Industry data provide evidence of what currently is occurring with financially distressed hospitals. According to Irving Levin Associates, Inc., hospital mergers and acquisitions are continuing at a pace greater than that experienced at the 10-year low in 2003: "Fifty domestic transactions were announced in 2005, involving 88 acute care hospitals with a combined 11,294 beds. This represents a drop from 2004 when, due to several portfolio sales, 59 deals were announced involving 236 hospitals and 25,300 beds."[11] The number of transactions is expected to slow in 2006 due to concerns about rising energy prices and mid-term congressional elections.[12]

Exhibit 12 on page 13 provides an eight-year look at hospital mergers and acquisitions. Data related to the number of hospitals affiliated with systems show that hospitals increasingly are joining, merging, or being acquired by healthcare systems. In 1999, approximately 2,525 community hospitals were affiliated with systems; by 2003, more than 2,600 hospitals were affiliated.[13]

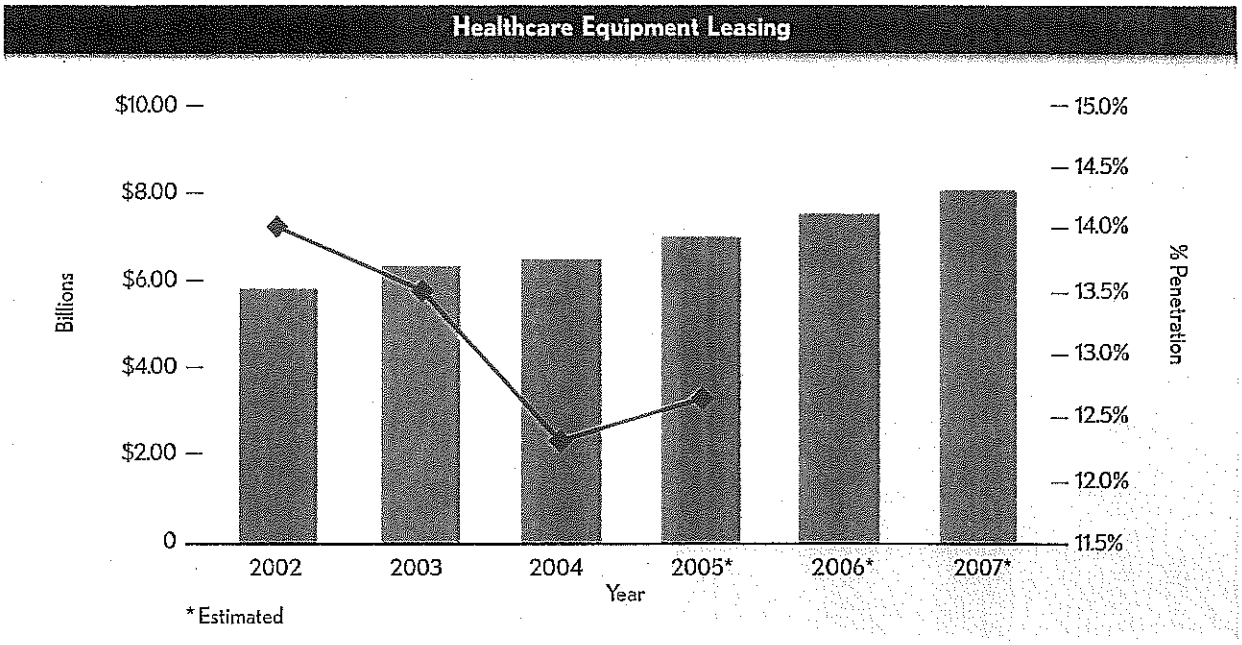
Our panel offered the following comments about merger, acquisition, and closure scenarios for struggling or unsuccessful hospitals.

Dick Clarke: "Hospitals that cannot respond to market and environmental challenges and cannot improve access to capital will have to merge with a stronger credit, transform themselves into a different kind of provider, or close."

Lisa Goldstein: "Hospitals that do not have critical mass in terms of bed size or admission size, or hospitals that are truly essential in their local market (with no other hospital around for miles) may look for capital partners either from other hospitals or larger systems. Or they may be acquired or merge.

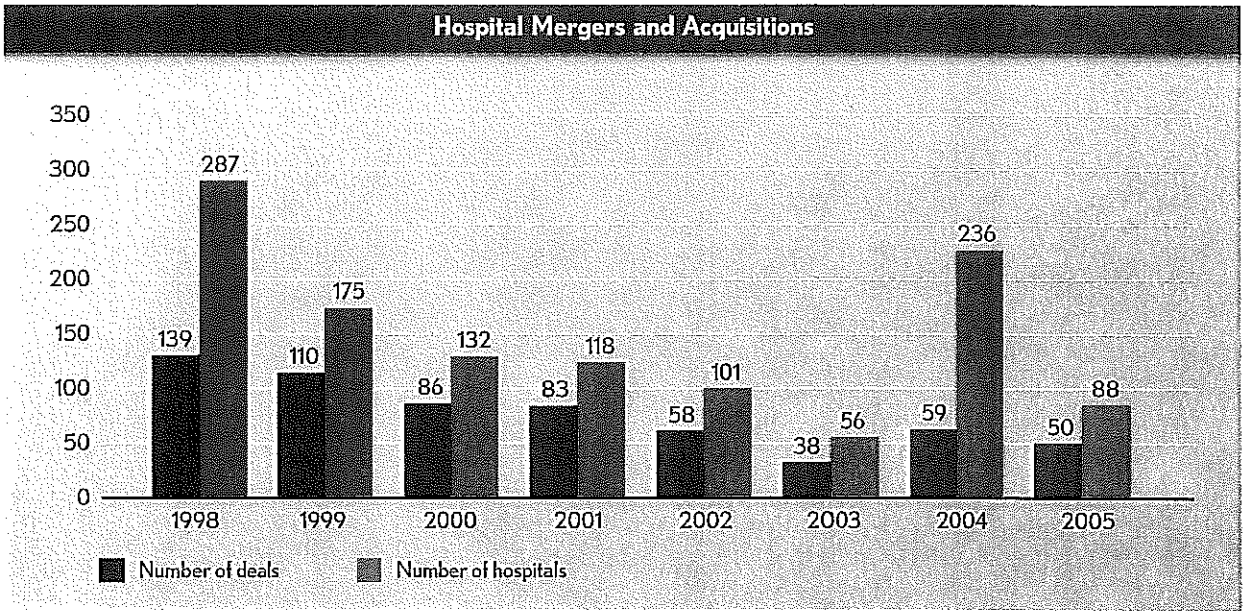
"We're also seeing an increased number of financial loans from larger hospitals or systems or other arrangements to help smaller hospitals meet their capital needs. These 'capital partnerships' or 80/20 joint ventures with for-profit companies that allow the smaller not-for-profit hospital to retain 20 percent interest are not called outright acquisitions, but at the end of the day, pretty much function like an acquisition as the tax-exempt bonded debt is redeemed. The for-profit partner is essentially in control."

Exhibit 11



Source: Equipment Leasing Association: *Healthcare Equipment Leasing. U.S. Market Dynamics and Outlook 2005-2007,* Oct. 2005. Study prepared by R.S. Carmichael & Co. for the Equipment Leasing Association. Reprinted with permission.

Exhibit 12



Source: Irving Levin Associates, Inc.: *The Health Care Acquisition Report, 12th Edition,* 2006 (www.levinassociates.com) Reprinted with permission.

Martin Arrick: "Struggling hospitals often experience a very slow downward spiral. As they lose the ability to access and deploy capital, their age of plant creeps up. They begin to be unable to meet consumer and competitive needs, and eventually, if they are not acquired, they wind down and close. But, in small rural areas where there is no competition, such hospitals can hang on for quite a long time."

Randy Fuller: "Many for-profit entities are looking to acquire hospitals with a reasonable patient and service mix in attractive markets. Hospitals without these would not be acquisition candidates; closure may be their only option. This is likely to become an important public policy issue in both federal and state governments. We've already seen New York State convene a panel to 'rightsize' its provider capacity. With the increasing focus on hospitals' roles in emergency care and providing surge capacity, will struggling hospitals be allowed to close or will some vehicle be developed to provide additional support to those hospitals with a critical role in providing emergency capacity?"

Paul Ginsburg: "I would hope that closure or being acquired would be the response for hospitals that cannot improve financial performance and access needed capital. However, we know that many will continue to stay open, despite being unable to provide state-of-the-art care. There is substantial opportunity for for-profit chains to acquire nonprofit hospitals well regarded in their communities but without sufficient capital to remain competitive."

Closing Comment

Since publication of the first *Financing the Future* series, most healthcare organizations have continued to experience financial pressures related to increased competition, constrained payment, and growing capital needs. Development and methodical execution of corporate finance-based strategies to improve financial position, using the processes described in this series, are critical to ongoing capital market access and continued hospital operations.

"Financial performance must be sufficient to meet the cash flow requirements of the strategic plan and, at the same time, maintain or improve the financial integrity of the organization within an appropriate credit and risk context," comments Ken Kaufman of Kaufman Hall. "Corporate finance holds that if you're earning an adequate return, you're going to have access to capital. If you're not earning an adequate return, you're not going to have adequate access to capital. End of story."

We end the story here, too, with a restatement of the series' cornerstone principle: Adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance.

HFMA wishes to acknowledge the significant contributions of writer Nancy Gorham Haiman for reports one through six in the *Financing the Future II* series.

References

1 2006 HIMSS analytics; AHA at www.aha.org/aha/press_room-info/content/CostCaring.pdf.

2 2006 HIMSS Leadership Survey. Chicago, HIMSS. www.himss.org/2006survey/healthcareCIO_home.asp.

3 Solucient: *The Health of Our Nation's Hospitals*, 1997-2004, December 2005. www.solucient.com/docs/HoNH05-lowres.pdf.

4 Moody's Investors Service: *The Capital Spending Ratio*, Special Comment, Dec 2004.

5 Standard & Poor's and Fitch Ratings add to the definition the words "plus amortization expense."

6 "Using Metrics to Assess Capital Spending." *The Kaufman Hall Report*, Spring 2005. www.kaufmanhall.com.

7 Association for Healthcare Philanthropy, "Unprecedented Challenges to Community Hospital Philanthropy Possible for Decades 2010 to 2030," Press release, February 2005, www.ahp.org/in-the-news/press-releases/docs/2005/021505.php.

8 Haderlein, J., "Unleashing the Untapped Potential of Hospital Philanthropy." *Health Affairs* 25(2): 541-545, March/April 2006.

9 Hubbell, G.J., *Forces of Change: The Coming Challenges in Hospital Philanthropy*. Falls Church, Va.: Association for Healthcare Philanthropy, 2005.

10 "Healthcare Equipment Leasing. U.S. Market Dynamics and Outlook 2005-2007." Equipment Leasing Association, Arlington Va.

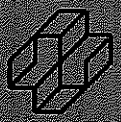
11 Irving Levin Associates, Inc. "M&A Activity for Health Care Services Rises 19% in 2005." Press release, March 22, 2006. www.levinassociates.com.

12 As cited in Galloro, V., "Dealmaking Will Cool in 2006: Report." *Modern Healthcare*, March 27, 2006.

13 The Lewin Group analysis of American Hospital Association Annual Survey data, 1999-2003, for Community Hospitals as it appeared in AHA's *Trendwatch Chartbook 2005*.

Financing the Future II

HFMA's *Financing the Future* series began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. *Financing the Future II* continues this process. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second *Financing the Future* series seeks to help healthcare organizations of all sizes "raise the bar" on financial performance. *Financing the Future II* is being developed in partnership with GE Healthcare Financial Services and Kaufman, Hall and Associates, Inc., and will include six reports for healthcare financial leaders, their staffs, and healthcare executives and board members. For more information about *Financing the Future II*, visit www.financingthefuture.org.



hfma
healthcare financial management association

HFMA is the nation's leading membership organization for more than 34,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. HFMA offers educational and professional development opportunities; information on key issues affecting healthcare financial managers; resources, such as technical data, checklists, and research reports; and networking opportunities—all of which provide our members with the practical tools and ideas they need to ensure career and organizational successes. For more information, visit HFMA's web site at www.hfma.org.

GE
Healthcare Financial Services

GE Healthcare Financial Services is the premier provider of capital, financial solutions, and related services for the global healthcare market. With $15 billion in assets, GE Healthcare Financial Services offers a full range of financing capabilities from equipment leasing and real estate financing to working capital lending, vendor programs, and acquisition financing. With a dedicated focus and a deep knowledge of the healthcare industry, GE Healthcare Financial Services collaborates with customers to create tailored financial solutions that help them improve their productivity and profitability. For more information, visit www.gehealthcarefinance.com.

Kaufman Hall

Founded in 1985, Kaufman, Hall & Associates is counted among the country's most respected independent financial and capital consultants, working with healthcare organizations of all types and sizes. Kaufman Hall provides financial advisory services to debt transactions; prepares and implements integrated strategic, financial, and capital plans; designs comprehensive capital allocation processes; and assists in the evaluation, structuring, and negotiation of merger, acquisition, and divestiture transactions. In addition, Kaufman Hall developed and markets the ENUFF Advisor® Suite of financial management software products. Kaufman Hall serves its clients from offices in Chicago, Los Angeles, San Francisco, Boston, and Atlanta.

Attachment VIII

Signed Letter of Intent between YNHH and SRHS/HSR

YALE-NEW HAVEN HOSPITAL

March 25, 2011

Sister Maureen Shaughnessy
General Superior
Sisters of Charity of Saint Elizabeth
2 Convent Road
Morristown, NJ 07960

Christopher M. O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System, Inc. and
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

Re: Letter of Intent Regarding Proposed Affiliation

Dear Sister Maureen and Mr. O'Connor:

We are pleased to formalize the progress made to date among Sisters of Charity of Saint Elizabeth, a New Jersey non-profit corporation ("SOC"), Saint Raphael Healthcare System, Inc., a Connecticut non-profit corporation ("SRHS"), Hospital of Saint Raphael, a Connecticut non-profit corporation ("HSR"), Yale-New Haven Health Services Corporation d/b/a Yale New Haven Health System, a Connecticut non-profit corporation ("YNHHS"), and Yale-New Haven Hospital, Inc., a Connecticut non-profit corporation ("YNHH"), regarding the proposed affiliation among the parties pursuant to the principal terms set forth in the term sheet (the "Term Sheet") attached hereto as Exhibit 1 (the "Affiliation Transaction").

This Letter of Intent (the "Letter of Intent") sets forth the agreement among YNHHS, YNHH, SOC, SRHS and HSR regarding the conduct of exclusive negotiations among the parties with respect to the Affiliation Transaction and the preparation of the definitive agreements necessary to effect the Affiliation Transaction. SRHS, HSR, Saint Regis Health Center, Inc., d/b/a The Sister Anne Virginie Grimes Health Center (the "Grimes Health Center"), Saint Raphael Foundation, Inc. (the "Foundation"), Lukan Indemnity Company, Ltd., Caritas Insurance Company, Ltd., and their affiliates that conduct business in the State of Connecticut are individually referred to in this Letter of Intent and the Term Sheet as a "Saint Raphael Organization" or collectively as the "Saint Raphael Organizations."

As a part of the process related to the negotiation of the Affiliation Transaction, we expect that the parties will request further access to the proprietary information and facilities of the other, including, without limitation, access to the acute care hospital located at 1450 Chapel Street, New Haven, Connecticut, its outpatient departments and other provider-based facilities (collectively, the "Saint Raphael Hospital Facilities") and the skilled nursing facility located at 1354 Chapel Street, New Haven, Connecticut (the "SNF").

As a result, by this Letter of Intent, YNHHS and YNHH wish to set out the following agreement with SOC, SRHS and HSR on the terms and conditions that will govern the furnishing of access to such proprietary information and facilities:

1. Negotiation of Affiliation Transaction. During the Exclusivity Period (as defined below), SOC, SRHS, HSR, YNHHS and YNHH will exercise good faith and use their reasonable efforts to negotiate and agree upon the terms and usual and customary covenants, conditions, indemnities, representations and warranties of the definitive agreements related to the Affiliation Transaction, all of which are to be generally consistent with the provisions of the Term Sheet. As further provided in Section 3, the parties acknowledge and agree that execution of any definitive agreements and consummation of the Affiliation Transaction will be subject to the approval of their respective governing bodies (including boards of directors and members as applicable), relevant government authorities and such other approvals as may be required by canon law or otherwise.

2. Exclusive Negotiations. SOC, SRHS and HSR agree to enter into exclusive negotiations with YNHHS and YNHH regarding the Affiliation Transaction. The exclusive negotiations will be governed by the following terms:

2.1 Exclusivity. Except as otherwise set forth in Section 6.2, SOC, SRHS and HSR represent and warrant that none of SOC, SRHS, HSR nor any of their affiliates has any commitments or understandings with any third party regarding a current or potential change in control or management, affiliation, sale, merger, consolidation, reorganization, or other material change in the operation or control of, any or all of the Saint Raphael Organizations or the assets thereof. Each of SOC, SRHS and HSR agrees that, during the Exclusivity Period, it will not, and will ensure that none of its affiliates or any person on its or their behalf will, directly or indirectly, encourage, solicit, consider, review, entertain, accept from or discuss with any third party any offer, inquiry or proposal regarding the change in control, affiliation, sale, merger, consolidation, reorganization, management, or other material change in the operation or control of, any or all of the Saint Raphael Organizations or the assets thereof, or otherwise enter into any transaction or agreement that might adversely affect its ability to enter into or consummate the proposed Affiliation Transaction.

2.2 Exclusivity Period. The "Exclusivity Period" will be the period beginning on the date that this Letter of Intent is signed by SOC, SRHS and HSR (the "Execution Date") and ending on the earlier of (a) 120 days following the Execution Date or (b), in the event that SOC, SRHS or HSR elect to terminate this letter of intent without cause, 30 days following the effective date of such termination (as provided in Section 6.11 below). As of the expiration or earlier termination of the Exclusivity Period, unless the parties have entered into definitive agreements regarding the Affiliation Transaction or agreed to extend the Exclusivity Period, the exclusive negotiations among the parties regarding the Affiliation Transaction will cease and the provisions of this Section 2 (other than Section 2.3 below) will be of no further force or effect.

2.3 Limited Disclosure after Exclusivity Period. Unless the parties have entered into definitive agreements regarding the Affiliation Transaction or have otherwise agreed in writing, following the expiration or earlier termination of the Exclusivity Period and the cessation of exclusive negotiations, any party may disclose to any person or entity without violating the covenants and restrictions contained in Section 4 below that the parties engaged in exclusive negotiations regarding an Affiliation Transaction and were unable to reach agreement on the terms and conditions of an Affiliation Transaction. Any further disclosures regarding the exclusive negotiations or the terms and conditions of an Affiliation Transaction will be subject to the covenants and restrictions contained in Section 4 below.

3. Binding Letter of Intent, Not Definitive Agreement. The obligations of the parties set forth in this Letter of Intent are intended to be binding obligations of the parties. Notwithstanding the foregoing, the terms set forth on the Term Sheet merely represent only a current expression of intent regarding the Affiliation Transaction. Accordingly, no party will be bound as a result of entry into this Letter of Intent to consummate the Affiliation Transaction. The Affiliation Transaction will only be consummated upon execution of definitive agreements for the Affiliation Transaction and the satisfaction of all other conditions to closing as the parties may determine therein. As a result, in the absence of definitive agreements among the parties with respect to the Affiliation Transaction, neither the expiration nor earlier termination of the Exclusivity Period, the failure by either party to agree to extend the Exclusivity Period, nor the failure by any party to agree to definitive agreements will give rise to any legally enforceable right or claim for damages or injunctive relief or any other form of judicially recognized award or right with respect to the Affiliation Transaction. However, the parties agree to otherwise be bound by this Letter of Intent.

4. Due Diligence and Confidentiality.

4.1 Due Diligence. SOC, SRHS and HSR will provide YNHHS and YNHH and their representatives, including attorneys, auditors, accountants, and other consultants (the "Representatives"), with reasonable access to, and (paper or electronic) copies of, all information regarding the Saint Raphael Organizations and all assets and liabilities thereof that YNHHS or YNHH reasonably deems necessary to analyze the Affiliation Transaction or to negotiate the definitive agreements related thereto (the "Information"), subject to Section 4.2 below. In addition, SOC, SRHS and HSR will provide to YNHH and the Representatives reasonable access to the Saint Raphael Hospital Facilities, SNF, clinics, medical offices, administrative offices and other facilities and equipment of the Saint Raphael Organizations that may become part of the Affiliation Transaction (collectively the "Facilities"), subject to Section 4.2 below. YNHHS and YNHH will provide SOC, SRHS and HSR and their Representatives with reasonable access to, and (paper or electronic) copies of, certain information regarding YNHHS and YNHH that SOC, SRHS or HSR reasonably deems necessary to analyze the Affiliation Transaction or to negotiate the definitive agreements related thereto (also, the "Information"). Unless otherwise agreed, all due diligence requests will be made by and responded to by the parties' respective counsel: Ropes & Gray LLP and Verrill Dana LLP (for SOC, SRHS and HSR) and Jones Day and Wiggin & Dana LLP (for YNHHS and YNHH).

4.2 Due Diligence Inspection and Review of Information and Facilities.

(a) Requests for Information will be in writing and will specify in reasonable detail the Information sought. The parties will exercise good faith and use reasonable efforts to provide access to all reasonably available Information. Information will be made available during regular administrative hours (or at such other times as may be agreed upon by the parties) in a medium and/or at location(s) agreed by the parties, including electronic medium. Each party will be solely liable and responsible for its fees, costs and expenses incurred in connection with the due diligence inspection and review of Information.

(b) HSR will provide reasonable access to the Facilities and personnel of the Saint Raphael Organizations. When access to the Facilities and personnel is granted by the respective Saint Raphael Organization, neither YNHH nor its Representatives will unreasonably interfere with any activities then being conducted at the Facilities, and will observe mutually agreed-upon protocol related to the communication of the purposes of the inspection.

(c) YNHH will provide reasonable access to YNHH's and its affiliates' facilities and personnel. When access to facilities and personnel is granted by YNHH, neither HSR nor its Representatives will unreasonably interfere with any activities then being conducted at the YNHH facilities or by its affiliates, and will observe mutually agreed-upon protocol related to the communication of the purposes of the inspection.

4.3 Proprietary Nature of Information. The parties acknowledge the confidential and proprietary nature of all Information supplied or provided to the other, including but not limited to the terms set forth on the Term Sheet and in the definitive agreements and all discussions, communications and negotiations among the parties relating thereto, and, except as expressly provided in this Letter of Intent, will hold and maintain all such Information subject to the terms and restrictions set forth in this Section 4 of this Letter of Intent. In addition, all Information that is not public and that constitutes a "trade secret" within the meaning of the Uniform Trade Secrets Acts set forth in the General Statutes of Connecticut Sections 35-50 et seq., (the "Act") will be afforded the protections under such Act, and in addition to the rights and remedies established in this Letter of Intent, the parties will be entitled to all protections, and be afforded all remedies, available under such Act applicable to such trade secrets.

4.4 Restricted Disclosure and Use Of Information.

(a) The parties agree that all Information (a) will be kept and maintained by the recipient as strictly confidential, and (b) without limiting the foregoing, will not be disclosed to any person or entity except as expressly permitted in Section 2.3 or Section 4 of this Letter of Intent. The parties further agree that neither will use Information for any reason or purpose other than to evaluate, negotiate and approve the Affiliation Transaction.

(b) The parties may disclose Information only to those employees, officers, directors and Representatives that (a) reasonably need such Information for the purpose

of evaluating, negotiating or approving the Affiliation Transaction (but, to the extent practicable, only such part of the Information that is reasonably needed to be so disclosed), (b) are informed by the recipient party of the confidential and proprietary nature of the Information and the restrictions related thereto contained in this Letter of Intent, and (c) agree to abide by the terms of the confidentiality provisions of this Letter of Intent.

4.5 Non-Disclosure of Term Sheet or Exclusive Negotiations. Except as expressly permitted by Sections 2.3 and 4.4 above, by the mutual agreement of the parties, or by the definitive agreements related to the Affiliation Transaction, no party nor any of their respective employees, officers, directors or Representatives will disclose to any person or entity (a) that the parties have entered into exclusive negotiations regarding the Affiliation Transaction, (b) any of the specific terms or conditions of the Term Sheet or any other agreement, document or instrument specifying the terms and conditions of the Affiliation Transaction, (c) the fact that the Information has been or will be made available, or (d) that its Representatives have inspected any portion of the Information or Facilities. If the parties agree to any public disclosures (including any press releases), the content of all such disclosures will be subject to the prior approval of both YNHH and HSR or their respective authorized Representatives.

4.6 Exceptions to Non-Disclosure. The restrictions set forth in this Section 4 do not apply to that part of the Information that (a) was or becomes available to the general public other than as a result of a disclosure by the parties or their Representatives; or (b) was or becomes available to the recipient party or its Representatives on a non-confidential basis prior to its disclosure by the producing party.

4.7 Subpoenas or Other Legal Process. If any of the parties or their Representatives is requested or becomes legally compelled (by interrogatories, requests for information or documents, subpoena, civil or criminal investigative demand, or other similar process) or is required by a regulatory body or governmental entity to make any disclosure that is prohibited or otherwise constrained by this letter, such party or such Representative, as the case may be, will provide the other with prompt written notice of such request so that the producing party may seek an appropriate protective order or other appropriate remedy. Subject to the foregoing, such party or such Representative may furnish that portion (and only that portion) of the Information that, the party or such Representative is legally compelled or is otherwise required to disclose; provided, however, that the parties and their Representatives must use reasonable efforts to obtain reliable assurance that confidential treatment will be afforded any of the Information so disclosed.

4.8 Return Of Information. If the parties for any reason fail to consummate the Affiliation Transaction the parties and their Representatives will (a) promptly return to the producing party all written documents or other written materials containing Information, together with all copies thereof, or, if the producing party so requests or gives its written consent, the recipient party and its Representatives will destroy all such written documents or other written materials containing Information in their possession, and (b) will destroy all electronic Information in its possession.

4.9 Nonsolicitation. During the Exclusivity Period, neither YNHHS nor YNHH nor any affiliates thereof will directly solicit for employment any individual employed by the Saint Raphael Organizations, without the prior written consent of SRHS or HSR. SRHS and HSR acknowledge and agree that direct solicitation for purposes of this Section 4.9 shall not include, among other things, the placing of advertisements in newspapers, posting on websites, conducting job fairs or other general communication methods, or responding to requests for employment.

5. Ordinary Course Operations. During the Exclusivity Period, except as otherwise agreed in writing by YNHH, SOC, SRHS, HSR and their affiliates will operate the business of and Facilities used by the Saint Raphael Organizations in the ordinary course of business and will not take any extraordinary actions in anticipation of the Affiliation Transaction, except as are necessary to conduct the due diligence and prepare for the Affiliation Transaction according to the terms agreed upon. Specifically, SOC, SRHS, HSR and their affiliates agree as follows:

5.1 Accounting. Each Saint Raphael Organization will maintain its accounting methods and forms of financial reporting that were in effect on September 30, 2010, excepting any changes required by such entity's independent auditors, which changes, if any, SOC, SRHS and HSR will fully inform YNHHS and YNHH within 10 days of signing this Letter of Intent. Thereafter, during the Exclusivity Period, SOC, SRHS and HSR will notify YNHHS and YNHH in writing within 5 business days of any change to the methods of accounting or of reporting financial data utilized by the Saint Raphael Organizations.

5.2 Transfers and Loans. During the Exclusivity Period, SOC, SRHS and HSR will notify YNHHS and YNHH in writing within 5 business days of any transfer or loan of any cash (except in the ordinary course of business or intercompany transfers between or among the Saint Raphael Organizations), including any loan or advance by a Saint Raphael Organization to any officer, manager or trustee.

5.3 Assets. During the Exclusivity Period, SOC, SRHS and HSR will notify YNHHS and YNHH in writing within 5 business days of any transfer or encumbrance of any asset owned, leased or held for use by any Saint Raphael Organization to any third party, except in the ordinary course of business.

5.4 New Debt. During the Exclusivity Period, SOC, SRHS and HSR will notify YNHHS and YNHH in writing within 5 business days of any increase in the long term or short term indebtedness of any Saint Raphael Organization that is recorded on the general ledger of such entity or of its affiliates as of December 31, 2010, in excess of an aggregate of $100,000. To the extent that any such additions to debt have occurred since December 31, 2010, SOC, SRHS and HSR will fully inform YNHHS and YNHH within 10 days of signing this Letter of Intent.

5.5 Employment Agreements and Benefits. During the Exclusivity Period, except for the retention agreements contemplated in Exhibit 1, no Saint Raphael Organization

will materially alter its terms of employment or the terms of any benefit of any kind with any director, officer or manager. During the Exclusivity Period, no Saint Raphael Organization will make any representations about the terms of future employment or benefits to employees of any Saint Raphael Organization without prior coordination and consent of YNHH.

6. Miscellaneous.

6.1 Regulatory Approvals. At such time as the parties mutually agree, the parties will cooperate to make promptly the requisite filings under the Hart Scott Rodino Act to the extent required and Connecticut law, and thereafter to make or commence such other filings or regulatory approval processes as may be necessary.

6.2 No Effect of Rights of HSR Bond Holders. YNHHS and YNHH acknowledge and agree that nothing set forth in this Agreement, including but not limited to Section 2 or Section 4 shall limit, or be construed as limiting, the rights conferred by the loan agreements associated with the CHEFA Hospital of Saint Raphael Series H, L and M bond financing (collectively, the "HSR Financing Agreements") to the holders of the Series H, L or M bonds (collectively, the "HSR Bond Holders").

6.3 Entire Agreement; Future Modifications. Subject to the execution of any definitive agreements, this Letter of Intent constitutes the full and complete agreement and understanding between the parties hereto concerning the subject matter hereof and supersedes any prior written and oral agreements with regard to such subject matter, including all prior agreements between the parties regarding the confidentiality of Information. This Letter of Intent may be modified or waived only by a separate written agreement signed by the parties hereto.

6.4 Waiver. The rights and remedies of the parties to this Letter of Intent are cumulative and not alternative. Neither the failure nor any delay by any party in exercising any right, power or privilege under this Letter of Intent will operate as a waiver of such right, power or privilege, and no single or partial exercise of such right, power or privilege will preclude any other or further exercise of any other right, power or privilege. To the maximum extent permitted by applicable law, (i) no claim or right arising out of this Letter of Intent can be discharged by one party, in whole or in part, by a waiver or renunciation of the claim or right unless in writing signed by the other party; (ii) no waiver that may be given by a party will be applicable except in the specific instance for which it is given; and (iii) no notice to or demand on one party will be deemed to be a waiver of any obligation of such party or of the right of the party giving such notice or demand to take further action without notice or demand as provided in this Letter of Intent.

6.5 Severability. The invalidity or unenforceability of any provision of this Letter of Intent will not affect the validity or enforceability of any other provisions of this Letter of Intent, which will remain in full force and effect. If any of the covenants or provisions of this Letter of Intent are determined to be unenforceable by reason of its extent, duration, scope or

otherwise, then the parties contemplate that the court making such determination will reduce such extent, duration, scope or other provision and enforce them in their reduced form for all purposes contemplated by this Letter of Intent.

6.6 Costs and Expenses. Except as otherwise specifically provided herein, each party will bear its own costs and expenses (including legal fees, experts and consultants) incurred in connection with this Letter of Intent and the Affiliation Transaction. Notwithstanding the foregoing, HSR and YNHH have agreed to split the fees and expenses of any jointly retained consultants as hereinafter indicated:

Consultant	HSR	YNHH
Charles River Associates	50% of fees (up to total fees of $250,000)	50% of fees (up to total fees of $250,000) plus 100% of any fees in excess of $250,000
Deloitte Corporate Finance LLC	50% of fees	50% of fees
Other Jointly Retained Consultants	0% of fees	100% of fees

6.7 Section Headings. The headings of sections in this Letter of Intent are provided for convenience only and will not affect its construction or interpretation.

6.8 Governing Law. This Letter of Intent will be governed by the laws of the State of Connecticut without regard to conflicts of law principles.

6.9 Counterparts. This Letter of Intent may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Letter of Intent, and all of which, when taken together, will be deemed to constitute one and the same agreement.

6.10 Notices. All notices, requests, demands or other communications required or permitted to be given under this Letter of Intent agreement will be in writing and will be delivered to the party to whom notice is to be given either (i) by personal delivery (in which case such notice will be deemed given on the date of delivery), or (ii) by next business day courier service (e.g., Federal Express, UPS or other similar service) (in which case such notice will be deemed given on the business day following the date of deposit with the courier service), or (iii) by United States mail, first class, postage prepaid, registered or certified, return receipt requested (in which case such notice will be deemed given on the 3rd day following the date of deposit with the United States Postal Service), or (iv) by dated electronic mail (in which case it will be deemed given on the next day after the date thereof), in each case addressed to the parties

at their addresses set forth below. Any party may change the address to which notices are to be sent by mailing written notice thereof to the other party as provided in this Section 6.10.

if to YNHHS or YNHH:

Marna P. Borgstrom
President and Chief Executive Officer
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

with a copy to:

William J. Aseltyne
Vice President & General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

if to SOC, SRHS or HSR:

Christopher M. O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System, Inc./Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

with a copy to:

Janeanne Lubin-Szafranski
Vice President and General Counsel
Saint Raphael Healthcare System
1450 Chapel Street
New Haven, CT 06511

6.11 Term. The term of this Letter of Intent will commence as of the Execution Date. At any time prior to the expiration of the Exclusivity Period, any party may immediately terminate this Letter of Intent upon giving the other parties hereto written notice of its intent to terminate. In addition, this Letter of Intent will automatically expire without further action on the part of any party if the definitive agreements are not executed on or before the end of the Exclusivity Period, except as that date may be extended by mutual written agreement of the parties.

Exhibit 1

YALE-NEW HAVEN HOSPITAL

HOSPITAL OF SAINT RAPHAEL

OUTLINE OF PROPOSED AFFILIATION

Affiliation Transaction Overview: Structure and Included Assets

Subject to due diligence and mutual agreement among the parties, YNHH or its designee will acquire the following:

- All or substantially all of the assets of HSR, except for (i) corporate records (other than medical records, which will be acquired), (ii) employee benefit plans, (iii) Medicare, Medicaid or other payor agreements or provider numbers and (iv) any assets specifically identified and excluded by the parties during the negotiation of the Affiliation Transaction.

- As mutually agreed upon by the parties, such other assets owned, leased or otherwise used by SRHS and other Saint Raphael Organizations in the conduct of their respective businesses.

- Each Saint Raphael Organization will transfer these assets to YNHH or its designee free and clear of all liens, claims and encumbrances.

- With respect to any real property included as part of the assets, the Saint Raphael Organization holding title to such property will transfer fee simple title to YNHH or its designee. The transfer of such real property will constitute an alienation of stable patrimony subject to approval of the Holy See. The Affiliation Transaction will be contingent on receiving such approval in advance.

- SOC and each Saint Raphael Organization will agree not to operate in competition with YNHHS and YNHH and their respective affiliates in the State of Connecticut for a period of 5 years post-closing.

Affiliation Transaction Structure: Liabilities and Contracts

Each of the Saint Raphael Organizations will remain solely responsible for all of its respective liabilities, indebtedness or obligations arising prior to closing, including its current liabilities and any medical malpractice liabilities. However, subject to due diligence and mutual agreement among the parties, YNHH will assume the current contracts, leases and other agreements of the Saint Raphael Organizations (excluding agreements relating to debt for borrowed money, labor, pension, payor and other matters identified and excluded by the parties during the negotiation of the Affiliation Transaction). Each of the Saint Raphael Organizations will be solely responsible for all costs associated with its respective operations post-closing and ultimately the winding-up of its respective affairs.

Consideration

At the closing, the parties' goal is that the Saint Raphael Organizations will have sufficient assets to pay and discharge all the then-existing liabilities of the Saint Raphael Organizations (other than the liabilities for the frozen accrued benefits under the Plan (as that term is defined below) and the liabilities incurred by HSR under its post-retirement medical benefits plan), including sufficient liquid assets to pay and discharge at the closing all liabilities under the HSR Financing Agreements or other debt instruments so that clean title to the transferred assets can be delivered. Prior to execution of the definitive agreements, the parties will engage in a process to determine the quality and liquidity of the assets of the Saint Raphael Organizations to determine if sufficient assets will be available for such purposes at closing. The definitive agreement will address the parties' rights and responsibilities in the event that such assets are insufficient for such purposes at closing. To the extent legally permitted, the Saint Raphael Organizations will agree to transfer to YNHH any assets remaining after satisfaction of their liabilities.

In consideration of the Affiliation Transaction, YNHH will pay an amount to be finalized in the definitive agreement to HSR over a 7 year period, which shall be used solely to fund the frozen accrued benefits under the Plan and the liabilities incurred by HSR under its post-retirement medical benefits plan. At the fourth anniversary of the closing, such amounts will be reevaluated to determine the adequacy of funding. The

Sponsoring Organization will agree to use such funds solely to fund the frozen accrued benefits under the Plan and the liabilities incurred by HSR under its post-retirement medical benefits plan. HSR may assign its right to receive such funds to the Sponsoring Organization. None of the Sponsoring Organizations will make any further contributions to these plans prior to closing.

Pension Plan

SRHS sponsors The Retirement Plan for Employees of The Hospital of Saint Raphael (the "Plan"), a frozen defined benefit pension plan that qualifies as a church plan described in Section 414(e) of the Internal Revenue Code. After the Affiliation Transaction, SRHS will continue its role as the sponsor of the Plan or will designate and maintain an organization controlled or associated with the Catholic Church that has as its principal purpose or function the administration or funding of the Plan (SRHS or the designated organization are referred to in this Term Sheet as the "Sponsoring Organization"). Any amounts paid by YNHH to the Sponsoring Organization as part of the consideration for the Affiliation Transaction are not intended to establish, and shall not be construed by any party as establishing, any relationship between YNHHS or YNHH and the Plan. At all times after the closing of the Affiliation Transaction, the Sponsoring Organization shall administer and maintain the Plan as a church plan.

Catholic Heritage

In light of the parties' understanding of and respect for the commitment of HSR to the principle that care for the sick, the poor and the dying has deep roots in its Catholic ministry, YNHH will continue to operate the Saint Raphael Hospital Facilities in a manner that respects its Catholic heritage and this ethical principle as described herein. YNHH will:

- Cause the appointment of a Catholic Heritage Committee. The Committee shall be formed to ensure that the clinical services provided at the Saint Raphael Hospital Facilities are consistent with Catholic ethical tradition as referenced in the Ethical and Religious Directives for Catholic Health Care Services (Fifth Edition) (the "Directives"), as adapted to the conditions of modern science and medicine and as deemed appropriate by SOC from time to time. The Committee will engage in self-evaluation,

education and policy review, and may collaborate with other community organizations around mutually held goals. The Committee shall meet no less than twice annually and shall review clinical services provided at the Saint Raphael Hospital Facilities, including, if applicable, any inquiry made by an employee, physician, patient or other regarding such clinical services. The Committee shall be composed of five (5) staff members, including three (3) staff members nominated by SOC. The YNHH Executive for Catholic Heritage and Pastoral Care shall serve on the Committee as one of the five staff members.

- Modify the existing Community Advisory Committee in order to continue to support the parties' shared mission to provide services to improve access to health care services by including members nominated by SOC. Such members shall compose not less than twenty-five percent (25%) of the membership of the Committee.

- Engage an individual selected by YNHH in consultation with SOC as the Executive for Catholic Heritage and Pastoral Care. The Executive shall have responsibility for Catholic heritage and pastoral care activities at the Saint Raphael Hospital Facilities and shall be a member of the YNHH senior team.

- Amend medical staff bylaws, employee code of conduct and other documents, as appropriate and as agreed to by the parties, to state the requirement to adhere to the Directives at the Saint Raphael Hospital Facilities. Provide annual education for medical staff members and other personnel at the Saint Raphael Hospital Facilities concerning the Directives.

- Consider an advisory fee to SOC at a level and for a time period appropriate to the unique elements of the Affiliation Transaction.

- Maintain the Chapel at the Saint Raphael Hospital Facilities as a place for Catholic, ecumenical and interreligious services as needed and appropriate for the benefit of staff, patients and families, and maintain appropriate signage and other symbols of Catholic identity at the Saint Raphael Hospital Facilities, including but not limited to the name, "The

Hospital of Saint Raphael in the tradition of the Sisters of Charity of Saint Elizabeth." Such Chapel, signage and religious symbols as SOC wish to remain both within and on the external walls of the Saint Raphael Hospital Facilities will so remain; however, in the event they cease to be used for any reason, they shall be transferred to SOC.

- To honor SOC, YNHH will host a celebration of Founder's Day at the Saint Raphael Hospital Facilities on an annual basis.

The commitments set forth herein shall continue except as may be modified as follows: If, as a result of changes in clinical services or programs, practices or locations, or as a result of changes in the interpretation of the Directives, YNHH finds, acting reasonably and in good faith, that continued compliance with certain Directives will create a significant operational or patient care burden on YNHH, then YNHH shall work in good faith with the Catholic Heritage Committee to find a way to mitigate the burden while preserving the other commitments described herein. If, after working together for a period of at least 90 days, YNHH and the Catholic Heritage Committee have not found a practical way to reconcile mitigation of the burden with compliance with the Directives at issue, then the matter will be presented to the YNHH Board of Trustees for consideration and resolution. The decision by the YNHH Board of Trustees with respect to such matter shall be final. SOC may, at any time, terminate the mutual commitments set forth herein by providing 90 days prior written notice to the YNHH Board of Trustees. Upon the effect of such termination, SOC may reclaim any religious symbols utilized at the Saint Raphael Hospital Facilities..

Operations Development

Subject to due diligence, YNHH will operate its hospital facilities and the Saint Raphael Hospital Facilities as a single organization and under a single license. All services will be integrated and select services may be delivered at only one location. Patients will have full access to all inpatient and outpatient services and facilities of the combined hospital. Medical records of YNHH and the Saint Raphael Hospital Facilities will be fully integrated.

YNHHS and SOC will mutually agree upon and identify the individuals to be elected to the YNHH Board of Trustees. Such individuals will serve as Trustees consistent with the rights and responsibilities set forth in the YNHH Bylaws.

YNHH intends to make substantial capital expenditures at the Saint Raphael Facilities during the first 5 years post-closing in a manner consistent with its financial resources and its expenditures at other YNHH facilities to ensure the continued delivery of safe, effective, and efficient patient care at the Saint Raphael Facilities, which YNHH estimates the amount of such expenditures to be $135,000,000.

Medical Staff

Subject to the approval of the YNHH Medical Board, all members of the Medical Staff of the Saint Raphael Hospital Facilities at closing will become members of and combined with and become a part of the Medical Staff of YNHH. There will be a single Medical Staff organizational structure for the YNHH hospital facilities and the Saint Raphael Hospital Facilities, and a single set of YNHH Medical Staff Bylaws, Rules and Regulations, and Fair Hearing Plan that governs all members of such combined YNHH Medical Staff.

Subject to mutual agreement of the parties, YNHH will include representatives of the leadership of the Medical Staff of the Saint Raphael Hospital Facilities on the Medical Board of the YNHH Medical Staff and in Departmental and Section leadership, where appropriate, all for a specified period time post-closing.

The parties will evaluate and agree upon a mutually acceptable manner of integrating and reconciling exclusive arrangements at the facilities.

HSR Senior Management

From and after the date hereof, HSR will put in place those agreements that are necessary to secure the continued services of its chief executive officer and other key employees (collectively, the "HSR Senior Management") through the closing of the Affiliation Transaction.

Employees

The following general terms and conditions shall apply to the obligations of YNHH and its affiliates to

employees of the Saint Raphael Organizations:

- ***HSR Employees.*** The parties intend to minimize any job loss that results from the transaction by realizing operating efficiencies through vacancies and attrition. Consistent with that objective, following the execution of a definitive agreement, YNHH and HSR will prepare a staffing plan pursuant to which YNHH or its designee upon or immediately prior to the closing will offer job opportunities to all HSR employees in good standing as set forth below.

- All non-bargaining unit employees of HSR (other than those positions expressly identified by the parties) who are in good standing as of the date of the closing with HSR and who agree to become employed under YNHH terms and conditions of employment (the "HSR Non-Bargaining Unit Employees") will be offered employment. Such offers will be subject to the review of objective eligibility criteria including the U.S. Department of Health and Human Services OIG "excluded persons list" and the validation of licensure and other qualifications where applicable. Those HSR Non-Bargaining Unit Employees to whom YNHH or its designee offers employment will be provided compensation that is consistent with that provided to YNHH employees in similar roles at the time. YNHH benefits eligibility and vesting will recognize HSR employees' length of service at HSR and otherwise will be structured commensurate with those benefits offered to any newly hired employee by YNHH at that time. YNHH or its designee will not assume any liability for any accrued vacation, severance or sick leave expenses of the HSR Non-Bargaining Unit Employees who become employed by YNHH or its designee, and in connection therewith, HSR will be solely responsible for ensuring that any such amount owed are paid upon the closing.

- YNHH or its designee will offer job opportunities, pursuant to terms and conditions of employment to be established by YNHH or its designee to substantially all employees of HSR currently represented by the Teamsters Local 443 (the "Teamsters") who are in good standing as of the date

of the closing with HSR and who agree to become employed under YNHH's terms and conditions of employment (the "HSR Bargaining Unit Employees"). YNHH or its designee will not assume any liability for any accrued vacation, severance or sick leave expenses of the HSR Bargaining Unit Employees who become employed by YNHH or its designee, and in connection therewith, HSR will be solely responsible for ensuring that any such amounts owing are paid upon the closing. YNHH will not assume the existing collective bargaining agreements between HSR and the Teamsters. If, as expected, HSR Bargaining Unit Employees constitute a majority of the employees in an appropriate bargaining unit or units at the Saint Raphael Hospital Facilities at the time that YNHH or its designee has hired the majority of the workforce in such unit(s), YNHH or its designee will recognize the Teamsters as the collective bargaining agent for such unit(s) and will enter into negotiations with the Teamsters regarding a new collective bargaining agreement for such unit(s).

Other Employees of Saint Raphael Organizations. YNHH or its designee will offer job opportunities, pursuant to terms and conditions of employment to be established by YNHH or its designee, to employees of the Saint Raphael Organizations (other than HSR and the Grimes Health Center) who are identified in an exhibit to the Definitive Agreement (the "Additional Employees"). For those Additional Employees to whom YNHH or its designee offers employment, YNHH or its designee will provide compensation and benefits that is the same as what is provided by YNHH or its designee to its employees in similar roles at the time of closing. YNHH benefits eligibility and vesting will recognize the length of service of such Additional Employees to the Saint Raphael Organizations and otherwise will be structured commensurate with those benefits offered to any newly hired employee by YNHH or its designee at that time. YNHH or its designee will not assume any liability for any accrued vacation, severance or sick leave expenses of the Additional Employees who become employed by YNHH or its designee, and in connection therewith, each Saint Raphael Organization will be solely responsible for

ensuring that any such amounts owing to the Additional Employees are paid upon the closing.

Foundation

YNHH acknowledges and agrees that the Foundation has received grants and holds other funds for the benefit of the Saint Raphael Organizations or the HSR Hospital Facilities. From and after the closing of the Affiliation Transaction, the parties intend that such grants and other funds will be transferred to YNHH for use in the delivery of health care services at the HSR Hospital Facilities. Accordingly, prior to the execution of the definitive agreement, the parties will review any restrictions imposed on the transfer of such funds to YNHH, whether by the donor or otherwise, and identify those funds that may be transferred to YNHH to benefit the delivery of health care services at the HSR Hospital Facilities, seeking court approval when necessary. To the extent legally permissible, any remaining funds will be used by the Foundation to satisfy the liabilities of the Saint Raphael Organizations that exist following the consummation of the Affiliation Transaction or to fund mutually agreed upon activities that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area.

Notices/Press Announcements/Advocacy

YNHH and HSR will develop jointly a communications plan. The parties will jointly determine and agree upon the form, timing and content of all public announcements, press releases or other public statements concerning the negotiations of the parties and the Affiliation Transactions described in this term sheet.

Definitive Agreement

Execution of the definitive agreements relating to the Affiliation Transaction is targeted to occur on or before June 30, 2011, following approval of the Affiliation Transaction by the respective parties' governing bodies and members. The parties will move expeditiously thereafter to obtain all required governmental and church approvals and close the Affiliation Transaction.

If the Term Sheet and the provisions of this Letter of Intent are acceptable to SOC, SRHS and HSR, we ask that you please sign and date this Letter of Intent where indicated on the following page. When signed, please fax me a copy of this Letter of Intent and Term Sheet. Thereafter, please return the signed and completed original of this Letter of Intent and Term Sheet to me by overnight delivery. The other original of this Letter of Intent and Term Sheet enclosed herewith is for your records.

We look forward to working with you to reach a successful conclusion of our negotiations. If you have any questions or wish to discuss anything contained in this letter, please do not hesitate to call me.

Very truly yours,

Marna P. Borgstrom
President and Chief Executive Officer
Yale-New Haven Hospital/Yale New Haven Health System

Attachment: Exhibit 1

Accepted and Agreed:

SISTERS OF CHARITY OF SAINT ELIZABETH

By: Maureen Shaughnessy S.C.
Sister Maureen Shaughnessy
General Superior

Dated: March 25, 2011

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

By:
Christopher M. O'Connor
President and Chief Executive Officer

Dated: March 25, 2011

HOSPITAL OF SAINT RAPHAEL

By:
Christopher M. O'Connor
President and Chief Executive Officer

Dated: March 25, 2011

PAGE INTENTIONALLY LEFT BLANK

Committee to Preserve an Independent Hospital of St. Raphael

RECEIVED
MAR 2 1 2012
OFFICE OF
HEALTH CARE ACCESS

March, 2012

Dear Commissioner Vogel,

We are a group of CT physicians who see the proposed merger between Yale-New Haven Hospital and Hospital of Saint Raphael as potentially devastating to the status of healthcare in CT. We are well informed about the Connecticut health care market in general, and both Yale-New Haven Hospital and the Hospital of Saint Raphael in particular.

The Federal Trade Commission has begun a phase of examination of the proposed Yale-New Haven Hospital/Hospital of St. Raphael (YNHH/HSR) merger during which they are welcoming comments from informed individuals. The FTC until now has received virtually nothing from the public regarding the merger. In late February, we sent a letter, which is included in this package, to the lead contact person at the FTC, Attorney Stephen Sockwell, who was very appreciative. He stated that it was very well received by him and his colleagues who are examining the merger, and in fact 'changed the way they are thinking' about the merger. He stated the FTC is very interested in additional points of view.

Hundreds of physicians and health care leaders in CT have now received a copy of our letter. We strongly urge you to read the letter and consider the harmful effects the merger will have on the delivery of health care in CT. Our intention is to initiate public discourse on a matter that will affect many of the citizens of CT.

Enclosures:

1. Letter to the FTC from the Committee to Preserve an Independent Hospital of Saint Raphael
2. Department of Justice and FTC Statements of AntiTrust Enforcement Policy in Healthcare

LETTER TO THE FEDERAL TRADE COMMISSION
FEBRUARY 2012

Attorney Stephen Sockwell
Federal Trade Commission
Room 5249
601 New Jersey Avenue
Washington D.C. 20580
Tel: 202-326-2950

Via email: ssockwell@ftc.gov

Dear Attorney Sockwell:

Stripped to the essence, YNHH wants more beds to expand, and HSR needs a significant infusion of money to reduce or eliminate its debt. This is the driving force behind the request for the merger. However, we will argue that it is unnecessary, anti-competitive, and likely to be harmful to the welfare of the citizens of Connecticut.

Unnecessary

The reason for HSR's difficulties is mismanagement, not any structural issues or anything irreversible. The Sisters of Charity who run HSR, wonderful people, are terrible managers, and everyone there saw the place slowly drifting into serious financial trouble. The Sisters are on the Board of Trustees, and have had final say on all HSR decisions for over 100 years. The prior and current CEOs have not done anything like what was needed to counterbalance the Sisters' mismanagement, as they were still in place.

The reason this merger is being advocated by HSR is that the youngest of the Sisters is now in her 70s, their Order is literally dying out, and the surviving Sisters wish to retire at this time. They are looking for a quick exit and a cash infusion, which Yale is willing to supply in order to completely dominate the market in southern Connecticut. However, the exit of the sisters represents an opportunity to bring in new management that will re-invigorate HSR's finances, without the need for a merger.

The three largest cities in Connecticut are Hartford, Bridgeport and New Haven, all of roughly equal population. Hartford has two thriving Hospitals – St. Francis and Hartford Hospital. Bridgeport has two thriving hospitals – Bridgeport Hospital and St. Vincent's. For more than 100 years, New Haven has had YNHH and HSR. There is a clear pattern of a large independent Hospital co-existing with a large Catholic Hospital. The demographics and payor mix of the three areas are not dissimilar. If anything, Bridgeport's mix is less advantageous to hospital economics than what exists in New Haven. Mismanagement is the only reason that, of the three pairs of competing hospitals in the three cities, only HSR is in trouble.

YNHH and HSR are presenting complete merger as the only option that will solve their problems. This is highly debatable. Bridgeport Hospital and Greenwich Hospital are completely independent, with separate licenses, but are part of the Yale-New Haven health system, from which they have gained enormous benefit to the bottom line. The lion's share of any benefit that the merger would create for HSR could be achieved merely by becoming a member of the Yale health system, with its bargaining power for purchasing, shared resources for information technology, human resources, etc.

In other words, the cost savings that are necessary in the current environment can be achieved in other ways other than the anti-competitive full merger of the only two major Hospitals in the New Haven area. New management coupled with becoming a member of the Yale Health system would suffice.

This merger is also not the last hope for HSR. The alternative is not for HSR to close its doors; there is already a 'Plan B' well known to the staff there, which involves going to a national chain like Vanguard Health Systems. For other hospitals, for example, St. Vincent's participation in the Ascension system, this has been very successful.

Anti-competitive

YNHH is already the largest hospital in the state of Connecticut. HSR is the fourth largest, and a merger would create a monolith which is double the size of the second largest, Hartford Hospital. This, especially as it is coupled with the fact that YNHH is the leader of a consortium of three hospitals (YNHH, Bridgeport, Greenwich) in the southern part of the state, obviously requires, on the face of it, careful scrutiny.

YNHH, the main teaching hospital for the Yale School of Medicine, is highly inefficient, as teaching hospitals tend to be, probably inescapably so. As a consequence of the vital role such institutions play, however, this is accepted by third party payors as necessary, and YNHH enjoys the highest reimbursement rates of any hospital in the state. The poor managers at HSR see this as a quick fix to their problems (although all the other Hospitals except the University of Connecticut have dealt effectively with this relative disadvantage). If HSR were merged, these inflated rates would be paid to almost 50% more patients than is currently the case. It is not that Yale School of Medicine needs access to more patients to train its students, residents and fellows. There are not enough medical students to go around even now, especially as Yale is a small medical school.

The leaders at the two institutions see this as an easy way to enhance the revenue stream, without even changing a thing. They benefit, but the people who pay the insurance premiums, whether private or public, will pay the price.

Going forward, the anti-competitive aspect will only worsen. Imagine the bargaining power that a merged YNHH/HSR will have as the only hospital in a catchment area which was previously served by the largest and fourth largest hospitals in the state! Add that to the YNHH Health system consortium, and one has a regional monopoly. The only competitors in any of the Health system's markets will be miniscule in comparison.

Patients have nowhere else to go. This would be an inescapably anti-competitive move, one which should only be considered as a true last resort to save an institution, which this is not.

Harmful

To understand why this would be harmful beyond the economics of the merger, one must have insight into the cultures that exist at the two institutions. YNHH is a very large, impersonal, academic medical center. It attracts physicians who are interested in research more than pure patient care. HSR attracts clinicians who value excellent clinical care above all else. The difference is very easily felt by patients. At Yale, a patient calls a centralized number to attempt to reach a physician, whom he or she very likely won't know, who is covering for a huge department – whereas at HSR the same person calls their doctor's practice, and gets a prompt response from a physician they know. Many Yale doctors practice medicine part-time, and when they are doing their research, they are unavailable. When ill, the patient sees someone else, who will also be unavailable when they are doing research, and so on. While necessary to the health of society at large, this academic model is not optimal for many patients and their families.

We believe it is not understood by the outside world that at YNHH, the Chairs of all the clinical departments of the hospital are actually employees of the Medical School, not YNHH. These academic Chairs have interests that benefit the Medical School and the University, which is often at loggerheads with YNHH. They wish only to recruit people who are productive in the sense of publications, to enhance their department's prestige or grant income, not really caring about their clinical expertise or bedside manner. While this is not true of the leadership of YNHH, the conflict is something that does not exist at HSR currently. However, one of the tenets of the merger that has been handed down to the staff at HSR is that all the departments will be under the control of the Chairs at Yale Medical School. This will absolutely, inevitably destroy the patient-oriented culture of the Medical Staff at HSR.

It must be stressed that whatever the leadership may say at YNHH about how they will preserve the culture at HSR, it is an empty promise. The leopard cannot change its spots, as the academic Chairs will really be in charge, not the YNHH administration.

The difference in culture extends to the attitudes of the support staff. Many employees at HSR have been there their entire adult working life, even though in general YNHH pays more for comparable positions. There is a powerful sense of being part of the HSR 'family', which does not exist among the staff at YNHH. This difference is also felt by patients in how they are treated at the two institutions.

Furthermore, no one at either institution, and we include the very top leadership, has a clear idea or vision for how the merged Hospitals would function – what services would be integrated, at which campus, etc. The opportunities for catastrophic failure are legion. Medical leaders outside of the two Hospitals are shaking their heads in disbelief, and they too cannot fathom how it will work. The uncertainty and inevitable chaos of unifying

two very different institutions, with very different cultures, has stopped recruitment of new physicians and managers cold, and there is already a rising tide of people leaving HSR at the earliest opportunity.

This is not at all to say that one place is superior to the other. Society needs both types of hospitals. Patients need access to academic, research institutions, which are high-tech, low-touch, and high-cost for many serious illnesses. However, many patients who have routine maladies are much better served by mid-tech, high touch, lower cost providers. Additionally, many patients in the region strongly prefer to receive their care at a Catholic Hospital.

As sophisticated physicians with knowledge of all that is involved, if we had to have a gallbladder removed, we would surely go to HSR now rather than YNHH. If one of us had a rare endocrine disorder, he or she would surely go to YNHH. We would personally be very dismayed to see that choice disappear. We are certain that view would be shared by the citizens of southern Connecticut.

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION

STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

STATEMENT 1: ENFORCEMENT POLICY ON MERGERS AMONG HOSPITALS

INTRODUCTION

~~Most hospital mergers and acquisitions ("mergers") do not present competitive concerns.~~ While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[1] This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. ANTITRUST SAFETY ZONE: MERGERS OF HOSPITALS THAT WILL NOT BE CHALLENGED, ABSENT EXTRAORDINARY CIRCUMSTANCES, BY THE AGENCIES

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

B. THE AGENCIES' ANALYSIS OF HOSPITAL MERGERS THAT FALL OUTSIDE THE ANTITRUST SAFETY ZONE

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice/Federal Trade Commission 1992 *Horizontal Merger Guidelines.*

Applying the analytical framework of the Merger Guidelines to particular facts of specific hospital mergers, the Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects. Such situations include transactions where the Agencies found that: (1) the merger would not increase the likelihood of the exercise of market power either because of the existence post-merger of strong competitors or because the merging hospitals were sufficiently differentiated; (2) the merger would allow the hospitals to realize significant cost savings that could not otherwise be realized; or (3) the merger would eliminate a hospital that likely would fail with its assets exiting the market.

Antitrust challenges to hospital mergers are relatively rare. Of the hundreds of hospital mergers in the United States since 1987, the Agencies have challenged only a handful, and in several cases sought relief only as to part of the transaction. Most reviews of hospital mergers conducted by the Agencies are concluded within one month.

If hospitals are considering mergers that appear to fall within the antitrust safety zone and believe they need additional certainty regarding the legality of their conduct under the antitrust laws, they can take advantage of the Department's business review procedure (28 C.F.R. § 50.6 (1992)) or the Federal Trade Commission's advisory opinion procedure (16 C.F.R. §§ 1.1-1.4 (1993)). The Agencies will respond to business review or advisory opinion requests on behalf of hospitals considering mergers that appear to fall within the antitrust safety zone within 90 days after all necessary information is submitted.

FOOTNOTES:

1. The Agencies are confident that conduct falling within the antitrust safety zones contained in these policy statements is very unlikely to raise competitive concerns. Accordingly, the Agencies anticipate that extraordinary circumstances warranting a challenge to such conduct will be rare.

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com

VIA HAND DELIVERY

April 30, 2012

Marianne I. Horn, Esq.
Legal Director
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application; Docket Number 12-31747-CON Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Horn:

As requested, enclosed are two encrypted disks: one contains, in searchable .pdf format, the Deloitte Report and the other contains, also in searchable .pdf format, the Navigant Reports and related documents. These documents are being submitted to the Office of Health Care Access pursuant to a confidentiality protocol set forth in a letter dated April 16, 2012 from the Department of Pubic Health. Accordingly, both the disks and the documents contained on them require a password for access. The password has been emailed directly to you by Aaron Bayer.

We are still in the process of converting the unredacted Asset Purchase Agreement (together with all exhibits and schedules) into a searchable .pdf format. We expect to provide you with disks containing this set of documents later today or tomorrow.

Thank you for your continued efforts to provide us with an expeditious review of the above-referenced CON application.

Very truly yours,

Rebecca A. Matthews

cc (w/o encls.): William J. Aseltyne, General Counsel, Yale-New Haven Hospital, Inc.
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael
Aaron S. Bayer, Wiggin and Dana LLP

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 9, 2012 VIA EMAIL AND FAX ONLY

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System &
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Ahn and Ms. Estes,

On April 12, 2012, the Office of Health Care Access ("OHCA") received Applicants' completeness responses to the Certificate of Need ("CON") application for Yale-New Haven Hospital's ("YNHH") acquisition of the Saint Raphael Healthcare System Inc. ("SRHS"), including the Hospital of Saint Raphael ("HSR").

OHCA has incorporated the information provided in the completeness responses ("Completeness Responses") into the initial submission and requests additional information pursuant to Connecticut General Statutes § 19a-639a(c).

1. Please confirm that no community-based program currently provided by HSR, including but not limited to those listed at pages 106-109 of the Completeness Responses, will be terminated as a result of, or directly following, YNHH's acquisition of HSR.

2. In response to Question 6b at page 117 of the Completeness Responses, Applicants state that "HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011, the date used to negotiate the agreed upon purchase price of $160 million" between the parties. Applicants further state that since

then, the estimated Church plan pension shortfall on a termination basis has risen to approximately $135 million as of December 31, 2011 and that "the sources of funds available to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price." Please describe what affect, if any, the inability to fully satisfy this pension shortfall would have on the parties' ability to consummate the transaction under the present terms and the operations of YNHH following the acquisition of HSR.

3. In response to Question 7c at page 120 of the Completeness Responses, Applicants state that a total of 499 beds could be operational at the HSR campus beginning in FY 2013, including 15 of the 27 licensed beds that have been removed as a result of renovations at HSR in recent years. Please provide the following information:

    a. Does the HSR campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
    b. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the HSR campus?
    c. Does the YNHH campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
    d. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the YNHH campus?

4. In light of the approval given under OHCA Docket No. 11-31714-CON for YNHH and Bridgeport Hospital to consolidate their pediatric services into a single program owned and operated by YNHH, please explain Applicants' rationale for excluding the 22 licensed beds at Bridgeport Hospital from the calculations of bed capacity set forth in Attachment II to the Completeness Responses.

5. Please explain the reasons for the discrepancies between the projections of average daily census ("ADC"), Beds Available and Beds Required for YNHH in FYs 2012 to 2016 as set forth in the table at page 34 of the CON Application and Attachment II to the Completeness Responses.

6. Please provide copies of the YNHH financial assistance policies that will be applicable to both the YNHH and HSR campuses post-acquisition.

7. In response to Question 11 at page 139 of the Completeness Responses, Applicants' state that "YNHH has committed an additional $129.5 million over five years in spending on long-overdue facility upgrades, medical equipment and information technology investments that restore Saint Raphael's facilities and infrastructure to a level commensurate with the level of care that it has historically provided." Please describe the nature of this commitment and confirm whether or not there is any contractual obligation for YNHH to provide such funding.

8. Please provide evidence that the 4 new adult trauma bays and 1 pediatric trauma bay located in the Emergency Department on YNHH's campus will be sufficient to accommodate the consolidated trauma service of both YNHH and HSR post-acquisition.

9. Please describe the process the Applicants have undertaken to integrate the medical staffs of YNHH and HSR to assure that there will be sufficient medical and support staff coverage at both the YNHH and HSR campuses on the closing date of the transaction.

In responding to the questions contained in this letter, please repeat each question before providing your response. Paginate and date your response. Information filed must be numbered sequentially from the applicants' document preceding it. For example, if the last submission concludes with page 100, your completeness response letter would begin with page 101. Please reference "Docket Number 12-31747-CON" and submit one (1) original and five (5) hard copies of your response. In addition, please submit a scanned copy of your response, including all attachments, on CD using MS Word format or Adobe Acrobat.

Upon receipt of the responses to this letter and after incorporating the provided information into the initial submission, OHCA staff will review the CON application to determine completeness. If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steve W. Lazarus/gnt

Steven W. Lazarus
Associate Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2906
RECIPIENT ADDRESS	912036885013
DESTINATION ID	
ST. TIME	05/09 14:56
TIME USE	01'32
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: ✓ **JEAN AHN (203) 688-5013 YALE-NEW HAVEN HOSPITAL**

TERRIE ESTES (203) 867-5665 HOSPITAL OF ST. RAPHAEL

FROM: **JACK HUBER FOR STEVE LAZARUS**

DATE: **5/9/2012** **Time:** **~2:45 pm**

NUMBER OF PAGES: **4**
(including transmittal sheet)

Comments: Transmitted: Completeness Letter
Yale-New Haven Hospital
Proposal to Acquire SRHS & HSR
DN: 12-31748-CON

PLEASE PHONE Jack A. Huber at (860) 418-7069
IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2907
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	05/09 15:01
TIME USE	01'13
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JEAN AHN (203) 688-5013 YALE-NEW HAVEN HOSPITAL

✓ TERRIE ESTES (203) 867-5665 HOSPITAL OF ST. RAPHAEL

FROM: JACK HUBER FOR STEVE LAZARUS

DATE: 5/9/2012 **Time:** ~2:45 pm

NUMBER OF PAGES: 4
(including transmittal sheet)

Comments: Transmitted: Completeness Letter
Yale-New Haven Hospital
Proposal to Acquire SRHS & HSR
DN: 12-31748-CON

PLEASE PHONE Jack A. Huber at (860) 418-7069
IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Olejarz, Barbara
Sent: Friday, May 11, 2012 4:38 PM
To: Greer, Leslie
Cc: Lazarus, Steven; Martone, Kim
Subject: FW: Completeness Responses - YNHH Acquisition of HSR DN 12-31747-CON
Attachments: DN12-31747YNHH Acquisition of HSR_CompletenessResponsesMay112012.doc.pdf

5/11/12

Leslie,

This email came in late on Friday, can you log it in and distribute etc. as being received on 5/11/12

Thanks

Barbara

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Friday, May 11, 2012 4:21 PM
To: Martone, Kim; Olejarz, Barbara
Subject: Completeness Responses - YNHH Acquisition of HSR DN 12-31747-CON

Kim and Barbara-
As was discussed by phone, please find attached completeness responses for YNHH and HSR to OHCA's completeness letter dated May 9, 2012.

Hard copies will be delivered to OHCA on Monday May 14, 2012.

Thank you so much. Karen

Karen M. Banoff

kmb consulting llc

91 Old Hollow Road
Trumbull,CT 06611
(203) 459-1601 (Phone/Fax)
kbanoff@kmbconsult.com

www.kmbconsultingllc.com

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael

RECEIVED
MAY 11 2012
OFFICE OF HEALTH CARE ACCESS

May 11, 2012

Lisa Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application; Docket Number 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Deputy Commissioner Davis:

Enclosed are responses of Yale-New Haven Hospital, Inc. ("YNHH") and the Hospital of Saint Raphael ("HSR") to the completeness questions posed by the Office of Health Care Access ("OHCA") on May 9, 2012.

As noted in our cover letter dated April 12, 2012, capacity issues at YNHH continue to tax YNHH's existing facilities and, of more immediate concern, HSR's deteriorating financial situation threatens its continued viability as key personnel leave and HSR is unable to recruit replacement personnel.

We have worked hard to provide these responses in just two days in order to facilitate OHCA's completeness review process and sincerely hope that the agency has all the information necessary to deem this CON application complete.

Thank you in advance for your consideration.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Richard D'Aquila
Title: President and Chief Operating Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: Steven W. Lazarus, Associate Health Care Analyst, Office of Health Care Access
Kimberly Martone, Director of Operations, Office of Health Care Access

Yale-New Haven Hospital
Saint Raphael Healthcare System & Hospital of Saint Raphael

Certificate of Need Application
Docket Number: 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of
the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Responses to Completeness Questions #2

1. Please confirm that no community-based program currently provided by HSR, including but not limited to those listed at pages 106-109 of the Completeness Responses, will be terminated as a result of, or directly following, YNHH's acquisition of HSR.

   Response

   Yale-New Haven Hospital does not have plans to terminate any community-based program currently provided by HSR as a result of or directly following the acquisition. The Hospital of Saint Raphael provides many community-based programs that are similar to programs offered at YNHH or that are designed to serve the same communities and to achieve similar outcomes. Such programs may be integrated to ensure that they are run effectively and not working at cross purposes. In addition, YNHH is not familiar with every community-based program operated by HSR. Consequently, following the transaction, YNHH would expect to evaluate such programs to ensure that they were consistent with YNHH's mission and achieving their intended goals, but again, YNHH does not have plans to terminate any such community-based program.

2. In response to Question 6b at page 117 of the Completeness Responses, Applicants state that "HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011, the date used to negotiate the agreed upon purchase price of $160 million" between the parties. Applicants further state that since then, the estimated Church plan pension shortfall on a termination basis has risen to approximately $135 million as of December 31, 2011 and that "the sources of funds available to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price." Please describe what affect, if any, the inability to fully satisfy this pension shortfall would have on the parties' ability to consummate the transaction under the present terms and the operations of YNHH following the acquisition of HSR.

   Response

   In the event HSR is unable to fully fund its pension plan, there would be no consequence to consummating the transaction or on YNHH's operations following the acquisition. The HSR pension is a Church-sponsored plan and will remain as an HSR obligation following the acquisition.

   As previously stated, HSR's goals in pursuing the transaction with YNHH were to ensure continuation of its mission and to realize financial stability, including

addressing significant debt and pension obligations and providing much needed capital. When the parties executed the Asset Purchase Agreement, it was anticipated that the HSR pension obligation could change—increase or decrease over the life of the pension plan—based on market conditions. The continued expectation is for HSR to use proceeds from the sale of its assets to increase pension plan funding. As a result, the HSR plan will be significantly better funded—to the benefit of vested employees and retirees—than it is today or would be without the acquisition.

3. In response to Question 7c at page 120 of the Completeness Responses, Applicants state that a total of 499 beds could be operational at the HSR campus beginning in FY 2013, including 15 of the 27 licensed beds that have been removed as a result of renovations at HSR in recent years. Please provide the following information:

   a. Does the HSR campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
   Response
   HSR does not currently have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings.

   b. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the HSR campus?
   Response
   There are several construction/renovation options that could be explored to re-create the additional 12 beds within HSR's existing buildings. However, each of these options would require additional capital in the range of $7 – $9 million dollars, and a potential reduction in the capacity for inpatient rehabilitation services, inpatient child psychiatry services, and/or single patient rooms.

   c. Does the YNHH campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
   Response
   YNHH has the physical capacity to accommodate these 12 beds on East Pavilion 8-8 but will require some renovation which is described in the response to question 3(d).

   d. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the YNHH campus?
   Response
   The construction/renovation that would be required to locate 12 beds on East Pavilion 8-8 includes replacement of plumbing fixtures which were removed.

As stated throughout YNHH's CON Application for 70 additional beds (Docket No. 12-31745-CON) and in this CON Application, all of HSR's 511 licensed beds as well as 70 additional beds, requested in Docket No. 12-31745-CON, are necessary for YNHH to operate at an appropriate occupancy level for the next several years and avoid the pursuit of constructing a new patient care tower.

4. In light of the approval given under OHCA Docket No. 11-31714-CON for YNHH and Bridgeport Hospital to consolidate their pediatric services into a single program owned and operated by YNHH, please explain Applicants' rationale for excluding the 22 licensed beds at Bridgeport Hospital from the calculations of bed capacity set forth in Attachment II to the Completeness Responses.

   Response

   As described in the CON application Docket No. 11-31714-CON and outlined in OHCA's Final Decision, the 22 licensed beds at Bridgeport Hospital and transferred to YNHH's license, are for use in a consolidated pediatric program with a satellite located at Bridgeport Hospital. The bed capacity analysis (Attachment II to the April 12, 2012 CON Completeness Responses) does not include either the patient days or the pediatric beds located at Bridgeport Hospital. Capacity constraints in adult medicine/surgery at YNHH's New Haven campus cannot be addressed with these 22 beds and therefore were excluded from Attachment II's calculations. The bed transfer was pursued in order to provide share resources (i.e. specialized medical staff from Yale New Haven Children's Hospital who will obtain privileges and provide services at Bridgeport Hospital) and to enhance system-wide integration and patient care coordination in pediatrics. As these beds reside on a separate campus located 20 miles from YNHH's New Haven campus, they are not relevant to the bed capacity analysis for the New Haven campus.

5. Please explain the reasons for the discrepancies between the projections of average daily census ("ADC"), Beds Available and Beds Required for YNHH in FYs 2012 to 2016 as set forth in the table at page 34 of the CON Application and Attachment II to the Completeness Responses.

   Response

   The slight differences between the projections of ADC, Beds Available and Beds Required for YNHH in FY 2012 – 2016 as set forth in the table on page 34 of the CON application and Attachment II to the April 12, 2012 completeness responses can be explained as outlined below. Please note that an updated copy of Attachment II has been included as *Attachment I* to these completeness question responses to correct a few minor typographical errors.

   - **The table on page 34 of the CON application contained projections that were prepared at an earlier date to coincide with the financial models provided by Deloitte for the proposed transaction. Attachment II to the Completeness Responses was prepared more recently and represents the following differences from the projections shown on page 34:**

- **Projected patient days and ADC (which is calculated by dividing patient days by 365) in Attachment II were adjusted based on actual volumes experienced in FY 2011 (note: the projections included in the table on page 34 were prepared before FY 2011 concluded).**
- **Bed requirements differ because Attachment II allocated projected patient days into clinical services based on how each department utilizes beds in the hospital. For example, the Department of Orthopedics (grouped into adult medical/surgical in Attachment II) has 10% of its patient days on pediatric beds. Target occupancy levels vary for clinical services as noted in the footnotes in Attachment II and therefore modify the "Beds Required" statistic slightly. The differences are between 4 and 11 beds between Attachment II and the table on page 34, depending on the fiscal year.**
- **Beds available differ because Attachment II reflects a more up-to-date plan for adding 70 additional beds to the YNHH campus, assuming approval of Docket No. 12-31745-CON. Initially it was thought that 28 beds could be added in FY 2012, however upon further planning, 23 beds will be added in FY 2012 and the remaining 47 will be operational in FY 2013. The only difference in the "Beds Available" statistics between the two is present in FY 2012 as just described.**

6. Please provide copies of the YNHH financial assistance policies that will be applicable to both the YNHH and HSR campuses post-acquisition.

Response

***Attachment II* includes copies of the following YNHH financial assistance policies that will be applicable to both YNHH and HSR campuses post-acquisition:**

- **Distribution of "Free Care" Funds**
- **Financial Assistance Programs for Hospital Services**
- **Financial Assistance/Charity Care Policy Sliding Scale Discounting Program**
- **Addendum to Financial Assistance Policies (March 2006)**
- **Administrative Policy for Credit and Collections**

7. In response to Question 11 at page 139 of the Completeness Responses, Applicants' state that "YNHH has committed an additional $129.5 million over five years in spending on long-overdue facility upgrades, medical equipment and information technology investments that restore Saint Raphael's facilities and infrastructure to a level commensurate with the level of care that it has historically provided." Please describe the nature of this commitment and confirm whether or not there is any contractual obligation for YNHH to provide such funding.

Response

When YNHH's acquisition of HSR's assets is approved and the transaction is consummated, YNHH will operate the current HSR facilities as a campus of YNHH, with a single license, a single medical staff and a single workforce. As a single legal entity, the organization also will have one executive leadership team and one Board

of Trustees. YNHH has a commitment to safe, high quality patient care which includes maintaining an appropriate environment for that care. The amount of capital funding specifically for the HSR campus is not fixed by contract but as described in the CON Completeness Responses, HSR has substantial deferred capital needs that are intended to be addressed as funding priorities post-closing. The information technology and certain HVAC-like infrastructure needs have already been included in the $129.5 million. After determining the most appropriate clinical services to be concentrated on that campus, appropriate allocations of capital will be made to support those services.

8. Please provide evidence that the 4 new adult trauma bays and 1 pediatric trauma bay located in the Emergency Department on YNHH's campus will be sufficient to accommodate the consolidated trauma service of both YNHH and HSR post-acquisition.

Response

YNHH currently has two designated adult trauma bays and will have four following the ED renovation, thus doubling its adult trauma bay capacity. HSR had 836 trauma cases in FY 2011 and 359 were discharged directly from the ED. HSR's trauma volume represents 2.3 additional trauma cases per day to YNHH. YNHH had 4,677 trauma cases in FY 2011 or 12.8 per day. The addition of 2.3 cases from HSR's volume can be accommodated with the two additional adult trauma bays that will be available.

9. Please describe the process the Applicants have undertaken to integrate the medical staffs of YNHH and HSR to assure that there will be sufficient medical and support staff coverage at both the YNHH and HSR campuses on the closing date of the transaction.

Response

YNHH and HSR have undertaken a deliberate process to integrate the medical staffs and to ensure coverage at both campuses at closing. First, the parties have almost completed (and will have completed by closing) the process of credentialing the HSR physicians who did not already have privileges at YNHH. More than 400 doctors, physician assistants and APRNs/midwives are being added to the YNHH medical staff. Second, the chief medical officers of both organizations have convened several joint meetings with medical staff leaders, departmental chiefs, medical directors, hospital based physicians and community physicians to continue planning the clinical integration. Third, meetings have been held with all employed physicians at HSR to provide them information on benefits and explain how the combined organization will function. Fourth, the parties have held several open forums for the entire medical staff at both organizations to encourage interaction, information sharing and to address questions regarding the transaction. Finally the medical staff leadership at both organizations has focused on "day one" readiness to ensure continuity of patient care upon the closing of the transaction.

Similar actions are taking place with management staff and employees in general. Additionally, a web site has been developed specifically for the proposed transaction where "frequently asked questions" and answers are posted and the salient points of the transaction are described.

Attachment 1
to Completeness Responses
dated May 11, 2012
Docket No. 12-31747

YNHH Bed Capacity and Bed Need[1] for FY 2012 based on Projected Annual ADC[2] according to Three Scenarios:
1. Addition of 70 beds, 2. Acquisition of HSR, 3. Addition of 70 beds and Acquisition of HSR

	YNHH FY 2012	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2012 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2012 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR
Adult Medical/ Surgical																	
General Care	476.2	203.1	533	556	859	882	595	254	849	-62	-39	10	33	89%	85%	79%	77%
Critical Care	92.3	59.9	107	107	192	192	115	75	190	-8	-8	-8	-8	86%	86%	84%	84%
Adult Med/Surg Subtotal	*568.5*	*263.0*	*640*	*663*	*1,041*	*1,064*	*710*	*329*	*1,039*	*-70*	*-47*	*2*	*25*	*89%*	*86%*	*80%*	*78%*
Children's Hospital																	
General Care	54.5	0.5	71	71	74	74	73	1	74	-2	-2	0	0	77%	77%	75%	75%
Critical Care	11.2		19	19	19	19	15		15	4	4	4	4	59%	59%	59%	59%
Children's Subtotal	*65.7*	*0.5*	*90*	*90*	*93*	*93*	*88*	*1*	*89*	*2*	*2*	*4*	*4*	*73%*	*73%*	*71%*	*71%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.4	21.4	78	78	99	99	82	24	106	-9	-9	-8	-8	101%	101%	97%	97%
Child Psychiatry	19.5	14.5	15	15	33	33	15	16	31	0	0	2	2	90%	90%	86%	86%
Maternity	39.3	19.9	56	56	75	75	52	15	67	4	4	8	8	70%	70%	87%	87%
Available Beds Total	769.4	321.7	874	897	1,358	1,381	947	399	1,346	-73	-50	12	35	87%	86%	80%	78%
NBSCU - Critical Care Bassinets	42.1	4.5	52	52	60	60	55	6	62	-4	-4	-2	-2	81%	81%	78%	78%
Newborn Bassinets	27.4	7.5	40	40	54	54	37	10	47	3	3	7	7	69%	69%	65%	65%
Bassinets Subtotal	69.5	12.0	92	92	114	114	93	16	109	-1	-1	5	5	76%	76%	71%	71%
Total	839.9	333.7	966	989	1,472	1,495	1,040	415	1,456	-74	-51	17	40	86%	84%	79%	78%

[1] Projected Bed Need was based on inpatient projections only. Observation patients and other outpatient care for in inpatient bed were excluded. Target Utilization; Adult med/surg and Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[2] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[3] for FY 2013 based on Projected Annual ADC[4] according to Three Scenarios

	YNHH FY 2013	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2013 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2013 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	486.0	203.1	533	596	872	935	606	254	860	-73	-10	12	75	91%	81%	79%	74%
Critical Care	94.4	59.9	107	114	182	189	118	75	193	-11	-4	-11	-4	88%	83%	85%	82%
Adult Med/Surg Subtotal	*578.4*	*263.0*	*640*	*710*	*1,054*	*1,124*	*724*	*329*	*1,053*	*-84*	*-14*	*1*	*71*	*91%*	*82%*	*80%*	*75%*
Children's Hospital																	
General Care	66.7	0.6	71	71	74	74	74	1	75	-3	-3	-1	-1	78%	78%	76%	76%
Critical Care	11.4		19	19	19	19	15		15	4	4	4	4	60%	60%	60%	60%
Children's Subtotal	*67.1*	*0.6*	*90*	*90*	*93*	*93*	*89*	*1*	*90*	*1*	*1*	*3*	*3*	*75%*	*75%*	*73%*	*73%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	74.5	21.4	73	73	98	98	83	24	107	-10	-10	-9	-9	102%	102%	98%	98%
Child Psychiatry	13.6	14.6	15	15	35	35	15	16	31	0	0	4	4	92%	92%	82%	82%
Maternity	39.8	10.9	56	56	75	75	53	15	68	3	3	7	7	71%	71%	68%	68%
Available Beds Total	774.5	321.7	874	944	1,373	1,443	964	399	1,363	-90	-20	9	79	89%	82%	80%	76%
NBSCU - Critical Care Bassinets	42.9	4.6	52	52	60	60	57	6	63	-5	-5	-3	-3	83%	83%	79%	79%
Newborn Bassinets	27.9	7.5	40	40	54	54	37	10	47	3	3	7	7	70%	70%	66%	66%
Bassinets Subtotal	70.8	12.0	92	92	114	114	94	16	110	-2	-2	4	4	77%	77%	73%	73%
Total	845.4	333.7	966	1,036	1,487	1,557	1,058	415	1,473	-92	-22	13	83	88%	82%	79%	76%

[3] Target Utilization: Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[4] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[5] for FY 2014 based on Projected Annual ADC[6] according to Three Scenarios

	YNHH FY 2014	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2014 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2014 Projected Bed Utilization			
			YNHH - existing	Scenario 1	Scenario 2	Scenario 3					Scenario 1	Scenario 2	Scenario 3				
	ADC	ADC		YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	494.5	203.1	538	596	672	930	618	264	872	-85	-22	0	58	93%	83%	80%	75%
Critical Care	96.5	59.9	107	114	182	189	121	75	196	-14	-7	-14	-7	90%	85%	66%	63%
Adult Med/Surg Subtotal	*591.0*	*263.0*	*640*	*710*	*1,054*	*1,124*	*739*	*329*	*1,068*	*-99*	*-29*	*-14*	*57*	*92%*	*83%*	*81%*	*76%*
Children's Hospital																	
General Care	66.9	0.6	71	71	74	74	76	1	77	-5	-5	-3	-3	80%	80%	78%	78%
Critical Care	11.6		19	19	19	19	16		16	3	3	3	3	61%	61%	61%	61%
Children's Subtotal	*68.5*	*0.6*	*90*	*90*	*93*	*93*	*92*	*1*	*93*	*-2*	*-2*	*0*	*1*	*76%*	*76%*	*74%*	*74%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	75.7	21.4	73	73	98	98	84	24	108	-11	-11	-10	-10	104%	104%	99%	99%
Child Psychiatry	14.1	14.8	15	15	35	35	16	16	32	-1	-1	3	3	94%	94%	83%	83%
Maternity	40.3	10.9	56	56	75	75	54	15	69	2	2	6	6	72%	72%	68%	68%
Available Beds Total	789.6	321.7	874	944	1,373	1,443	986	399	1,384	-111	-41	-11	59	90%	84%	81%	77%
NBSCU - Critical Care Bassinets	43.8	4.6	52	52	60	60	58	6	64	-6	-6	-4	-4	84%	84%	81%	81%
Newborn Bassinets	28.5	7.5	40	40	54	54	38	10	48	2	2	6	6	71%	71%	67%	67%
Bassinets Subtotal	72.3	12.0	92	92	114	114	96	16	112	-4	-4	2	2	79%	79%	74%	74%
Total	861.9	333.7	966	1,036	1,487	1,557	1,081	415	1,496	-115	-45	-9	61	89%	83%	80%	77%

[5] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[6] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[7] for FY 2015 based on Projected Annual ADC[8] according to Three Scenarios

	YNHH FY 2015	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2015 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2015 Projected Bed Utilization			
			YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
	ADC	ADC															
Adult Medical/ Surgical																	
General Care	503.5	203.1	533	536	672	935	630	254	884	-97	-34	-12	51	94%	94%	81%	75%
Critical Care	98.7	59.9	107	114	182	189	123	76	199	-16	-9	-16	-9	92%	87%	87%	84%
Adult Med/Surg Subtotal	602.2	263.0	640	710	1,054	1,124	753	329	1,082	-113	-43	-28	42	94%	85%	82%	77%
Children's Hospital																	
General Care	58.1	0.6	71	71	74	74	77	1	78	-6	-6	-4	-4	82%	82%	79%	79%
Critical Care	11.9		19	19	19	19	16		16	3	3	3	3	63%	63%	63%	63%
Children's Subtotal	70.0	0.6	90	90	93	93	93	1	94	-3	-3	-1	-1	78%	78%	76%	76%
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	75.8	21.4	73	73	98	98	85	24	109	-12	-12	-11	-11	105%	105%	100%	100%
Child Psychiatry	14.4	14.8	15	15	35	35	16	16	32	-1	-1	3	3	96%	96%	83%	83%
Maternity	40.8	10.9	55	55	75	75	54	15	69	2	2	6	6	73%	73%	69%	69%
Available Beds Total	804.2	321.7	874	944	1,373	1,443	1,001	399	1,400	-127	-57	-27	43	92%	85%	82%	78%
NBSCU - Critical Care Bassinets	44.7	4.5	52	52	60	60	50	6	56	-8	-8	-5	-5	86%	86%	82%	82%
Newborn Bassinets	29.1	7.5	40	40	54	54	39	10	49	1	1	5	5	73%	73%	66%	66%
Bassinets Subtotal	73.8	12.0	92	92	114	114	89	16	105	-7	-7	-1	-1	80%	80%	75%	75%
Total	878.0	333.7	966	1,036	1,487	1,557	1,190	415	1,605	-134	-64	-28	42	91%	85%	81%	78%

[7] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets; 75%.
[8] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[9] for FY 2016 based on Projected Annual ADC[10] according to Three Scenarios

	YNHH FY 2016	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2016 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2016 Projected Bed Utilization			
				Scenario 1	Scenario 2	Scenario 3					Scenario 1	Scenario 2	Scenario 3		Scenario 1	Scenario 2	Scenario 3
	ADC	ADC	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	512.5	203.1	593	593	872	935	641	254	895	-108	-48	-23	40	96%	86%	82%	77%
Critical Care	100.8	59.9	107	114	182	189	126	75	201	-19	-12	-19	-12	94%	88%	88%	85%
Adult Med/Surg Subtotal	*613.3*	*263.0*	*640*	*710*	*1,054*	*1,124*	*767*	*329*	*1,096*	*-127*	*-57*	*-42*	*28*	*96%*	*86%*	*83%*	*78%*
Children's Hospital																	
General Care	59.3	0.6	71	71	74	74	78	1	80	-8	-8	-6	-8	84%	84%	81%	81%
Critical Care	12.1		19	19	19	19	16		16	3	3	3	3	64%	64%	64%	64%
Children's Subtotal	*71.4*	*0.6*	*90*	*90*	*93*	*93*	*95*	*1*	*96*	*-5*	*-5*	*-3*	*-3*	*79%*	*79%*	*77%*	*77%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.0	21.4	73	73	98	98	87	24	111	-14	-14	-13	-13	107%	107%	101%	101%
Child Psychiatry	14.3	14.3	15	15	35	35	16	16	32	-1	-1	3	3	97%	97%	84%	84%
Maternity	41.3	10.9	56	56	75	75	55	15	70	1	1	5	5	74%	74%	70%	70%
Available Beds Total	818.3	321.7	874	944	1,373	1,443	1,020	399	1,419	-146	-76	-46	24	94%	87%	83%	79%
NBSCU - Critical Care Bassinets	45.5	4.5	52	52	60	60	61	6	67	-9	-9	-7	-7	88%	88%	84%	84%
Newborn Bassinets	29.7	7.5	40	40	54	54	40	10	50	0	0	4	4	74%	74%	69%	69%
Bassinets Subtotal	75.3	12.0	92	92	114	114	101	16	117	-9	-9	-3	-3	82%	82%	77%	77%
Total	893.6	333.7	966	1,036	1,487	1,557	1,121	415	1,536	-155	-85	-49	21	93%	86%	83%	79%

[9] Target Utilization: Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[10] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	Distribution of "Free Care" Funds	Manual Code:	NC:F-2
Reviewed:	9/20/00, 9/1/01, 6/1/05, 7/1/07, 7/1/10	Revised:	3/1/91, 9/11/01, 9/1/03, 3/28/12
Supersedes Manual Code:		Dated:	
Approved By:	James Staten – Senior Vice President of Finance		

I. PURPOSE:

To establish the policy for the use of funds that have been donated to Yale-New Haven Hospital (YNHH or the "Hospital") and other funds that have been designated by YNHH to provide free care. The Hospital also has other policies related to charity care.

II. PROCEDURES:

A. General Statement of Need

The Hospital has received charitable contributions to endowment that are restricted by the donors to use to provide free care to patients (hereinafter referred to as "Free Bed Funds"). Some of the donated funds contain additional restrictions (home address of patient, church, nominator, etc.); other funds have no additional restrictions. The Hospital has established a spending policy on the distribution of these Free Bed Funds. In addition, YNHH provides additional free care to patients from Hospital operating funds (hereinafter referred to as "YNHH designated funds" or "free care funds").

B. Notice

The Hospital will provide notice and information to patients about Free Care Funds in a number of ways, including publishing notices in newspapers of general circulation; posting notices in appropriate locations throughout the Hospital; ensuring the availability of a one-page summary description of Free Bed Funds and how to apply for them; providing individual written notice to patients; making available written information in other forms that may be helpful to patients; and holding open houses.

The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Donated Free Bed Funds with No Specified Nominator

The Hospital has Free Bed Funds where the historical dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay, but no specific nominator is named. The allocation of the availability of these funds is based on the Hospital's Endowment Spending Policy.

These Free Bed Funds will be available only to patients with no specified nominator after all possibilities of third party reimbursement have been exhausted. Patients must have applied for State assistance, and provide formal documentation showing legitimate denial.

Patients will be considered eligible for the use of Free Bed Funds if their income level does not exceed two and a half times (250%) the poverty level and in appropriate cases and circumstances, the Hospital has determined that they do not have liquid assets that can be used to pay all or some portion of the bill without financial hardship or distress. The Hospital will establish appropriate documentation requirements to verify eligibility.

In addition, the Hospital, at its discretion and on a case by case basis, may provide Free Bed Funds to patients with insurance, assuming they satisfy the other criteria outlined above and there are no other prohibitions on them receiving such assistance. If the patient is insured by a governmental program (Medicare, Medicaid or Tricare) or a private insurer, the Hospital will consider requests for Free Bed Funds for co-pays, deductibles, and/or spenddowns on a case by case basis. If granted, these amounts will be relieved at the amounts determined under the contract or program in question. In addition, the Hospital will consider requests for Free Bed Funds when a patient's insurance or maximum coverage benefits have been exhausted. In making these decisions, the Hospital will consider medical and financial hardship. It may also choose to provide Free Bed Funds for only a portion of the request, if in its judgment, awarding Free Bed Funds for the entire request would adversely affect other applicants who meet the qualifications, but are without insurance (and thus may carry a larger debt).

D. **Eligibility for Donated Free Bed Funds with Geographic or other Additional Restrictions but no Specified Nominator**

Patients must fulfill the above eligibility guidelines for "Donated Free Bed Funds with No Specific Nominator", and reside in the specific geographic location dictated by the original gift or meet the other additional eligibility restrictions contained in the original gift.

E. **Eligibility for YNHH Designated Funds**

Once Free Bed Funds with no nominator or other special restriction are exhausted up to the annual endowment spending policy limit, if there are patients eligible for Free Bed Funds who do not meet the restrictions for eligibility for any available restricted Free Bed Funds, YNHH will provide additional free care to patients from YNHH designated funds. Patients must fulfill the eligibility guidelines for "Donated Free Bed Funds with No Specified Nominator" to be eligible for free care designation from YNHH designated funds.

YNHH will also make available additional free care funds from operations for other types of requests where the patient demonstrates a compelling hardship or personal circumstance which warrants providing financial assistance. These requests will be identified and recommended for free care funds by a committee comprised by Management.

F. **Eligibility for Donated Funds Restricted to Use by an Outside Nominator**

The Hospital has Free Bed Funds where the historic dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay and a nominator is named. The allocation of the available funds is based on the Hospital's Endowment spending policy.

The Hospital will notify nominators semi-annually of the status of Free Bed Funds for which they have a nomination role. The nominator may request the use of Free Bed Funds for any eligible patient who meets the guidelines for a given fund. Each nominator will receive an annual report of Free Bed Funds utilized by patient (subject to privacy restrictions). Nominators may request to rollover unused funds to the subsequent year for their purposes or designate remaining funds to be used by YNHH for general free care purposes. In addition, YNHH may award funds in cases in which the donor provided that the Hospital has the power to award the funds if the nominator did not.

G. Accounting of Free Funds

1. **For donated Free Bed Funds with no specified nominator and donated Free Bed Funds with geographic or other additional restrictions but no specified nominator:**

   The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the patient requests up to 90 days after the close of the Funds' fiscal year. During this 90-day period, accounts will be identified and recommended for Free Bed Funds by a committee comprised by Management. The funds will be relieved at cost.

2. **For YNHH Designated Funds:**

   For patients whose income level does not exceed two and a half times (250%) the poverty level and deemed eligible for the use of free funds, YNHH designated funds will be available subsequent to the exhaustion of the Free Bed Funds available according to the Endowment Spending Policy for "donated Free Bed Funds with no specified nominator." The funds will be relieved at cost.

3. **For donated Free Bed Funds restricted to Use by an Outside Nominator:**

   The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the nominator requests up to 90 days after the close of the Free Funds' fiscal year. If the total amount available to be spent in a year is not applied based on nominator request, the remaining amounts can be carried forward and made available for use in the following year or may, depending on the nominator's wishes and/or the terms of the original gift, be awarded by the Hospital to eligible patients. Funds utilized for patients who meet the financial criteria for other Free Bed Funds will be relieved at cost.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	Financial Assistance Programs for Hospital Services	Manual Code:	NC:F-4
Reviewed:	8/1/05, 7/1/07, 7/1/10	Revised:	
Supersedes Manual Code:		Dated:	8/1/05
Approved By:	James Staten – Senior Vice President of Finance		

I. PURPOSE:

Yale-New Haven Hospital ("YNHH" or the "Hospital") recognizes that many patients may be uninsured, may not have adequate insurance or may otherwise lack the financial resources to pay for quality health care services without financial assistance. Consistent with its mission, YNHH is committed to assuring that ability to pay will be considered carefully when settling amounts due for health care services.

In recognition of its role to help those in need of financial assistance, the Hospital has established the YNHH Financial Assistance Programs for Hospital Services ("the Programs"). Those Programs include free care policies, sliding scale discounting policies, prompt pay discount, and certain billing/collection policies. The objectives of the Programs are to:

A. Maintain a humane environment for our patients and their families;

B. Assist patients in gaining access to government insurance programs;

C. Provide clear information regarding the Programs;

D. Ensure easy and timely access to the Programs.

E. Consistently apply the Programs to all patients;

F. Apply fair and equitable business practices with respect to collections for patient services; and

G. Comply with all applicable laws, rules and regulations.

All patients will have the option to apply for government or hospital financial assistance programs based on financial need.

II. PROCEDURES:

A. Scope

1. The Programs apply to hospital inpatient, outpatient and ancillary services billed by the Hospital.

2. The Programs apply to:
   a. Uninsured patients (as defined by CT Public Act 03-266)
   b. Patients with no insurance coverage.
   c. Non-covered services (as determined by the patient's third party payer benefits) that are medically necessary.

d. Under-insured patients with significant co-payments and deductibles;
e. Charges incurred after patients' exhaustion of third party payer benefits.

3. The Programs exclude:

a. Routine waiver of deductibles, co-payments and co-insurance imposed by third party payers on hospital claims.
b. Private room or private duty nurses.
c. Services that are not medically necessary, such as elective cosmetic surgery.
d. Other fees that may not be charged directly by YNHH (e.g., television or telephone charges).

4. The patient will be ineligible for some or all financial assistance if any of the following occur:

a. It is determined that false information fundamentally related to financial eligibility and/or status was provided by the patient or responsible party during the application or billing and collection process.
b. The patient or responsible party fails to apply for government insurance programs, and such an application is an eligibility requirement for certain types of assistance in the Programs.
c. The patient or responsible party fails to provide information necessary to complete the eligibility process.

5. YNHH reserves the right to evaluate a patient's eligibility on a case-by-case basis, especially where complex medical, scientific or financial situations exist.

B. **Access to Information**

Patients will obtain information on eligibility for government or hospital programs primarily from the Hospital's Patient Account Representative. Patients will be alerted to the Financial Assistance Programs in a number of ways, including notices in English and Spanish posted in appropriate locations throughout the Hospital, a summary of free care availability and information on how to apply for free care, information distributed in the admission package, and information on the Hospital's web site. Information will also be provided when direct inquiries are made to YNHH. The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and that is designed to make information easily available and accessible to patients.

All patients will have access to information regarding estimated charges for particular services or actual charges for hospital services that have been provided.

C. **Summary of Financial Assistance Programs**

1. <u>Free Care Funds</u>

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients who meet the specific criteria and are unable to pay for services rendered. The Hospital also has other funds that have been designated by YNHH to provide free care. Additional information regarding these funds is contained in the Hospital's Policy for Free Care Funds.

The Hospital will use the same Free Care Application ("Application") to assess both eligibility for Free Care Funds as well as the Sliding Scale Discounting Programs. A Patient Account Representative will perform a financial screening on all patients with payment obligations not covered by insurance for the purpose of determining potential eligibility for financial assistance with any unpaid balances and encouraging patients to apply for assistance.

2. Sliding Scale Discounting Programs

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients who do not meet the criteria in the Policy for Free Care Funds, but do meet criteria in the Financial Assistance/Charity Care Policy: Sliding Scale Discounting Program. Additional information regarding this program is contained in the Hospital's Sliding Scale Discounting Program.

3. Prompt Payment and Extended Payment Plans

For patients who do not qualify for assistance either under the Policy for Free Care Funds or the Hospital's Sliding Scale Discounting Program, the Hospital provides financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options.

D. Credit, Collections and Bad Debt

YNHH will identify, and distinguish between, the accounts of those patients who have the financial resources to pay for all or some portion of their Hospital bills and the accounts of those who do not. The Hospital will evaluate all past-due accounts for appropriate disposition and follow-up, consistent with this policy, the Hospital's Administrative Policy for Credit and Collection, and Connecticut law.

The Hospital will maintain contractual relationships with one or more collection agencies and law firms for collection of past due accounts. Each such collection agency or law firm must comply with the Hospital's Administrative Policy for Credit and Collections and Connecticut law.

If, at any time, the Hospital, or a collection agency or law firm, receives information that a patient is or may be eligible for financial assistance under one of these Programs or under any governmental or other program, the Hospital, collection agency, or law firm shall, consistent with Connecticut law, cease collection efforts until the Hospital determines the patient's eligibility for assistance.

The Hospital will classify a past due account as bad debt in accordance with the Hospital's Administrative Policy for Credit and Collections and relevant financial accounting standards and law. In determining bad debt, the Hospital may use a variety of collection efforts, including subsequent billings, follow up letters, telephone calls, personal contacts and referral to a collection agency or law firm.

E. Management Oversight Committee

1. Purpose

The Programs will be overseen by a management oversight committee ("Committee"). The Committee will, among other oversight responsibilities, review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless may demonstrate compelling hardship or personal circumstances which warrant financial assistance. The Committee will also review financial assistance requests from patients who are insured, but demonstrate financial hardship in paying co-payments or deductibles.

2. Composition of Committee

The Committee will be chaired by a Senior Vice President of Yale-New Haven Hospital. Additional Committee members may include System Business Office senior management, patient financial services representatives, patient relations representatives, finance and medical staff liaisons as needed. The Committee will meet on a bi-monthly basis or more frequently, if necessary.

3. **Operating Protocols**

Patient accounts may be referred to the Committee for review by Patient Financial Services, Patient Relations Representatives, or other appropriate referral sources. In general, the Committee will review patient accounts that do not meet the standard eligibility requirements for the various Financial Assistance Programs.

Typical referrals to the Committee will include:

a. Insured patients with co-payments and deductibles that present financial hardship.
b. Self-pay patients with income/assets above 400% of the poverty level with a significant bill that presents a financial hardship.
c. Insured patients who have exhausted insurance benefits or maximum coverage amounts with a significant bill that presents financial hardship.

d. Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

The Committee will typically deny financial assistance requests for the following situations:

a. Services denied by an insurance plan as experimental or non-FDA approved.
b. Financial hardship caused by the intentional failure of a patient to follow through with; a) medical advice, or b) health plan requirements such as payment of premium, notification of admission, or other requirements outlined in the patient's subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as writing to the affected patient.

F. **Accounting and Reporting of Financial Assistance Programs**

The System Business Office will collect and distribute information to senior management regarding these Programs on a quarterly basis. This information may include, but is not limited to:

a. Number of cases referred;
b. Number of cases processed;
c. Number of cases determined eligible for and referred to government insurance programs;
d. Number of Free Care Applications distributed;
e. Number of Free Care Applications received (complete and incomplete), accepted and rejected and reasons for rejection; and
f. Average time required to process Free Care Applications.

The Budget and Finance Committee of the Board of Trustees of Yale-New Haven Hospital will be provided at least annually with a report concerning the status of these Programs.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	Financial Assistance/Charity Care Policy Sliding Scale Discounting Program	Manual Code:	NC:F-5
Reviewed:	May 11, 2012	Revised:	7/1/07, 7/1/10
Supersedes Manual Code:		Dated:	6/1/05
Approved By:	James Staten – Senior Vice President of Finance		

I. PURPOSE:

To establish the policy for providing financial assistance under a sliding scale discounting program to uninsured patients who are determined under the hospital's eligibility criteria to lack the ability to pay for care at full charges. Yale-New Haven Hospital (the "Hospital") is guided by a mission to provide high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, including payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and that take into account an individual's ability to pay for medically necessary health care services.

In addition to charity care provided under this sliding scale discounting program established by the Hospital, free care is provided to uninsured and insured patients in accordance with the Hospital's Policy for Free Care Funds. The free care is provided to patients eligible for it and is funded by free bed funds given to the Hospital as well as by Hospital operating funds. Further, the Hospital provides Relief and assistance to insured patients by waiving or reducing co-payments and/or deductibles and Medicaid spend-down requirements on a case-by-case basis determined on grounds of medical and financial hardship.

II. PROCEDURES:

A. General Statement of Need

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. The Hospital will establish appropriate documentation requirements to verify financial status.

B. Notice

The Hospital will provide notice and information to patients about the availability of charity care under the sliding scale discounting program in a number of ways, including describing this policy on the one page summary description of free bed funds and other free or reduced care policies.

The Hospital will provide notice and information in a manner that complies with requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Sliding Scale Program:

The Hospital provides care through the sliding scale discounting programs to uninsured patients that do not have the ability to pay for medically necessary services at full charges. The sliding scale discounting program is designed to assist uninsured patients eligible for the sliding scale who are not otherwise eligible or do not comply with the application process for assistance under the Hospital's Policy for Free Care Funds.

Additional financial assistance programs are provided by the Hospital for patients who do not qualify for the sliding scale program or free care under the Hospital's Policy for Free Care Funds. These programs include prompt pay discounts and extended payment terms with no interest. In addition, the Hospital provides relief to patients not eligible for free care or the sliding scale program on a case-by-case basis.

Patients must fulfill the following eligibility guidelines:

1. **At or below 400 percent of the federal poverty level**

   Patients will be considered eligible for the sliding scale discount program if their income level does not exceed 400 percent of the federal poverty level and the Hospital, having considered the patient's resources, has determined that they lack the ability to pay all or some portion of the bill. The Hospital will establish appropriate documentation requirements to verify eligibility. Generally, the patient must apply for consideration under the sliding scale program within 30 days of determining self-pay or uninsured status. Eligibility will be granted for one-year, unless otherwise determined by the Hospital, at which time the patient may reapply for sliding scale status. For patients that qualify for the sliding scale program and whose annual family income is at or below 400 percent of the federal poverty level, the patient's bill for services will reflect full charges and then be discounted to a percentage that approximates cost. This cost to charge percentage will be reviewed and set on an annual basis. The discount will be considered free/charity care. The balance will be the patient's financial responsibility.

2. **Over 400 percent of the federal poverty level**

   For patients whose annual family income is greater than 400 percent of the federal poverty level, the patient will not be eligible for the sliding scale discount program, and unless provided relief under a case-by-case review, will be billed for services at gross charges; the charges billed will be the patient's financial responsibility. Under the case-by-case review, discounts up to or exceeding 40% of the charges billed may be granted.

   Any patient with aggregate Yale-New haven Hospital bills that exceed 10% of the patient's annual household income will be eligible for a discount equal to the hospital's approximation of cost.

D. **Charity Care Determination**

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. Free care is a component of charity care based on established eligibility criteria that awards free care to qualified individuals. The Hospital's determination of charity care for eligible patients may occur at any time during the patient's admission, dates of service, discharge or collection process. The collection process may further allow the Hospital to determine whether patients qualify for sliding scale programs or ultimately are designated as charity care based on inability to pay.

E. **Payment Guidelines**

Extended payment arrangements may be established with the patient whether they qualify for sliding scale payment, or they are ineligible. If the patient does not honor the payment arrangement based on the eligibility guideline, the amount is referred to a collection agency at the discounted rate.

F. **Accounting for Charity and Free Care**

Only that portion of a patient account that meets the sliding scale program criteria is recognized as charity care; charity and free care is a reduction in charges made by the Hospital because of the patient's inability to pay for services at charges.

REFERENCE:

YALE-NEW HAVEN HOSPITAL

ADDENDUM TO
FINANCIAL ASSISTANCE POLICIES
March, 2006

1. Yale New Haven Health System hospitals will begin to employ in early 2006 a financial screening tool in conjunction with the major credit reporting agencies. Such screening tool will allow member hospitals to triage self-pay accounts as well as potential accounts with underinsurance for ability to pay. Threshold criteria will be established to triage accounts for further collection.

2. Policies will be modified to allow Yale-New Haven and Bridgeport Hospital to consider a patient's financial assets when determining an ability to pay. (Greenwich Hospital currently has the ability to review assets)

3. The current policies at Yale-New Haven and Bridgeport Hospitals require a Medicaid denial prior to approval for free care. We have been asked to review the wisdom of this policy in light of the high certainty of denials for undocumented residents. After careful review and discussion, we believe that this requirement should stand. There are many examples of coverage by Medicaid for services that were originally thought ineligible. We also do not want to set up special consideration for undocumented residents when we require documented residents to obtain a Medicaid denial. Greenwich Hospital currently does not require a Medicaid denial.

4. The sliding scale program should be made available to as many patients as possible. Currently, patients are required to submit proof of income prior to obtaining the sliding scale discount. We recommend that this process continue to be considered, but all patient denials for sliding scale should be reviewed by a manager prior to rejection to confirm that any and all attempts have been made to obtain the required information.

5. Currently, patients who present for non-emergency services and who have no ability to pay, are denied access to services without full or partial payment. In all cases, the physician is notified and asked to determine the emergent or non-emergent condition. Patients may complete a financial assistance application for coverage and when approved, are granted access to services. We propose that this policy be modified to restrict access to services only until a patient has completed our financial assistance application and provided proof of income. Patients who are ultimately denied financial assistance will be noted in the records and upon the patient's next visit, must comply with the non-emergent payment policy.

6. Patients who complete a financial assistance application, provide proof of income, but do not provide a Medicaid denial (50% of cases) will be screened for income eligibility. If the patient meets the income criteria, the account would be referred to Century, even if the patient is employed or owns property. No accounts will be referred to a collection attorney if income is below 400% of FPL.

7. Any patient may avail themselves of a payment plan for their portion of the hospital bill. Such payment plans shall be limited to balances of greater than $50. Greenwich Hospital currently uses and may continue to use a $10 threshold. Depending upon the balance due, payment plans may be established for up to 12 months interest free. Larger balance payment plans for an extended period may be established upon the approval of the Vice President, Corporate Business Services, or an SVP of the health system (including hospital CFOs). In 2006, the health system will establish credit arrangements with one or more health care credit card companies to assist patients with a periodic payment plan. This plan will be initially rolled out at Yale-New Haven and Bridgeport Hospitals.

8. Any care provided to patients that do not complete the appropriate financial assistance applications and are deemed to be unable to pay their health care bill will be classified as charity care. This includes international patients for whom the hospital agrees to provide services at no cost, either prospectively or retrospectively due to the patient's financial circumstances. These will no longer be classified as administrative allowances.

9. The policy will be modified to automatically write off small balances of under $50 after the full cycle of bills have been provided to a patient. The previous ceiling was $100. As a note, any balance of under $1000 is always referred to Century collections as only balances over $1000 are referred to collection attorneys. Greenwich Hospital currently has established a write off threshold of $10 and will continue to use this amount.

YALE-NEW HAVEN HOSPITAL

ADMINISTRATIVE POLICY

FOR CREDIT AND COLLECTIONS

I. Purpose

The primary goal of Yale-New Haven Hospital ("YNHH or the "Hospital") is to provide the highest quality of medical care to its patients at the lowest cost. In order to do so, an efficient and equitable system must be established that will maximize the collection of patient account receivable balances in order to provide the cash flow required to operate the institution effectively.

In accordance with the above, the following credit and collection policy is hereby established for Yale-New Haven Hospital. Detailed procedures will be included in a credit and collection manual as maintained by the System Business Office. As references to this policy, the Table of Contents from various Credit and Collections Operation Manuals from the System Business Office ("SBO") are attached as Exhibits to this policy:

- Exhibit A: SBO Procedure Manual
- Exhibit B: Inpatient Access and ED Dept Reg.Procedure Manual
- Exhibit C: Medical Oncology, One Day Surgery and PT Manual
- Exhibit D: Private Referred Operations Manual
- Exhibit E: PCC and Women's Center Operations Manual

II. Source of Payment

A. Patient

The primary responsibility of settlement of the account will rest with the patient. Except in an emergency, all patients capable of doing so, will be required to sign a payment guarantee prior to admission or receipt of inpatient service.

The patient portion of the hospital bill is to be satisfied through payment via one or more of the following sources:

1. Cash, money order, personal check, bank check, or travelers checks
2. Credit cards acceptable to the hospital
3. Savings accounts, income tax refunds
4. Sale of investments, conversion of insurance policies
5. Loans from banks, credit unions, finance companies, etc.

6. Money Transfer
7. ATM Debit Cards

B. Third Party Coverage

Yale-New Haven Hospital will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows:

Blue Cross
Managed Care Payers (HMO and PPO programs)
Medicare
Tricare
Commercial Insurance Companies
(upon assignment of benefit to Hospital)
Workers Compensation
Medicaid

Yale-New Haven Hospital will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.

C. Payment of Hospital Charges For Elective Hospital Services Not Covered By Insurance

Yale-New Haven Hospital will require, or request payment for the difference between the estimated patient bill and the total available insurance coverage or approved social assistance. This procedure will be applied after giving consideration to the amount of the "patient portion", employment history and other hospital indebtedness. Consideration of these factors will result in the distinction between required and requested payments, which are defined as follows:

Required Payment

Any non-emergency patient will be required to make a deposit or pay estimated charges prior to visit. All past due accounts would also be required to be paid prior to the current admission. This encompasses co-payments, co-insurance, and deductibles.

Requested Payment

Patients will be informed of the estimated patient portion of the bill, and a request for a deposit or payment of charges will not affect the admission procedure. These payments include co-payments, co-insurance, and deductibles.

D. Free Care Funding

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients that meet the specific criteria and are unable to pay for services rendered. The Patient Financial Services Representative will perform a financial screening on all self-pay patients for the purpose of potential financial assistance with any unpaid balances. Please refer to the Hospital's Free Care Policy for additional information.

E. Sliding Scale Discounting Program

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients that do not meet the criteria for Free Bed Funds, but meet criteria to receive hospital services at cost. Please refer to the Hospital's Sliding Scale Discounting Program for additional information.

F. Prompt Payment and Extended Payment Plans

For patients who do not qualify for either Free Care Bed Funds or the Hospital's Sliding Scale Discounting Program, the Hospital provided financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options. Please refer to Section V below for additional information.

G. Patient Inquiries

Patient inquiries related to the credit and collection policies of the hospital may be answered or addressed only by those individuals designated within Patient Financial & Admitting Services.

IV. Admission Procedures

A. Pre-Admissions

Yale-New Haven Hospital will pre-admit patients whenever possible. The payment sources chosen for settlement of a patient's account must be verified prior to admission (i.e. confirmation directly with insurance plan, employer, or by examination and photocopy of appropriate insurance data).

B. Elective Admissions

Elective admission referrals must be received in the Admitting office no later than 12 (noon) the business day prior to the expected admission date.

All Elective admissions are subject to the payment of Hospital charges not covered by insurance.

C. Emergency Admissions

Yale-New Haven Hospital will admit all emergency cases irrespective of the financial condition of the patient. All admissions of an emergency nature will be handled and controlled through the Admitting office. The admitting physician must certify as to the emergency status when requesting the admission. If the Admitting/Registration Department needs assistance, the Chairman of the Respective Department will handle the admission.

V. Prompt Payment and Extended Payment Terms

The Hospital, at its discretion, may enter into an agreement for settlement of a patient's bill through monthly payments not to exceed 24 months. Under this plan, patients with account balances greater than $100 that are determined to be the patient's responsibility (after Sliding Scale discount eligibility has been determined) may satisfy their accounts through interest-free monthly payments. The Hospital may also entertain settlement offers of no less than 80% of the balance for Sliding Scale and other patients if payments are made within 30 days.

Patients who are unable to settle bills under the 24 month arrangements must make alternate arrangements for repayment within a twenty-four months repayment period with the collection manager's approval. Any exceptions to the extended payment policy requires pre-approval from the Senior Vice President, YNHH and will be coordinated with the Management Oversight Committee.

VI Billing Policy and Procedures

All patients/guarantors will receive a series of statements, when there is any third party coverage, and/or bills when there is no third party coverage or all third party coverage has been satisfied (paid or rejected).

VII Collection Policies and Procedures

These collection policies and procedures apply to all pending Welfare, non-contractual insurance and self-pay (pure self-pay and residual self-pay) accounts. All rejected third party accounts will also be classified as self-pay until such time as further insurance is verified. Final bills are processed after discharge and are referred to the collection section of the Systems Business Office ("SBO").

VIII Analysis of accounts prior to collection turnover.

Prior to the turnover of any account into the outside collection process (collection agency or collection attorney), the System Business Office, specifically a Turnover Expeditor, will review each account in detail. The Expeditor will verify the following:

a) All third party insurance opportunities have been exhausted; this will include review of previous patient accounts for third party insurance coverage, including Medicaid coverage.
b) Employment.
c) Liquid asset values if they can be obtained.
d) No free care application is currently in process.

Based on the account review, and if the account value is under $1000, the account may be referred to the collection agency. If the account is over $1000, and is determined under the Hospital's eligibility criteria that the patient lacks the ability to pay, the account may be referred to the collection agency, or referred to an outside collection attorney if the Expeditor believes that the patient has the financial ability to pay as determined under the Hospital's eligibility criteria.

In all cases, the cycle detailed for all accounts in this procedure will be interrupted by the following occurrences:

a. Receipt and verification of third party coverage

b. Payment arrangements are agreed to and followed by the patient/guarantor

c. Evidence that the accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

d. If at any time the patient indicates potential eligibility or interest in initiating an application for free care or sliding scale discount services. Patient will be referred to a Free Care Coordinator to receive a Free Care Application in this situation.

IX Bad Debt

1. General Statement of Need

Bad Debts are amounts considered to be uncollectible for which no likelihood of recovery at anytime in the future is expected. Bad debts are differentiated from

charity care, which is defined as the inability to pay versus bad debt as the unwillingness of the patient to pay.

2. **Patient Responsibility**

The patient is deemed responsible for the payment of provided services. Patient's responsibility also refers to all non-covered third party charges, such as insurance deductibles and copayments.

3. **Uncollectible Debt**

If after reasonable and customary attempts to collect a bill, the debt remains unpaid, the debt may be deemed as uncollectible. The Hospital's collection efforts may include the use of a collection agency or attorney in addition to subsequent billings, follow up letters, telephone calls, and personal contact.

4. **Account for Bad Debt**

Amounts determined as bad debt are recorded as expense net of recoveries and classified accordingly on the Hospital's Financial Statements.

X. **Policies Governing Collection Attorneys**

1. **Free care eligibility.**

If at any time in the collection process the collection attorney becomes aware of a potential eligibility for free care, the collection is stopped and the account is referred back to the Hospital for pursuit of free care or other financial assistance programs. Collection attorneys will include Summary Notice of Free Care Availability in all communications with debtors.

2. **Prior approval.**

Collection attorneys are instructed that pre-approval from YNHH is required prior to the initiation of any legal action concerning a referred account.

3. **Property Liens.**

Collection attorneys are instructed to severely limit the placement of property liens unless they can demonstrate significant financial assets by the debtor beyond the assets in the property. Pre-approvals will not be granted unless the account balance is over $1000 and the property(s) to be liened are at least $200,000 in assessed value. Even if the account meets these criteria, a property lien may not

be approved if in the view of YNHH, the placement of the lien will cause financial hardship on the debtor.

4. **Wage Garnishments.**

Pre-approvals will be granted for wage garnishments if the following criteria are met and a written letter has been provided to the patient reiterating the following:

- The debtor has had an opportunity to apply for free care and has either refused or been found ineligible for free care assistance.
- The debtor does not fall under the definition of "uninsured" as set by the State of Connecticut.
- The debtor has not applied or qualified for sliding scale discounts to assist in the payment of their debt, or has qualified and has not paid.
- The debtor has not elected to make voluntary payments towards their debt.
- The placement of a wage garnishment is being approved as a last course of legal remedy.

Wage garnishments, if approved, will only apply to account balances over $500. Additionally, any State Marshall fee for administering the wage garnishment will be absorbed by YNHH as a cost of collection. No interest will accrue on wage garnishments.

Any wage garnishments for employees of Yale New Haven Health, Yale-New Haven Hospital, Bridgeport Hospital or Greenwich Hospital, or their affiliates, will require special review and attempts will be made through Human Resources to develop an alternative payment arrangement.

5. **Bank Executions.**

All bank executions, in addition to pre-approval, require special review by YNHH to verify that the execution will not cause undue financial hardship on the debtor. If this cannot be determined, no bank execution will be ordered.

6. **Foreclosures and Writs of Capias.**

No foreclosures for property liens or the use of a Writ of Capias will ever be approved by YNHH.

7. **Interest and Court Costs.**

Interest will be allowed to accrue on accounts after legal court judgment is received. Interest will accrue at the new statutory rate of 5%. We will not allow interest to accrue greater than 50% of the account balance. If the principal is paid

in full, the Hospital will waive payment of interest. Court costs will be assumed by the hospital as a cost of collections and not charged to the debtor.

8. **Collection Agency and Collection Attorney Reporting**

Monthly performance reports will be prepared by each collection attorney firm and sent to YNHH each month. Quarterly meetings will be held with each firm to discuss collection activities, pending legal proceedings, and problematic collection accounts. Performance reports will include the following information:

- Number and value of accounts in current inventory.
- Number and value of accounts received monthly from YNHH.
- Number and value of accounts returned as uncollectible from law firm.
- Recoveries, net of costs and fees
- Court costs and fees due from YNHH.
- Number of property liens approved and placed.
- Number of wage executions approved and placed.
- Number of bank executions approved and placed.

XI. Administrative Write-offs

Due to the availability of specialized and tertiary level services at Yale-New Haven Hospital, requests will be made from time to time by Hospital medical staff members and/or outside special interest groups for the Hospital to care for an adult or child from the United State or from a foreign country who require these services. When these cases are identified, the following criteria will be considered in the decision to provide care with no consideration as to full payment:

- The clinical need of the patient, to include his/her prognosis.
- The adequacy of follow up care available in the patient's home country or city.
- The degree to which YNHH resources are especially suited for the care of the patient.
- The estimated costs of care.
- The availability of other specific funding to offset total costs of care.
- The willingness of physicians on YNHH medical staff to waive all or a portion of their professional and technical fees to support such patients.
- The total amount of free or discounted care provided by the Hospital to such patients during the fiscal year in which the request is made.

Requests must be made to the Senior Vice President, YNHH who will coordinate a review of the case based on the above mentioned criteria and who will utilize the Management Oversight Committee for direction and exceptions to the Financial Assistance Programs.

XII. Management Oversight Committee

1. Purpose

Financial Assistance Programs for Hospital Services will be overseen by a management oversight committee ("Committee") to review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless, may demonstrate a compelling hardship or personal circumstance which warrants financial assistance. The Committee will also review financial assistance requests from patients who are insured, but may demonstrate financial hardship causing difficulty in paying co-payments or deductibles.

2. Composition of Committee

The Committee is chaired a Senior Vice President for Yale New Haven Health System. Additional committee members may include Patient Financial Services Representatives, Patient Relations Representatives, finance and medical staff liaisons as needed. The committee will meet on a bi-monthly basis or more frequently if necessary.

3. Operating Protocols

- Patient accounts are referred to the Committee by patient financial services or patient relations representatives, or could be initiated by an appeal by the patient where free care services have been denied.
- Patients accounts reviewed by the Committee typically do not meet the eligibility requirements for the provision of free care.
- Typical Committee requests may include:
  - Insured patients with co-payments and deductibles where medical/financial hardship creates difficulty to pay patient's responsibility.

- Self-pay patients with income/assets placing them above 250% of the poverty level, but where the patient's bill is significant and presents a financial hardship.

- Medicare and Commercial insured patients that have exhausted insurance benefits or maximum coverage amounts.

- Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

• Committee will typically deny financial assistance requests for the following situations:

- Lack of medical necessity for a service requested by a patient.

- Cosmetic surgery

- Services denied by an insurance Plan as experimental or non-FDA approved.

- Financial hardship caused by the intentional failure of a patient to not follow through with a) medical advice, or b) health plan requirements such a payment of premium, notification of admission, or other requirements outlined in the patient's Subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as written communications to the affected patient.

IX General Policies

Several general policies have been established to control the activities in the credit and collection cycle.

1. Whenever possible, arrangements with local banks for loans to the patient should be secured to relieve the Hospital from the collection process.

2. Minor balances under $100.00, should be automatically written off 90 days after discharge if no response is received from the patient.

3. Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by the Director of

Patient Accounts, Vice President – SBO and the Senior Vice President – YNHHS.

X. Review of Administrative Policy for Credit and Collections

The Administrative Policies for Credit and Collection will be reviewed on a semi-annual basis along with affected detailed operational policies involved in credit and collection. This review will examine existing policies in light of the current economic market, comparison to other peer hospital institutions for best practices, and with respect to annual financial budgets.

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael

May 11, 2012

RECEIVED
MAY 14 2012
HEALTH

Lisa Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: ***Certificate of Need Application; Docket Number 12-31747-CON***
Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Deputy Commissioner Davis:

Enclosed are responses of Yale-New Haven Hospital, Inc. ("YNHH") and the Hospital of Saint Raphael ("HSR") to the completeness questions posed by the Office of Health Care Access ("OHCA") on May 9, 2012.

As noted in our cover letter dated April 12, 2012, capacity issues at YNHH continue to tax YNHH's existing facilities and, of more immediate concern, HSR's deteriorating financial situation threatens its continued viability as key personnel leave and HSR is unable to recruit replacement personnel.

We have worked hard to provide these responses in just two days in order to facilitate OHCA's completeness review process and sincerely hope that the agency has all the information necessary to deem this CON application complete.

Thank you in advance for your consideration.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Richard D'Aquila
Title: President and Chief Operating Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: Steven W. Lazarus, Associate Health Care Analyst, Office of Health Care Access
Kimberly Martone, Director of Operations, Office of Health Care Access

Yale-New Haven Hospital
Saint Raphael Healthcare System & Hospital of Saint Raphael

Certificate of Need Application
Docket Number: 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of
the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Responses to Completeness Questions #2

1. Please confirm that no community-based program currently provided by HSR, including but not limited to those listed at pages 106-109 of the Completeness Responses, will be terminated as a result of, or directly following, YNHH's acquisition of HSR.

   Response

   Yale-New Haven Hospital does not have plans to terminate any community-based program currently provided by HSR as a result of or directly following the acquisition. The Hospital of Saint Raphael provides many community-based programs that are similar to programs offered at YNHH or that are designed to serve the same communities and to achieve similar outcomes. Such programs may be integrated to ensure that they are run effectively and not working at cross purposes. In addition, YNHH is not familiar with every community-based program operated by HSR. Consequently, following the transaction, YNHH would expect to evaluate such programs to ensure that they were consistent with YNHH's mission and achieving their intended goals, but again, YNHH does not have plans to terminate any such community-based program.

2. In response to Question 6b at page 117 of the Completeness Responses, Applicants state that "HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011, the date used to negotiate the agreed upon purchase price of $160 million" between the parties. Applicants further state that since then, the estimated Church plan pension shortfall on a termination basis has risen to approximately $135 million as of December 31, 2011 and that "the sources of funds available to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price." Please describe what affect, if any, the inability to fully satisfy this pension shortfall would have on the parties' ability to consummate the transaction under the present terms and the operations of YNHH following the acquisition of HSR.

   Response

   In the event HSR is unable to fully fund its pension plan, there would be no consequence to consummating the transaction or on YNHH's operations following the acquisition. The HSR pension is a Church-sponsored plan and will remain as an HSR obligation following the acquisition.

   As previously stated, HSR's goals in pursuing the transaction with YNHH were to ensure continuation of its mission and to realize financial stability, including

addressing significant debt and pension obligations and providing much needed capital. When the parties executed the Asset Purchase Agreement, it was anticipated that the HSR pension obligation could change—increase or decrease over the life of the pension plan—based on market conditions. The continued expectation is for HSR to use proceeds from the sale of its assets to increase pension plan funding. As a result, the HSR plan will be significantly better funded—to the benefit of vested employees and retirees—than it is today or would be without the acquisition.

3. In response to Question 7c at page 120 of the Completeness Responses, Applicants state that a total of 499 beds could be operational at the HSR campus beginning in FY 2013, including 15 of the 27 licensed beds that have been removed as a result of renovations at HSR in recent years. Please provide the following information:

   a. Does the HSR campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
   Response
   HSR does not currently have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings.

   b. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the HSR campus?
   Response
   There are several construction/renovation options that could be explored to re-create the additional 12 beds within HSR's existing buildings. However, each of these options would require additional capital in the range of $7 – $9 million dollars, and a potential reduction in the capacity for inpatient rehabilitation services, inpatient child psychiatry services, and/or single patient rooms.

   c. Does the YNHH campus have the physical capacity to accommodate the remaining 12 licensed beds within its existing buildings?
   Response
   YNHH has the physical capacity to accommodate these 12 beds on East Pavilion 8-8 but will require some renovation which is described in the response to question 3(d).

   d. If the answer to the above question is no, what construction/renovation would be necessary to create such physical capacity on the YNHH campus?
   Response
   The construction/renovation that would be required to locate 12 beds on East Pavilion 8-8 includes replacement of plumbing fixtures which were removed.

As stated throughout YNHH's CON Application for 70 additional beds (Docket No. 12-31745-CON) and in this CON Application, all of HSR's 511 licensed beds as well as 70 additional beds, requested in Docket No. 12-31745-CON, are necessary for YNHH to operate at an appropriate occupancy level for the next several years and avoid the pursuit of constructing a new patient care tower.

4. In light of the approval given under OHCA Docket No. 11-31714-CON for YNHH and Bridgeport Hospital to consolidate their pediatric services into a single program owned and operated by YNHH, please explain Applicants' rationale for excluding the 22 licensed beds at Bridgeport Hospital from the calculations of bed capacity set forth in Attachment II to the Completeness Responses.

Response

As described in the CON application Docket No. 11-31714-CON and outlined in OHCA's Final Decision, the 22 licensed beds at Bridgeport Hospital and transferred to YNHH's license, are for use in a consolidated pediatric program with a satellite located at Bridgeport Hospital. The bed capacity analysis (Attachment II to the April 12, 2012 CON Completeness Responses) does not include either the patient days or the pediatric beds located at Bridgeport Hospital. Capacity constraints in adult medicine/surgery at YNHH's New Haven campus cannot be addressed with these 22 beds and therefore were excluded from Attachment II's calculations. The bed transfer was pursued in order to provide share resources (i.e. specialized medical staff from Yale New Haven Children's Hospital who will obtain privileges and provide services at Bridgeport Hospital) and to enhance system-wide integration and patient care coordination in pediatrics. As these beds reside on a separate campus located 20 miles from YNHH's New Haven campus, they are not relevant to the bed capacity analysis for the New Haven campus.

5. Please explain the reasons for the discrepancies between the projections of average daily census ("ADC"), Beds Available and Beds Required for YNHH in FYs 2012 to 2016 as set forth in the table at page 34 of the CON Application and Attachment II to the Completeness Responses.

Response

The slight differences between the projections of ADC, Beds Available and Beds Required for YNHH in FY 2012 – 2016 as set forth in the table on page 34 of the CON application and Attachment II to the April 12, 2012 completeness responses can be explained as outlined below. Please note that an updated copy of Attachment II has been included as *Attachment I* to these completeness question responses to correct a few minor typographical errors.

- **The table on page 34 of the CON application contained projections that were prepared at an earlier date to coincide with the financial models provided by Deloitte for the proposed transaction. Attachment II to the Completeness Responses was prepared more recently and represents the following differences from the projections shown on page 34:**

- **Projected patient days and ADC (which is calculated by dividing patient days by 365) in Attachment II were adjusted based on actual volumes experienced in FY 2011 (note: the projections included in the table on page 34 were prepared before FY 2011 concluded).**
- **Bed requirements differ because Attachment II allocated projected patient days into clinical services based on how each department utilizes beds in the hospital. For example, the Department of Orthopedics (grouped into adult medical/surgical in Attachment II) has 10% of its patient days on pediatric beds. Target occupancy levels vary for clinical services as noted in the footnotes in Attachment II and therefore modify the "Beds Required" statistic slightly. The differences are between 4 and 11 beds between Attachment II and the table on page 34, depending on the fiscal year.**
- **Beds available differ because Attachment II reflects a more up-to-date plan for adding 70 additional beds to the YNHH campus, assuming approval of Docket No. 12-31745-CON. Initially it was thought that 28 beds could be added in FY 2012, however upon further planning, 23 beds will be added in FY 2012 and the remaining 47 will be operational in FY 2013. The only difference in the "Beds Available" statistics between the two is present in FY 2012 as just described.**

6. Please provide copies of the YNHH financial assistance policies that will be applicable to both the YNHH and HSR campuses post-acquisition.

Response

***Attachment II* includes copies of the following YNHH financial assistance policies that will be applicable to both YNHH and HSR campuses post-acquisition:**

- **Distribution of "Free Care" Funds**
- **Financial Assistance Programs for Hospital Services**
- **Financial Assistance/Charity Care Policy Sliding Scale Discounting Program**
- **Addendum to Financial Assistance Policies (March 2006)**
- **Administrative Policy for Credit and Collections**

7. In response to Question 11 at page 139 of the Completeness Responses, Applicants' state that "YNHH has committed an additional $129.5 million over five years in spending on long-overdue facility upgrades, medical equipment and information technology investments that restore Saint Raphael's facilities and infrastructure to a level commensurate with the level of care that it has historically provided." Please describe the nature of this commitment and confirm whether or not there is any contractual obligation for YNHH to provide such funding.

Response

When YNHH's acquisition of HSR's assets is approved and the transaction is consummated, YNHH will operate the current HSR facilities as a campus of YNHH, with a single license, a single medical staff and a single workforce. As a single legal entity, the organization also will have one executive leadership team and one Board

of Trustees. YNHH has a commitment to safe, high quality patient care which includes maintaining an appropriate environment for that care. The amount of capital funding specifically for the HSR campus is not fixed by contract but as described in the CON Completeness Responses, HSR has substantial deferred capital needs that are intended to be addressed as funding priorities post-closing. The information technology and certain HVAC-like infrastructure needs have already been included in the $129.5 million. After determining the most appropriate clinical services to be concentrated on that campus, appropriate allocations of capital will be made to support those services.

8. Please provide evidence that the 4 new adult trauma bays and 1 pediatric trauma bay located in the Emergency Department on YNHH's campus will be sufficient to accommodate the consolidated trauma service of both YNHH and HSR post-acquisition.
Response
YNHH currently has two designated adult trauma bays and will have four following the ED renovation, thus doubling its adult trauma bay capacity. HSR had 836 trauma cases in FY 2011 and 359 were discharged directly from the ED. HSR's trauma volume represents 2.3 additional trauma cases per day to YNHH. YNHH had 4,677 trauma cases in FY 2011 or 12.8 per day. The addition of 2.3 cases from HSR's volume can be accommodated with the two additional adult trauma bays that will be available.

9. Please describe the process the Applicants have undertaken to integrate the medical staffs of YNHH and HSR to assure that there will be sufficient medical and support staff coverage at both the YNHH and HSR campuses on the closing date of the transaction.
Response
YNHH and HSR have undertaken a deliberate process to integrate the medical staffs and to ensure coverage at both campuses at closing. First, the parties have almost completed (and will have completed by closing) the process of credentialing the HSR physicians who did not already have privileges at YNHH. More than 400 doctors, physician assistants and APRNs/midwives are being added to the YNHH medical staff. Second, the chief medical officers of both organizations have convened several joint meetings with medical staff leaders, departmental chiefs, medical directors, hospital based physicians and community physicians to continue planning the clinical integration. Third, meetings have been held with all employed physicians at HSR to provide them information on benefits and explain how the combined organization will function. Fourth, the parties have held several open forums for the entire medical staff at both organizations to encourage interaction, information sharing and to address questions regarding the transaction. Finally the medical staff leadership at both organizations has focused on "day one" readiness to ensure continuity of patient care upon the closing of the transaction.

Similar actions are taking place with management staff and employees in general. Additionally, a web site has been developed specifically for the proposed transaction where "frequently asked questions" and answers are posted and the salient points of the transaction are described.

Attachment 1
to Completeness Responses
dated May 11, 2012
Docket No. 12-31747

YNHH Bed Capacity and Bed Need[1] for FY 2012 based on Projected Annual ADC[2] according to Three Scenarios:
1. Addition of 70 beds, 2. Acquisition of HSR, 3. Addition of 70 beds and Acquisition of HSR

	YNHH FY 2012	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2012 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2012 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + 23 of requested 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + 23 of requested 70 beds + HSR
Adult Medical/ Surgical																	
General Care	476.2	203.1	533	556	859	882	595	254	849	-62	-39	10	33	89%	86%	79%	77%
Critical Care	92.3	59.9	107	107	182	182	115	75	190	-8	-8	-8	-8	86%	86%	84%	84%
Adult Med/Surg Subtotal	*568.5*	*263.0*	*640*	*663*	*1,041*	*1,064*	*710*	*329*	*1,039*	*-70*	*-47*	*2*	*25*	*89%*	*86%*	*80%*	*78%*
Children's Hospital																	
General Care	54.5	0.6	71	71	74	74	73	1	74	-2	-2	0	0	77%	77%	75%	75%
Critical Care	11.2		19	19	19	19	15		15	4	4	4	4	59%	59%	59%	59%
Children's Subtotal	*65.7*	*0.6*	*90*	*90*	*93*	*93*	*88*	*7*	*89*	*2*	*2*	*4*	*4*	*73%*	*73%*	*71%*	*71%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.4	21.4	73	73	96	99	82	24	106	-9	-9	-6	-6	101%	101%	97%	97%
Child Psychiatry	13.5	14.8	15	15	33	33	15	16	31	0	0	2	2	90%	90%	86%	86%
Maternity	39.3	10.9	56	56	75	75	52	15	67	4	4	8	8	70%	70%	67%	67%
Available Beds Total	**760.4**	**321.7**	**874**	**897**	**1,358**	**1,381**	**947**	**399**	**1,346**	**-73**	**-50**	**12**	**35**	**87%**	**85%**	**80%**	**78%**
NBSCU - Critical Care Bassinets	42.1	4.5	52	52	60	60	56	6	62	-4	-4	-2	-2	81%	81%	76%	76%
Newborn Bassinets	27.4	7.5	40	40	54	54	37	10	47	3	3	7	7	69%	69%	65%	65%
Bassinets Subtotal	**69.5**	**12.0**	**92**	**92**	**114**	**114**	**93**	**16**	**109**	**-1**	**-1**	**5**	**5**	**76%**	**76%**	**71%**	**71%**
Total	**829.9**	**333.7**	**966**	**989**	**1,472**	**1,495**	**1,040**	**415**	**1,455**	**-74**	**-51**	**17**	**40**	**86%**	**84%**	**79%**	**78%**

[1] Projected Bed Need was based on inpatient projections only. Observation patients and other outpatient care for in inpatient bed were excluded. Target Utilization; Adult med/surg and Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.

[2] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[3] for FY 2013 based on Projected Annual ADC[4] according to Three Scenarios

	YNHH FY 2013	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2013 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2013 Projected Bed Utilization			
	ADC	ADC	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR	YNHH - existing	Scenario 1 YNHH + additional 70 beds	Scenario 2 YNHH + HSR	Scenario 3 YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	485.0	203.1	533	596	872	935	606	254	860	-73	-10	12	75	91%	81%	79%	74%
Critical Care	94.4	59.9	107	114	182	189	118	75	193	-11	-4	-11	-4	88%	83%	85%	82%
Adult Med/Surg Subtotal	*579.4*	*263.0*	*640*	*710*	*1,054*	*1,124*	*724*	*329*	*1,053*	*-84*	*-14*	*1*	*71*	*91%*	*82%*	*80%*	*75%*
Children's Hospital																	
General Care	55.7	0.6	71	71	74	74	74	1	75	-3	-3	-1	-1	78%	78%	76%	76%
Critical Care	11.4		19	19	19	19	15		15	4	4	4	4	60%	60%	60%	60%
Children's Subtotal	*67.1*	*0.6*	*90*	*90*	*93*	*93*	*89*	*1*	*90*	*1*	*1*	*3*	*3*	*75%*	*75%*	*73%*	*73%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	74.5	21.4	73	73	98	98	83	24	107	-10	-10	-9	-9	102%	102%	98%	98%
Child Psychiatry	13.8	14.8	15	15	35	35	15	16	31	0	0	4	4	92%	92%	82%	82%
Maternity	39.8	10.9	56	56	75	75	53	15	68	3	3	7	7	71%	71%	68%	68%
Available Beds Total	774.6	321.7	874	944	1,373	1,443	964	399	1,363	-90	-20	9	79	89%	82%	80%	76%
NBSCU - Critical Care Bassinets	42.9	4.5	52	52	60	60	57	6	63	-5	-5	-3	-3	83%	83%	79%	79%
Newborn Bassinets	27.9	7.5	40	40	54	54	37	10	47	3	3	7	7	70%	70%	66%	66%
Bassinets Subtotal	70.8	12.0	92	92	114	114	94	16	110	-2	-2	4	4	77%	77%	73%	73%
Total	845.4	333.7	966	1,036	1,487	1,557	1,058	415	1,473	-92	-22	13	83	88%	82%	79%	76%

[3] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[4] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[5] for FY 2014 based on Projected Annual ADC[6] according to Three Scenarios

	YNHH FY 2014	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2014 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2014 Projected Bed Utilization			
				Scenario 1	Scenario 2	Scenario 3					Scenario 1	Scenario 2	Scenario 3		Scenario 1	Scenario 2	Scenario 3
	ADC	ADC	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	494.5	203.1	533	596	872	935	618	254	872	-85	-22	0	63	93%	83%	80%	75%
Critical Care	96.5	59.9	107	114	162	169	121	75	196	-14	-7	-14	-7	90%	85%	86%	83%
Adult Med/Surg Subtotal	*591.0*	*263.0*	*640*	*710*	*1,054*	*1,124*	*739*	*329*	*1,068*	*-99*	*-29*	*-14*	*57*	*92%*	*83%*	*81%*	*76%*
Children's Hospital																	
General Care	56.9	0.6	71	71	74	74	76	1	77	-5	-5	-3	-3	80%	80%	78%	78%
Critical Care	11.6		19	19	19	19	16		16	3	3	3	3	61%	61%	61%	61%
Children's Subtotal	*68.5*	*0.6*	*90*	*90*	*93*	*93*	*92*	*1*	*93*	*-2*	*-2*	*0*	*1*	*76%*	*76%*	*74%*	*74%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	75.7	21.4	73	73	98	98	84	24	108	-11	-11	-10	-10	104%	104%	99%	99%
Child Psychiatry	14.1	14.8	15	15	35	35	16	16	32	-1	-1	3	3	94%	94%	83%	83%
Maternity	40.3	10.9	56	56	75	75	54	15	69	2	2	6	6	72%	72%	68%	68%
Available Beds Total	789.6	321.7	874	944	1,373	1,443	985	399	1,384	-111	-41	-11	59	90%	84%	81%	77%
NBSCU - Critical Care Bassinets	43.8	4.5	52	52	60	60	58	6	64	-6	-6	-4	-4	84%	84%	81%	81%
Newborn Bassinets	28.5	7.5	40	40	54	54	38	10	48	2	2	6	6	71%	71%	67%	67%
Bassinets Subtotal	72.3	12.0	92	92	114	114	96	16	112	-4	-4	2	2	79%	79%	74%	74%
Total	861.9	333.7	966	1,036	1,487	1,557	1,081	415	1,496	-115	-45	-9	61	89%	83%	80%	77%

[5] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[6] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[7] for FY 2015 based on Projected Annual ADC[8] according to Three Scenarios

	YNHH FY 2015	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2015 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2015 Projected Bed Utilization			
				Scenario 1	Scenario 2	Scenario 3					Scenario 1	Scenario 2	Scenario 3		Scenario 1	Scenario 2	Scenario 3
	ADC	ADC	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	503.5	203.1	533	596	672	935	630	254	884	-97	-34	-12	51	94%	84%	81%	76%
Critical Care	98.7	59.9	107	114	182	189	123	75	198	-16	-9	-16	-9	92%	87%	87%	84%
Adult Med/Surg Subtotal	*602.2*	*263.0*	*640*	*710*	*1,054*	*1,124*	*753*	*329*	*1,082*	*-113*	*-43*	*-28*	*42*	*94%*	*85%*	*82%*	*77%*
Children's Hospital																	
General Care	58.1	0.6	71	71	74	74	77	1	78	-6	-6	-4	-4	82%	82%	79%	79%
Critical Care	11.9		19	19	19	19	16		16	3	3	3	3	63%	63%	63%	63%
Children's Subtotal	*70.0*	*0.6*	*90*	*90*	*93*	*93*	*93*	*1*	*94*	*-3*	*-3*	*-1*	*-1*	*78%*	*78%*	*76%*	*76%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.8	21.4	73	73	98	98	85	24	109	-12	-12	-11	-11	105%	105%	100%	100%
Child Psychiatry	14.4	14.8	15	15	35	35	16	16	32	-1	-1	3	3	96%	96%	83%	83%
Maternity	40.8	10.9	56	56	75	75	54	15	69	2	2	6	6	73%	73%	69%	69%
Available Beds Total	**804.2**	**321.7**	**874**	**944**	**1,373**	**1,443**	**1,001**	**399**	**1,400**	**-127**	**-57**	**-27**	**43**	**92%**	**85%**	**82%**	**78%**
NBSCU - Critical Care Bassinets	44.7	4.5	52	52	60	60	60	6	66	-8	-8	-6	-6	86%	86%	82%	82%
Newborn Bassinets	29.1	7.5	40	40	54	54	39	10	49	1	1	5	5	73%	73%	68%	68%
Bassinets Subtotal	**73.8**	**12.0**	**92**	**92**	**114**	**114**	**99**	**16**	**115**	**-7**	**-7**	**-1**	**-1**	**80%**	**80%**	**75%**	**75%**
Total	**878.0**	**333.7**	**966**	**1,036**	**1,487**	**1,557**	**1,100**	**415**	**1,515**	**-134**	**-64**	**-28**	**42**	**91%**	**85%**	**81%**	**78%**

[7] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[8] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YNHH Bed Capacity and Bed Need[9] for FY 2016 based on Projected Annual ADC[10] according to Three Scenarios

	YNHH FY 2016	HSR FY 2011	Physical Bed Capacity Scenarios				FY 2016 Bed Need @ Target Utilization Based on Projected ADC			Variance between Capacity & Need				FY 2016 Projected Bed Utilization			
				Scenario 1	Scenario 2	Scenario 3					Scenario 1	Scenario 2	Scenario 3		Scenario 1	Scenario 2	Scenario 3
	ADC	ADC	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH	HSR	Total	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR	YNHH - existing	YNHH + additional 70 beds	YNHH + HSR	YNHH + additional 70 beds + HSR
Adult Medical/ Surgical																	
General Care	512.5	203.1	533	596	872	935	641	254	895	-108	-45	-23	40	96%	86%	82%	77%
Critical Care	100.8	59.9	107	114	182	189	126	75	201	-19	-12	-19	-12	94%	88%	88%	85%
Adult Med/Surg Subtotal	*613.3*	*263.0*	*640*	*710*	*1,054*	*1,124*	*767*	*329*	*1,096*	*-127*	*-57*	*-42*	*28*	*96%*	*86%*	*83%*	*78%*
Children's Hospital																	
General Care	59.3	0.6	71	71	74	74	79	1	80	-8	-8	-6	-6	84%	84%	81%	81%
Critical Care	12.1		19	19	19	19	16		16	3	3	3	3	64%	64%	64%	64%
Children's Subtotal	*71.4*	*0.6*	*90*	*90*	*93*	*93*	*95*	*1*	*96*	*-5*	*-5*	*-3*	*-3*	*79%*	*79%*	*77%*	*77%*
Rehab	0.0	11.0	0	0	18	18		14	14	0	0	4	4			61%	61%
Psychiatry	78.0	21.4	73	73	96	96	87	24	111	-14	-14	-13	-13	107%	107%	101%	101%
Child Psychiatry	14.5	14.3	15	15	35	35	16	16	32	-1	-1	3	3	97%	97%	84%	84%
Maternity	41.3	10.9	56	56	75	75	55	15	70	1	1	5	5	74%	74%	70%	70%
Available Beds Total	**818.6**	**321.7**	**874**	**944**	**1,373**	**1,443**	**1,020**	**399**	**1,419**	**-146**	**-76**	**-46**	**24**	**94%**	**87%**	**83%**	**79%**
NBSCU - Critical Care Bassinets	45.6	4.5	52	52	60	60	61	6	67	-9	-9	-7	-7	88%	88%	84%	84%
Newborn Bassinets	29.7	7.5	40	40	54	54	40	10	50	0	0	4	4	74%	74%	69%	69%
Bassinets Subtotal	**75.3**	**12.0**	**92**	**92**	**114**	**114**	**101**	**16**	**117**	**-9**	**-9**	**-3**	**-3**	**82%**	**82%**	**77%**	**77%**
Total	**893.9**	**333.7**	**966**	**1,036**	**1,487**	**1,557**	**1,121**	**415**	**1,536**	**-155**	**-85**	**-49**	**21**	**93%**	**86%**	**83%**	**79%**

[9] Target Utilization; Adult med/surg & Rehab: 80%, Psychiatric: 90%, Pediatrics, Maternity, & Bassinets: 75%.
[10] YNHH projected annual ADC is based on growth projections discharges and patient days developed by Finance. HSR growth assumed to be flat.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	Distribution of "Free Care" Funds	Manual Code:	NC:F-2
Reviewed:	9/20/00, 9/1/01, 6/1/05, 7/1/07, 7/1/10	Revised:	3/1/91, 9/11/01, 9/1/03, 3/28/12
Supersedes Manual Code:		Dated:	
Approved By:	James Staten – Senior Vice President of Finance		

I. PURPOSE:

To establish the policy for the use of funds that have been donated to Yale-New Haven Hospital (YNHH or the "Hospital") and other funds that have been designated by YNHH to provide free care. The Hospital also has other policies related to charity care.

II. PROCEDURES:

A. General Statement of Need

The Hospital has received charitable contributions to endowment that are restricted by the donors to use to provide free care to patients (hereinafter referred to as "Free Bed Funds"). Some of the donated funds contain additional restrictions (home address of patient, church, nominator, etc.); other funds have no additional restrictions. The Hospital has established a spending policy on the distribution of these Free Bed Funds. In addition, YNHH provides additional free care to patients from Hospital operating funds (hereinafter referred to as "YNHH designated funds" or "free care funds").

B. Notice

The Hospital will provide notice and information to patients about Free Care Funds in a number of ways, including publishing notices in newspapers of general circulation; posting notices in appropriate locations throughout the Hospital; ensuring the availability of a one-page summary description of Free Bed Funds and how to apply for them; providing individual written notice to patients; making available written information in other forms that may be helpful to patients; and holding open houses.

The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Donated Free Bed Funds with No Specified Nominator

The Hospital has Free Bed Funds where the historical dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay, but no specific nominator is named. The allocation of the availability of these funds is based on the Hospital's Endowment Spending Policy.

These Free Bed Funds will be available only to patients with no specified nominator after all possibilities of third party reimbursement have been exhausted. Patients must have applied for State assistance, and provide formal documentation showing legitimate denial.

Patients will be considered eligible for the use of Free Bed Funds if their income level does not exceed two and a half times (250%) the poverty level and in appropriate cases and circumstances, the Hospital has determined that they do not have liquid assets that can be used to pay all or some portion of the bill without financial hardship or distress. The Hospital will establish appropriate documentation requirements to verify eligibility.

In addition, the Hospital, at its discretion and on a case by case basis, may provide Free Bed Funds to patients with insurance, assuming they satisfy the other criteria outlined above and there are no other prohibitions on them receiving such assistance. If the patient is insured by a governmental program (Medicare, Medicaid or Tricare) or a private insurer, the Hospital will consider requests for Free Bed Funds for co-pays, deductibles, and/or spenddowns on a case by case basis. If granted, these amounts will be relieved at the amounts determined under the contract or program in question. In addition, the Hospital will consider requests for Free Bed Funds when a patient's insurance or maximum coverage benefits have been exhausted. In making these decisions, the Hospital will consider medical and financial hardship. It may also choose to provide Free Bed Funds for only a portion of the request, if in its judgment, awarding Free Bed Funds for the entire request would adversely affect other applicants who meet the qualifications, but are without insurance (and thus may carry a larger debt).

D. Eligibility for Donated Free Bed Funds with Geographic or other Additional Restrictions but no Specified Nominator

Patients must fulfill the above eligibility guidelines for "Donated Free Bed Funds with No Specific Nominator", and reside in the specific geographic location dictated by the original gift or meet the other additional eligibility restrictions contained in the original gift.

E. Eligibility for YNHH Designated Funds

Once Free Bed Funds with no nominator or other special restriction are exhausted up to the annual endowment spending policy limit, if there are patients eligible for Free Bed Funds who do not meet the restrictions for eligibility for any available restricted Free Bed Funds, YNHH will provide additional free care to patients from YNHH designated funds. Patients must fulfill the eligibility guidelines for "Donated Free Bed Funds with No Specified Nominator" to be eligible for free care designation from YNHH designated funds.

YNHH will also make available additional free care funds from operations for other types of requests where the patient demonstrates a compelling hardship or personal circumstance which warrants providing financial assistance. These requests will be identified and recommended for free care funds by a committee comprised by Management.

F. Eligibility for Donated Funds Restricted to Use by an Outside Nominator

The Hospital has Free Bed Funds where the historic dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay and a nominator is named. The allocation of the available funds is based on the Hospital's Endowment spending policy.

The Hospital will notify nominators semi-annually of the status of Free Bed Funds for which they have a nomination role. The nominator may request the use of Free Bed Funds for any eligible patient who meets the guidelines for a given fund. Each nominator will receive an annual report of Free Bed Funds utilized by patient (subject to privacy restrictions). Nominators may request to rollover unused funds to the subsequent year for their purposes or designate remaining funds to be used by YNHH for general free care purposes. In addition, YNHH may award funds in cases in which the donor provided that the Hospital has the power to award the funds if the nominator did not.

G. Accounting of Free Funds

1. **For donated Free Bed Funds with no specified nominator and donated Free Bed Funds with geographic or other additional restrictions but no specified nominator:**

   The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the patient requests up to 90 days after the close of the Funds' fiscal year. During this 90-day period, accounts will be identified and recommended for Free Bed Funds by a committee comprised by Management. The funds will be relieved at cost.

2. **For YNHH Designated Funds:**

   For patients whose income level does not exceed two and a half times (250%) the poverty level and deemed eligible for the use of free funds, YNHH designated funds will be available subsequent to the exhaustion of the Free Bed Funds available according to the Endowment Spending Policy for "donated Free Bed Funds with no specified nominator." The funds will be relieved at cost.

3. **For donated Free Bed Funds restricted to Use by an Outside Nominator:**

   The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the nominator requests up to 90 days after the close of the Free Funds' fiscal year. If the total amount available to be spent in a year is not applied based on nominator request, the remaining amounts can be carried forward and made available for use in the following year or may, depending on the nominator's wishes and/or the terms of the original gift, be awarded by the Hospital to eligible patients. Funds utilized for patients who meet the financial criteria for other Free Bed Funds will be relieved at cost.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	**Financial Assistance Programs for Hospital Services**	**Manual Code:**	**NC:F-4**
Reviewed:	**8/1/05, 7/1/07, 7/1/10**	**Revised:**	
Supersedes Manual Code:		**Dated:**	**8/1/05**
Approved By:	**James Staten – Senior Vice President of Finance**		

I. PURPOSE:

Yale-New Haven Hospital ("YNHH" or the "Hospital") recognizes that many patients may be uninsured, may not have adequate insurance or may otherwise lack the financial resources to pay for quality health care services without financial assistance. Consistent with its mission, YNHH is committed to assuring that ability to pay will be considered carefully when settling amounts due for health care services.

In recognition of its role to help those in need of financial assistance, the Hospital has established the YNHH Financial Assistance Programs for Hospital Services ("the Programs"). Those Programs include free care policies, sliding scale discounting policies, prompt pay discount, and certain billing/collection policies. The objectives of the Programs are to:

A. Maintain a humane environment for our patients and their families;

B. Assist patients in gaining access to government insurance programs;

C. Provide clear information regarding the Programs;

D. Ensure easy and timely access to the Programs.

E. Consistently apply the Programs to all patients;

F. Apply fair and equitable business practices with respect to collections for patient services; and

G. Comply with all applicable laws, rules and regulations.

All patients will have the option to apply for government or hospital financial assistance programs based on financial need.

II. PROCEDURES:

A. Scope

1. The Programs apply to hospital inpatient, outpatient and ancillary services billed by the Hospital.

2. The Programs **apply to:**
   a. Uninsured patients (as defined by CT Public Act 03-266)
   b. Patients with no insurance coverage.
   c. Non-covered services (as determined by the patient's third party payer benefits) that are medically necessary.

d. Under-insured patients with significant co-payments and deductibles.
e. Charges incurred after patients' exhaustion of third party payer benefits.

3. The Programs **exclude:**

a. Routine waiver of deductibles, co-payments and co-insurance imposed by third party payers on hospital claims.
b. Private room or private duty nurses.
c. Services that are not medically necessary, such as elective cosmetic surgery.
d. Other fees that may not be charged directly by YNHH (e.g., television or telephone charges).

4. The patient will be ineligible for some or all financial assistance if any of the following occur:

a. It is determined that false information fundamentally related to financial eligibility and/or status was provided by the patient or responsible party during the application or billing and collection process.
b. The patient or responsible party fails to apply for government insurance programs, and such an application is an eligibility requirement for certain types of assistance in the Programs.
c. The patient or responsible party fails to provide information necessary to complete the eligibility process.

5. YNHH reserves the right to evaluate a patient's eligibility on a case-by-case basis, especially where complex medical, scientific or financial situations exist.

B. Access to Information

Patients will obtain information on eligibility for government or hospital programs primarily from the Hospital's Patient Account Representative. Patients will be alerted to the Financial Assistance Programs in a number of ways, including notices in English and Spanish posted in appropriate locations throughout the Hospital, a summary of free care availability and information on how to apply for free care, information distributed in the admission package, and information on the Hospital's web site. Information will also be provided when direct inquiries are made to YNHH. The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and that is designed to make information easily available and accessible to patients.

All patients will have access to information regarding estimated charges for particular services or actual charges for hospital services that have been provided.

C. Summary of Financial Assistance Programs

1. **Free Care Funds**

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients who meet the specific criteria and are unable to pay for services rendered. The Hospital also has other funds that have been designated by YNHH to provide free care. Additional information regarding these funds is contained in the Hospital's Policy for Free Care Funds.

The Hospital will use the same Free Care Application ("Application") to assess both eligibility for Free Care Funds as well as the Sliding Scale Discounting Programs. A Patient Account Representative will perform a financial screening on all patients with payment obligations not covered by insurance for the purpose of determining potential eligibility for financial assistance with any unpaid balances and encouraging patients to apply for assistance.

2. **Sliding Scale Discounting Programs**

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients who do not meet the criteria in the Policy for Free Care Funds, but do meet criteria in the Financial Assistance/Charity Care Policy: Sliding Scale Discounting Program. Additional information regarding this program is contained in the Hospital's Sliding Scale Discounting Program.

3. **Prompt Payment and Extended Payment Plans**

For patients who do not qualify for assistance either under the Policy for Free Care Funds or the Hospital's Sliding Scale Discounting Program, the Hospital provides financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options.

D. Credit, Collections and Bad Debt

YNHH will identify, and distinguish between, the accounts of those patients who have the financial resources to pay for all or some portion of their Hospital bills and the accounts of those who do not. The Hospital will evaluate all past-due accounts for appropriate disposition and follow-up, consistent with this policy, the Hospital's Administrative Policy for Credit and Collection, and Connecticut law.

The Hospital will maintain contractual relationships with one or more collection agencies and law firms for collection of past due accounts. Each such collection agency or law firm must comply with the Hospital's Administrative Policy for Credit and Collections and Connecticut law.

If, at any time, the Hospital, or a collection agency or law firm, receives information that a patient is or may be eligible for financial assistance under one of these Programs or under any governmental or other program, the Hospital, collection agency, or law firm shall, consistent with Connecticut law, cease collection efforts until the Hospital determines the patient's eligibility for assistance.

The Hospital will classify a past due account as bad debt in accordance with the Hospital's Administrative Policy for Credit and Collections and relevant financial accounting standards and law. In determining bad debt, the Hospital may use a variety of collection efforts, including subsequent billings, follow up letters, telephone calls, personal contacts and referral to a collection agency or law firm.

E. Management Oversight Committee

1. **Purpose**

The Programs will be overseen by a management oversight committee ("Committee"). The Committee will, among other oversight responsibilities, review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless may demonstrate compelling hardship or personal circumstances which warrant financial assistance. The Committee will also review financial assistance requests from patients who are insured, but demonstrate financial hardship in paying co-payments or deductibles.

2. **Composition of Committee**

The Committee will be chaired by a Senior Vice President of Yale-New Haven Hospital. Additional Committee members may include System Business Office senior management, patient financial services representatives, patient relations representatives, finance and medical staff liaisons as needed. The Committee will meet on a bi-monthly basis or more frequently, if necessary.

3. **Operating Protocols**

Patient accounts may be referred to the Committee for review by Patient Financial Services, Patient Relations Representatives, or other appropriate referral sources. In general, the Committee will review patient accounts that do not meet the standard eligibility requirements for the various Financial Assistance Programs.

Typical referrals to the Committee will include:

a. Insured patients with co-payments and deductibles that present financial hardship.
b. Self-pay patients with income/assets above 400% of the poverty level with a significant bill that presents a financial hardship.
c. Insured patients who have exhausted insurance benefits or maximum coverage amounts with a significant bill that presents financial hardship.

d. Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

The Committee will typically deny financial assistance requests for the following situations:

a. Services denied by an insurance plan as experimental or non-FDA approved.
b. Financial hardship caused by the intentional failure of a patient to follow through with; a) medical advice, or b) health plan requirements such as payment of premium, notification of admission, or other requirements outlined in the patient's subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as writing to the affected patient.

F. Accounting and Reporting of Financial Assistance Programs

The System Business Office will collect and distribute information to senior management regarding these Programs on a quarterly basis. This information may include, but is not limited to:

a. Number of cases referred;
b. Number of cases processed;
c. Number of cases determined eligible for and referred to government insurance programs;
d. Number of Free Care Applications distributed;
e. Number of Free Care Applications received (complete and incomplete), accepted and rejected and reasons for rejection; and
f. Average time required to process Free Care Applications.

The Budget and Finance Committee of the Board of Trustees of Yale-New Haven Hospital will be provided at least annually with a report concerning the status of these Programs.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	**Financial Assistance/Charity Care Policy Sliding Scale Discounting Program**	**Manual Code:**	**NC:F-5**
Reviewed:	**May 11, 2012**	**Revised:**	**7/1/07, 7/1/10**
Supersedes Manual Code:		**Dated:**	**6/1/05**
Approved By:	**James Staten – Senior Vice President of Finance**		

I. PURPOSE:

To establish the policy for providing financial assistance under a sliding scale discounting program to uninsured patients who are determined under the hospital's eligibility criteria to lack the ability to pay for care at full charges. Yale-New Haven Hospital (the "Hospital") is guided by a mission to provide high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, including payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and that take into account an individual's ability to pay for medically necessary health care services.

In addition to charity care provided under this sliding scale discounting program established by the Hospital, free care is provided to uninsured and insured patients in accordance with the Hospital's Policy for Free Care Funds. The free care is provided to patients eligible for it and is funded by free bed funds given to the Hospital as well as by Hospital operating funds. Further, the Hospital provides Relief and assistance to insured patients by waiving or reducing co-payments and/or deductibles and Medicaid spend-down requirements on a case-by-case basis determined on grounds of medical and financial hardship.

II. PROCEDURES:

A. General Statement of Need

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. The Hospital will establish appropriate documentation requirements to verify financial status.

B. Notice

The Hospital will provide notice and information to patients about the availability of charity care under the sliding scale discounting program in a number of ways, including describing this policy on the one page summary description of free bed funds and other free or reduced care policies.

The Hospital will provide notice and information in a manner that complies with requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Sliding Scale Program:

The Hospital provides care through the sliding scale discounting programs to uninsured patients that do not have the ability to pay for medically necessary services at full charges. The sliding scale discounting program is designed to assist uninsured patients eligible for the sliding scale who are not otherwise eligible or do not comply with the application process for assistance under the Hospital's Policy for Free Care Funds.

Additional financial assistance programs are provided by the Hospital for patients who do not qualify for the sliding scale program or free care under the Hospital's Policy for Free Care Funds. These programs include prompt pay discounts and extended payment terms with no interest. In addition, the Hospital provides relief to patients not eligible for free care or the sliding scale program on a case-by-case basis.

Patients must fulfill the following eligibility guidelines:

1. **At or below 400 percent of the federal poverty level**

   Patients will be considered eligible for the sliding scale discount program if their income level does not exceed 400 percent of the federal poverty level and the Hospital, having considered the patient's resources, has determined that they lack the ability to pay all or some portion of the bill. The Hospital will establish appropriate documentation requirements to verify eligibility. Generally, the patient must apply for consideration under the sliding scale program within 30 days of determining self-pay or uninsured status. Eligibility will be granted for one-year, unless otherwise determined by the Hospital, at which time the patient may reapply for sliding scale status. For patients that qualify for the sliding scale program and whose annual family income is at or below 400 percent of the federal poverty level, the patient's bill for services will reflect full charges and then be discounted to a percentage that approximates cost. This cost to charge percentage will be reviewed and set on an annual basis. The discount will be considered free/charity care. The balance will be the patient's financial responsibility.

2. **Over 400 percent of the federal poverty level**

   For patients whose annual family income is greater than 400 percent of the federal poverty level, the patient will not be eligible for the sliding scale discount program, and unless provided relief under a case-by-case review, will be billed for services at gross charges; the charges billed will be the patient's financial responsibility. Under the case-by-case review, discounts up to or exceeding 40% of the charges billed may be granted.

   Any patient with aggregate Yale-New haven Hospital bills that exceed 10% of the patient's annual household income will be eligible for a discount equal to the hospital's approximation of cost.

D. Charity Care Determination

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. Free care is a component of charity care based on established eligibility criteria that awards free care to qualified individuals. The Hospital's determination of charity care for eligible patients may occur at any time during the patient's admission, dates of service, discharge or collection process. The collection process may further allow the Hospital to determine whether patients qualify for sliding scale programs or ultimately are designated as charity care based on inability to pay.

E. Payment Guidelines

Extended payment arrangements may be established with the patient whether they qualify for sliding scale payment, or they are ineligible. If the patient does not honor the payment arrangement based on the eligibility guideline, the amount is referred to a collection agency at the discounted rate.

F. Accounting for Charity and Free Care

Only that portion of a patient account that meets the sliding scale program criteria is recognized as charity care; charity and free care is a reduction in charges made by the Hospital because of the patient's inability to pay for services at charges.

REFERENCE:

YALE-NEW HAVEN HOSPITAL

ADDENDUM TO
FINANCIAL ASSISTANCE POLICIES
March, 2006

1. Yale New Haven Health System hospitals will begin to employ in early 2006 a financial screening tool in conjunction with the major credit reporting agencies. Such screening tool will allow member hospitals to triage self-pay accounts as well as potential accounts with underinsurance for ability to pay. Threshold criteria will be established to triage accounts for further collection.

2. Policies will be modified to allow Yale-New Haven and Bridgeport Hospital to consider a patient's financial assets when determining an ability to pay. (Greenwich Hospital currently has the ability to review assets)

3. The current policies at Yale-New Haven and Bridgeport Hospitals require a Medicaid denial prior to approval for free care. We have been asked to review the wisdom of this policy in light of the high certainty of denials for undocumented residents. After careful review and discussion, we believe that this requirement should stand. There are many examples of coverage by Medicaid for services that were originally thought ineligible. We also do not want to set up special consideration for undocumented residents when we require documented residents to obtain a Medicaid denial. Greenwich Hospital currently does not require a Medicaid denial.

4. The sliding scale program should be made available to as many patients as possible. Currently, patients are required to submit proof of income prior to obtaining the sliding scale discount. We recommend that this process continue to be considered, but all patient denials for sliding scale should be reviewed by a manager prior to rejection to confirm that any and all attempts have been made to obtain the required information.

5. Currently, patients who present for non-emergency services and who have no ability to pay, are denied access to services without full or partial payment. In all cases, the physician is notified and asked to determine the emergent or non-emergent condition. Patients may complete a financial assistance application for coverage and when approved, are granted access to services. We propose that this policy be modified to restrict access to services only until a patient has completed our financial assistance application and provided proof of income. Patients who are ultimately denied financial assistance will be noted in the records and upon the patient's next visit, must comply with the non-emergent payment policy.

6. Patients who complete a financial assistance application, provide proof of income, but do not provide a Medicaid denial (50% of cases) will be screened for income eligibility. If the patient meets the income criteria, the account would be referred to Century, even if the patient is employed or owns property. No accounts will be referred to a collection attorney if income is below 400% of FPL.

7. Any patient may avail themselves of a payment plan for their portion of the hospital bill. Such payment plans shall be limited to balances of greater than $50. Greenwich Hospital currently uses and may continue to use a $10 threshold. Depending upon the balance due, payment plans may be established for up to 12 months interest free. Larger balance payment plans for an extended period may be established upon the approval of the Vice President, Corporate Business Services, or an SVP of the health system (including hospital CFOs). In 2006, the health system will establish credit arrangements with one or more health care credit card companies to assist patients with a periodic payment plan. This plan will be initially rolled out at Yale-New Haven and Bridgeport Hospitals.

8. Any care provided to patients that do not complete the appropriate financial assistance applications and are deemed to be unable to pay their health care bill will be classified as charity care. This includes international patients for whom the hospital agrees to provide services at no cost, either prospectively or retrospectively due to the patient's financial circumstances. These will no longer be classified as administrative allowances.

9. The policy will be modified to automatically write off small balances of under $50 after the full cycle of bills have been provided to a patient. The previous ceiling was $100. As a note, any balance of under $1000 is always referred to Century collections as only balances over $1000 are referred to collection attorneys. Greenwich Hospital currently has established a write off threshold of $10 and will continue to use this amount.

YALE-NEW HAVEN HOSPITAL

ADMINISTRATIVE POLICY

FOR CREDIT AND COLLECTIONS

I. **Purpose**

The primary goal of Yale-New Haven Hospital ("YNHH or the "Hospital") is to provide the highest quality of medical care to its patients at the lowest cost. In order to do so, an efficient and equitable system must be established that will maximize the collection of patient account receivable balances in order to provide the cash flow required to operate the institution effectively.

In accordance with the above, the following credit and collection policy is hereby established for Yale-New Haven Hospital. Detailed procedures will be included in a credit and collection manual as maintained by the System Business Office. As references to this policy, the Table of Contents from various Credit and Collections Operation Manuals from the System Business Office ("SBO") are attached as Exhibits to this policy:

- Exhibit A: SBO Procedure Manual
- Exhibit B: Inpatient Access and ED Dept Reg.Procedure Manual
- Exhibit C: Medical Oncology, One Day Surgery and PT Manual
- Exhibit D: Private Referred Operations Manual
- Exhibit E: PCC and Women's Center Operations Manual

II. **Source of Payment**

A. Patient

The primary responsibility of settlement of the account will rest with the patient. Except in an emergency, all patients capable of doing so, will be required to sign a payment guarantee prior to admission or receipt of inpatient service.

The patient portion of the hospital bill is to be satisfied through payment via one or more of the following sources:

1. Cash, money order, personal check, bank check, or travelers checks
2. Credit cards acceptable to the hospital
3. Savings accounts, income tax refunds
4. Sale of investments, conversion of insurance policies
5. Loans from banks, credit unions, finance companies, etc.

6. Money Transfer
7. ATM Debit Cards

B. Third Party Coverage

Yale-New Haven Hospital will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows:

Blue Cross
Managed Care Payers (HMO and PPO programs)
Medicare
Tricare
Commercial Insurance Companies
(upon assignment of benefit to Hospital)
Workers Compensation
Medicaid

Yale-New Haven Hospital will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.

C. Payment of Hospital Charges For Elective Hospital Services Not Covered By Insurance

Yale-New Haven Hospital will require, or request payment for the difference between the estimated patient bill and the total available insurance coverage or approved social assistance. This procedure will be applied after giving consideration to the amount of the "patient portion", employment history and other hospital indebtedness. Consideration of these factors will result in the distinction between required and requested payments, which are defined as follows:

Required Payment

Any non-emergency patient will be required to make a deposit or pay estimated charges prior to visit. All past due accounts would also be required to be paid prior to the current admission. This encompasses co-payments, co-insurance, and deductibles.

Requested Payment

Patients will be informed of the estimated patient portion of the bill, and a request for a deposit or payment of charges will not affect the admission procedure. These payments include co-payments, co-insurance, and deductibles.

D. Free Care Funding

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients that meet the specific criteria and are unable to pay for services rendered. The Patient Financial Services Representative will perform a financial screening on all self-pay patients for the purpose of potential financial assistance with any unpaid balances. Please refer to the Hospital's Free Care Policy for additional information.

E. Sliding Scale Discounting Program

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients that do not meet the criteria for Free Bed Funds, but meet criteria to receive hospital services at cost. Please refer to the Hospital's Sliding Scale Discounting Program for additional information.

F. Prompt Payment and Extended Payment Plans

For patients who do not qualify for either Free Care Bed Funds or the Hospital's Sliding Scale Discounting Program, the Hospital provided financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options. Please refer to Section V below for additional information.

G. Patient Inquiries

Patient inquiries related to the credit and collection policies of the hospital may be answered or addressed only by those individuals designated within Patient Financial & Admitting Services.

IV. Admission Procedures

A. Pre-Admissions

Yale-New Haven Hospital will pre-admit patients whenever possible. The payment sources chosen for settlement of a patient's account must be verified prior to admission (i.e. confirmation directly with insurance plan, employer, or by examination and photocopy of appropriate insurance data).

B. Elective Admissions

Elective admission referrals must be received in the Admitting office no later than 12 (noon) the business day prior to the expected admission date.

All Elective admissions are subject to the payment of Hospital charges not covered by insurance.

C. Emergency Admissions

Yale-New Haven Hospital will admit all emergency cases irrespective of the financial condition of the patient. All admissions of an emergency nature will be handled and controlled through the Admitting office. The admitting physician must certify as to the emergency status when requesting the admission. If the Admitting/Registration Department needs assistance, the Chairman of the Respective Department will handle the admission.

V. Prompt Payment and Extended Payment Terms

The Hospital, at its discretion, may enter into an agreement for settlement of a patient's bill through monthly payments not to exceed 24 months. Under this plan, patients with account balances greater than $100 that are determined to be the patient's responsibility (after Sliding Scale discount eligibility has been determined) may satisfy their accounts through interest-free monthly payments. The Hospital may also entertain settlement offers of no less than 80% of the balance for Sliding Scale and other patients if payments are made within 30 days.

Patients who are unable to settle bills under the 24 month arrangements must make alternate arrangements for repayment within a twenty-four months repayment period with the collection manager's approval. Any exceptions to the extended payment policy requires pre-approval from the Senior Vice President, YNHH and will be coordinated with the Management Oversight Committee.

VI Billing Policy and Procedures

All patients/guarantors will receive a series of statements, when there is any third party coverage, and/or bills when there is no third party coverage or all third party coverage has been satisfied (paid or rejected).

VII Collection Policies and Procedures

These collection policies and procedures apply to all pending Welfare, non-contractual insurance and self-pay (pure self-pay and residual self-pay) accounts. All rejected third party accounts will also be classified as self-pay until such time as further insurance is verified. Final bills are processed after discharge and are referred to the collection section of the Systems Business Office ("SBO").

VIII Analysis of accounts prior to collection turnover.

Prior to the turnover of any account into the outside collection process (collection agency or collection attorney), the System Business Office, specifically a Turnover Expeditor, will review each account in detail. The Expeditor will verify the following:

a) All third party insurance opportunities have been exhausted; this will include review of previous patient accounts for third party insurance coverage, including Medicaid coverage.
b) Employment.
c) Liquid asset values if they can be obtained.
d) No free care application is currently in process.

Based on the account review, and if the account value is under $1000, the account may be referred to the collection agency. If the account is over $1000, and is determined under the Hospital's eligibility criteria that the patient lacks the ability to pay, the account may be referred to the collection agency, or referred to an outside collection attorney if the Expeditor believes that the patient has the financial ability to pay as determined under the Hospital's eligibility criteria.

In all cases, the cycle detailed for all accounts in this procedure will be interrupted by the following occurrences:

a. Receipt and verification of third party coverage

b. Payment arrangements are agreed to and followed by the patient/guarantor

c. Evidence that the accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

d. If at any time the patient indicates potential eligibility or interest in initiating an application for free care or sliding scale discount services. Patient will be referred to a Free Care Coordinator to receive a Free Care Application in this situation.

IX Bad Debt

1. General Statement of Need

Bad Debts are amounts considered to be uncollectible for which no likelihood of recovery at anytime in the future is expected. Bad debts are differentiated from

charity care, which is defined as the inability to pay versus bad debt as the unwillingness of the patient to pay.

2. **Patient Responsibility**

The patient is deemed responsible for the payment of provided services. Patient's responsibility also refers to all non-covered third party charges, such as insurance deductibles and copayments.

3. **Uncollectible Debt**

If after reasonable and customary attempts to collect a bill, the debt remains unpaid, the debt may be deemed as uncollectible. The Hospital's collection efforts may include the use of a collection agency or attorney in addition to subsequent billings, follow up letters, telephone calls, and personal contact.

4. **Account for Bad Debt**

Amounts determined as bad debt are recorded as expense net of recoveries and classified accordingly on the Hospital's Financial Statements.

X. Policies Governing Collection Attorneys

1. **Free care eligibility.**

If at any time in the collection process the collection attorney becomes aware of a potential eligibility for free care, the collection is stopped and the account is referred back to the Hospital for pursuit of free care or other financial assistance programs. Collection attorneys will include Summary Notice of Free Care Availability in all communications with debtors.

2. **Prior approval.**

Collection attorneys are instructed that pre-approval from YNHH is required prior to the initiation of any legal action concerning a referred account.

3. **Property Liens.**

Collection attorneys are instructed to severely limit the placement of property liens unless they can demonstrate significant financial assets by the debtor beyond the assets in the property. Pre-approvals will not be granted unless the account balance is over $1000 and the property(s) to be liened are at least $200,000 in assessed value. Even if the account meets these criteria, a property lien may not

be approved if in the view of YNHH, the placement of the lien will cause financial hardship on the debtor.

4. **Wage Garnishments.**

Pre-approvals will be granted for wage garnishments if the following criteria are met and a written letter has been provided to the patient reiterating the following:

- The debtor has had an opportunity to apply for free care and has either refused or been found ineligible for free care assistance.
- The debtor does not fall under the definition of "uninsured" as set by the State of Connecticut.
- The debtor has not applied or qualified for sliding scale discounts to assist in the payment of their debt, or has qualified and has not paid.
- The debtor has not elected to make voluntary payments towards their debt.
- The placement of a wage garnishment is being approved as a last course of legal remedy.

Wage garnishments, if approved, will only apply to account balances over $500. Additionally, any State Marshall fee for administering the wage garnishment will be absorbed by YNHH as a cost of collection. No interest will accrue on wage garnishments.

Any wage garnishments for employees of Yale New Haven Health, Yale-New Haven Hospital, Bridgeport Hospital or Greenwich Hospital, or their affiliates, will require special review and attempts will be made through Human Resources to develop an alternative payment arrangement.

5. **Bank Executions.**

All bank executions, in addition to pre-approval, require special review by YNHH to verify that the execution will not cause undue financial hardship on the debtor. If this cannot be determined, no bank execution will be ordered.

6. **Foreclosures and Writs of Capias.**

No foreclosures for property liens or the use of a Writ of Capias will ever be approved by YNHH.

7. **Interest and Court Costs.**

Interest will be allowed to accrue on accounts after legal court judgment is received. Interest will accrue at the new statutory rate of 5%. We will not allow interest to accrue greater than 50% of the account balance. If the principal is paid

in full, the Hospital will waive payment of interest. Court costs will be assumed by the hospital as a cost of collections and not charged to the debtor.

8. Collection Agency and Collection Attorney Reporting

Monthly performance reports will be prepared by each collection attorney firm and sent to YNHH each month. Quarterly meetings will be held with each firm to discuss collection activities, pending legal proceedings, and problematic collection accounts. Performance reports will include the following information:

- Number and value of accounts in current inventory.
- Number and value of accounts received monthly from YNHH.
- Number and value of accounts returned as uncollectible from law firm.
- Recoveries, net of costs and fees
- Court costs and fees due from YNHH.
- Number of property liens approved and placed.
- Number of wage executions approved and placed.
- Number of bank executions approved and placed.

XI. Administrative Write-offs

Due to the availability of specialized and tertiary level services at Yale-New Haven Hospital, requests will be made from time to time by Hospital medical staff members and/or outside special interest groups for the Hospital to care for an adult or child from the United State or from a foreign country who require these services. When these cases are identified, the following criteria will be considered in the decision to provide care with no consideration as to full payment:

- The clinical need of the patient, to include his/her prognosis.
- The adequacy of follow up care available in the patient's home country or city.
- The degree to which YNHH resources are especially suited for the care of the patient.
- The estimated costs of care.
- The availability of other specific funding to offset total costs of care.
- The willingness of physicians on YNHH medical staff to waive all or a portion of their professional and technical fees to support such patients.
- The total amount of free or discounted care provided by the Hospital to such patients during the fiscal year in which the request is made.

Requests must be made to the Senior Vice President, YNHH who will coordinate a review of the case based on the above mentioned criteria and who will utilize the Management Oversight Committee for direction and exceptions to the Financial Assistance Programs.

XII. Management Oversight Committee

1. Purpose

Financial Assistance Programs for Hospital Services will be overseen by a management oversight committee ("Committee") to review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless, may demonstrate a compelling hardship or personal circumstance which warrants financial assistance. The Committee will also review financial assistance requests from patients who are insured, but may demonstrate financial hardship causing difficulty in paying co-payments or deductibles.

2. Composition of Committee

The Committee is chaired a Senior Vice President for Yale New Haven Health System. Additional committee members may include Patient Financial Services Representatives, Patient Relations Representatives, finance and medical staff liaisons as needed. The committee will meet on a bi-monthly basis or more frequently if necessary.

3. Operating Protocols

- Patient accounts are referred to the Committee by patient financial services or patient relations representatives, or could be initiated by an appeal by the patient where free care services have been denied.
- Patients accounts reviewed by the Committee typically do not meet the eligibility requirements for the provision of free care.
- Typical Committee requests may include:
  - Insured patients with co-payments and deductibles where medical/financial hardship creates difficulty to pay patient's responsibility.

- Self-pay patients with income/assets placing them above 250% of the poverty level, but where the patient's bill is significant and presents a financial hardship.

- Medicare and Commercial insured patients that have exhausted insurance benefits or maximum coverage amounts.

- Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

• Committee will typically deny financial assistance requests for the following situations:

- Lack of medical necessity for a service requested by a patient.

- Cosmetic surgery

- Services denied by an insurance Plan as experimental or non-FDA approved.

- Financial hardship caused by the intentional failure of a patient to not follow through with a) medical advice, or b) health plan requirements such a payment of premium, notification of admission, or other requirements outlined in the patient's Subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as written communications to the affected patient.

IX General Policies

Several general policies have been established to control the activities in the credit and collection cycle.

1. Whenever possible, arrangements with local banks for loans to the patient should be secured to relieve the Hospital from the collection process.

2. Minor balances under $100.00, should be automatically written off 90 days after discharge if no response is received from the patient.

3. Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by the Director of

Patient Accounts, Vice President – SBO and the Senior Vice President – YNHHS.

X. Review of Administrative Policy for Credit and Collections

The Administrative Policies for Credit and Collection will be reviewed on a semi-annual basis along with affected detailed operational policies involved in credit and collection. This review will examine existing policies in light of the current economic market, comparison to other peer hospital institutions for best practices, and with respect to annual financial budgets.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 14, 2012 Via Fax and Regular Mail

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System &
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Ahn and Ms. Estes,

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 determined that the above-referenced application has been deemed complete as of May 14, 2012. The date of May 14, 2012, also begins the ninety-day review period of the application.

If you have any questions regarding this matter, please feel free to contact me at (860) 418-7069.

Sincerely,

Jack A. Huber

Jack A. Huber
OHCA Health Care Analyst

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2912
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	05/14 14:18
TIME USE	00'36
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: **JEAN AHN,** **Y-NHH** **(203) 688-5013**

✓ **TERRIE ESTES** **SRHS & HSR** **(203) 867-5665**

FROM: **JACK HUBER**

DATE: **5/14/2012** **Time:** ~2:10 pm

NUMBER OF PAGES: 2
(including transmittal sheet)

Comments: Transmitted:
YNHH Acquisition of SRHS & HSR
Letter Deeming CON Application Complete under
Docket Number: 12-31747-CON

PLEASE PHONE Jack A. Huber at (860) 418-7069

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 16, 2012

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System &
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Notice of Public Hearing

Dear Ms. Ahn and Ms. Estes:

With the receipt of the completed Certificate of Need ("CON") application information submitted by Yale-New Haven Hospital, Saint Raphael Healthcare System, Inc. and the Hospital of Saint Raphael ("Applicants") on May 14, 2012, the Office of Health Care Access ("OHCA") has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-638a (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)

Applicants: Yale New Haven Hospital
Saint Raphael Healthcare System Inc.
Hospital of Saint Raphael

Docket Number: 12-31747-CON

Proposal: Yale New Haven Hospital's Acquisition of the Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: June 5, 2012

Time: 10:00 a.m.

Place: Gateway Community College, Room 160
60 Sargent Drive, New Haven, Connecticut

The Applicants are designated as party in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *New Haven Register* pursuant to General Statutes § 19a-639a (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Marianne Horn, Department of Public Health
Joanne Yandow, Department of Public Health
Wendy Furniss, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:JAH:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of Health Care Access

May 16, 2012 Requisition # 38630

New Haven Register
40 Sargent Street
New Haven, CT 06531-0715

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 **Monday, May 21, 2012.** 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 Steven Lazarus 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:JAH:lmg

New Haven Register **May 16, 2012**
Notice of Public Hearing, Docket Number 12-31747-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearing

Statute Reference:	19a-638
Applicants:	Yale New Haven Hospital Saint Raphael Healthcare System Inc. Hospital of Saint Raphael
Town:	New Haven
Docket Number:	12-31747-CON
Proposal:	Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael with a total capital expenditure of $160,000,000
Date:	June 5, 2012
Time:	10:00 a.m.
Place:	Gateway Community College, Room 160 60 Sargent Drive, New Haven, Connecticut

Any person who wishes to request status in the above listed public hearing may file a written petition no later than May 31, 2012 (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.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Wednesday, May 16, 2012 3:43 PM
To: Greer, Leslie
Subject: Re: Notice of Public Hearing - Docket 12-31747-CON

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

PLEASE NOTE: New Department of Labor guidelines allow web base advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wed, 16 May 2012 15:37:06 -0400
To: ads <ads@graystoneadv.com>
Subject: Notice of Public Hearing - Docket 12-31747-CON

To Whom It May Concern,
Please run the attached Notice of Public Hearing in the New Haven Register by May 21, 2012. For billing refer to requisition 38630, if you have any questions feel free to call.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2923
RECIPIENT ADDRESS	912036885013
DESTINATION ID	
ST. TIME	05/16 16:03
TIME USE	01'40
PAGES SENT	6
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: JEAN AHN

FAX: (203) 688-5013

AGENCY: YALE-NEW HAVEN HOSPITAL

FROM: JACK HUBER

DATE: 5/16/12 **TIME:**

NUMBER OF PAGES: 6
(including transmittal sheet

Comments: DN: 12-31747-CON Notice of Public Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2922
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	05/16 16:05
TIME USE	01'21
PAGES SENT	6
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: **TERRIE ESTES**

FAX: **(203) 867-5665**

AGENCY: **SAINT RAPHAEL HEALTHCARE SYSTEM**

FROM: **JACK HUBER**

DATE: **5/16/12** **TIME:**

NUMBER OF PAGES: **6**
(including transmittal sheet

Comments: DN: 12-31747-CON Notice of Public Hearing

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Laurie <Laurie@graystoneadv.com>
Sent: Friday, May 18, 2012 11:36 AM
To: Greer, Leslie
Subject: FW: Notice of Public Hearing - Docket 12-31747-CON
Attachments: 10-31747np NH Register.doc

Your legal notice is all set to run as follows:

New Haven Register, 5/21 issue - $427.18

Thanks,
Laurie Miller

Graystone Group Advertising
2710 North Ave., Ste 200, Bridgeport, CT 06604
Ph: 203-549-0060, ext 319, Fax: 203-549-0061,Toll free: 800-544-0005
email: laurie@graystoneadv.com
www.graystoneadv.com

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wed, 16 May 2012 15:37:06 -0400
To: ads <ads@graystoneadv.com>
Subject: Notice of Public Hearing - Docket 12-31747-CON

To Whom It May Concern,
Please run the attached Notice of Public Hearing in the New Haven Register by May 21, 2012. For billing refer to requisition 38630, if you have any questions feel free to call.

Thank you,

Leslie M. Greer
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134
Phone: (860) 418-7013
Fax: (860) 418-7053
Website: www.ct.gov/ohca
Please consider the environment before printing this message

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2928
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	05/24 15:19
TIME USE	00'48
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: TERRIE ESTES

FAX: 203 867-5665

AGENCY: HOSPITAL OF SAINT RAPHAEL AND SRHS

FROM: STEVEN LAZARUS

DATE: 5/24/12 **TIME:**

NUMBER OF PAGES: 3
(including transmittal sheet

Comments:
Pre file testimony request for DN: 12-31747

PLEASE PHONE Barbara Olejarz at 860-418-7005 IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2929
RECIPIENT ADDRESS	912036885013
DESTINATION ID	
ST. TIME	05/24 15:17
TIME USE	01'06
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: **JEAN AHN**

FAX: **203 688-5013**

AGENCY: **YALE-NEW HAVEN HOSPITAL**

FROM: **STEVEN LAZARUS**

DATE: **5/24/12** **TIME:**

NUMBER OF PAGES: **3**
(including transmittal sheet

Comments:
Pre file testimony request for DN: 12-31747

PLEASE PHONE Barbara Olejarz at 860-418-7005 IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Joanne Yandow, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: May 22, 2012

RE: Yale New Haven Hospital, Saint Raphael Healthcare System, Inc. and Hospital of Saint Raphael –Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael with a total capital expenditure of $160,000,000, Docket Number: 12-31747-CON

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 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

May 24, 2012

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System &
Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Request for Prefiled Testimony

Dear Ms. Ahn and Ms. Estes,

The Office of Health Care Access ("OHCA") will hold a public hearing on Tuesday, June 5, 2012, at 10:00 a.m. at Gateway Community College, Room 160, 60 Sargent Drive, New Haven, Connecticut, regarding the Certificate of Need ("CON") application identified above. 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. The Applicants' prefiled testimony must be submitted to OHCA no later than 12:00 p.m. on Friday, June 1, 2012.

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. When submitting the prefiled testimony, please provide one original and six copies. Please number and date each page sequentially from the Applicants' document immediately preceding it.

Please contact Kimberly Martone at (860) 418-7029 if you have any questions concerning this request.

Sincerely,

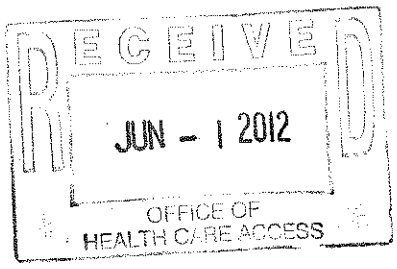
Joanne V. Yandow

Joanne V. Yandow
Hearing Officer

JVY:jah

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael



June 1, 2012

Joanne V. Yandow
Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: ***Certificate of Need Application (CON); Docket Number 12-31747-CON Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael - Prefile Testimony***

Dear Hearing Officer Yandow:

Please find enclosed an original and six (6) copies of Yale-New Haven Hospital, Inc. ("YNHH") and the Saint Raphael Healthcare System ("SRHS") and Hospital of Saint Raphael ("HSR") prefile testimony for the upcoming public hearing on June 5, 2012.

Also enclosed are Notices of Appearance for our attorneys.

Thank you in advance for your time and effort on this critically important CON application.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Marna Borgstrom
Title: Chief Executive Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: Lisa Davis, Deputy Commissioner, Office of Health Care Access, Dept. of Public Health
Steven W. Lazarus, Associate Health Care Analyst, Office of Health Care Access
Kimberly Martone, Director of Operations, Office of Health Care Access

Yale-New Haven Hospital
Saint Raphael Healthcare System
Hospital of Saint Raphael

Yale-New Haven Hospital's Acquisition of SRHS and HSR
DN: 12-31747-CON

Pre-file Testimony of Marna Borgstrom
Chief Executive Officer, Yale-New Haven Hospital

Hearing Officer Yandow and members of the OHCA staff, thank you for the opportunity to speak about this critically important Certificate of Need (CON) application before you for Yale-New Haven Hospital (YNHH) to acquire substantially all of the assets of the Saint Raphael Healthcare System (SRHS), including the Hospital of Saint Raphael (HSR). My name is Marna Borgstrom and I am the Chief Executive Officer of Yale-New Haven Hospital and President and CEO of the Yale New Haven Health System (YNHHS). On behalf of our employees, our Boards and our affiliated physicians, I want to offer our appreciation to OHCA for your careful deliberation of this historic integration. We recognize the challenges facing you in this evolving healthcare environment and are very grateful for your time and consideration.

I have the distinct privilege of introducing and highlighting the importance of the proposed acquisition of the Hospital of Saint Raphael and providing you with an overview of the reasons we are seeking regulatory approval for the transaction. You will also be hearing from my colleague, Dr. Peter Herbert, Yale-New Haven's Chief Medical Officer, as well as the Hospital of Saint Raphael's CEO, Chris O'Connor, and Chief Medical Officer, Dr. Alan Kliger.

This transaction is vital to our future and to the provision of high quality healthcare to the people of Connecticut in the years to come. The concept of this acquisition was founded upon three broad goals:

1. To continue to advance the quality and safety of care that we provide;

2. To preserve and extend access to that care; and
3. To provide that care in the most cost effective manner possible.

Underlying these three goals are two critical imperatives:

First, the financial challenges faced by the Hospital of Saint Raphael have increased and you will hear more about that from Mr. O'Connor; and second, the extraordinary capacity constraints faced by Yale-New Haven Hospital have reached a point where access to additional inpatient capacity is essential. The acquisition of the Hospital of Saint Raphael will help us to relieve our crowded conditions as soon as possible and will help to meet future demand at a much lower cost than building new inpatient beds. Dr. Herbert will describe our capacity issues in more detail.

This transaction represents a real opportunity for us to better manage and coordinate care in a collaborative fashion on behalf of the patients we serve. The ability for us to integrate care across the continuum of services, use an integrated electronic medical record system, and engage the very best, evidenced-based practice across two inpatient campuses will have a lasting, positive impact on our community and the State as a whole.

Through this acquisition we believe we also can have a significant influence on bending the healthcare cost curve. We can avoid duplication of investment in medical technology and talent and spread costs across a wider base of operations, achieving efficiencies that could not be attained under any other scenario. Our close proximity, in fact, provides us with the unique opportunity to better engage our caregivers in a way that provides a rational approach to the provision of high quality care.

Importantly for Yale-New Haven, this transaction represents the opportunity to avoid an investment of approximately $622 million (for a new patient care tower, chiller plant, parking facility, renovations to the West Pavilion and capitalized interest) in the near

term as we address our increased inpatient capacity through the creative uses of existing beds and operating room time on the Hospital of Saint Raphael campus.

Yale-New Haven is unique in the State for the level of care we provide to acutely ill patients, from Level 1 trauma to high acuity referrals from other institutions. In 2011, we launched our Y Access line, a single-source phone center exclusively for physicians who are interested in transferring a patient to YNHH. The referral line provides 24/7 access, with a single phone call, to our hospital for the sickest and most critically ill patients in Connecticut and beyond. In fact, we are not just a State resource, but a regional resource as well and the demand for that service has increased dramatically in recent years. In its first year of operation, referrals to our Y Access Line came from 34 Connecticut hospitals, 39 hospitals or healthcare facilities outside Connecticut and 7 hospitals outside the continental United States.

Attracting additional patients to Connecticut for their healthcare offers many benefits to the State of Connecticut. However, such demand requires a degree of flexibility in our capacity to handle these critical cases effectively. To manage our resources efficiently and effectively, we need to target a maximum census level of 80 percent. This overall target occupancy is quite reasonable and is frequently used by health care facility planning firms, as demonstrated in the attached letters from Heery International and Cannon Design (see Attachment I). Further, the Acute Care Subcommittee of the State-Wide Health Care Facilities and Services Plan, on which OHCA participated, identified several states where overall occupancy levels below 80% are utilized for facility planning purposes.

As a result of growth in demand for YNHH services, YNHH's overall existing bed utilization is already above 80% and most significantly, medical/surgical occupancy is above 90%. Our volume projections forecast occupancy of 93% by FY 2016 without additional capacity. These projections are conservative as they were in our Smilow Cancer Center CON (please see Attachment II which demonstrates the difference in our

actual volume as compared to what was forecasted in the Smilow Cancer Center CON application).

The acquisition of the Hospital of Saint Raphael will relieve our most pressing capacity issues in the short-term, assuming we can bring all 511 licensed beds on the Hospital of Saint Raphael campus online. Our projections clearly take us beyond just the use of existing Hospital of Saint Raphael capacity, and we remain convinced that there is a need for 70 additional beds which can be opened on the YNHH campus. In deference to the extraordinary demands placed upon OHCA at this time, we agreed to defer consideration of those beds until we complete your consideration of this acquisition. However, we did this in anticipation of OHCA's approval to transfer all 511 beds that are part of the Hospital of Saint Raphael's license through this transaction.

In addition to addressing HSR's financial issues and YNHH's capacity issues, this transaction will bring other benefits. It preserves existing commitments to charitable care and investments in our community. Last year alone, Yale-New Haven provided more than $160 million in free, under-reimbursed and charitable care and our more liberal charitable policies, including a free care and sliding scale to those in need, are going to prevail following the acquisition. As part of this acquisition we have agreed to honor the heritage of the Hospital of Saint Raphael, including the recognition of the Catholic Ethical and Religious Directives in the care provided on that campus, while preserving access to the same breadth of medical services offered in our community today.

The transaction also provides an opportunity to reinvest in one of the great hospitals in the State of Connecticut. Under the proposal, Yale-New Haven has provided its firm commitment to strongly support the Hospital of Saint Raphael campus by investing in the capital infrastructure and ensuring its place as a healthy and vibrant resource for the future. The opportunity to integrate certain clinical services will support improvements in the quality of care and the creation of new Centers of Excellence. This transaction

permits the two hospitals to integrate clinical services and support functions across the two campuses, providing cost savings of up to $300 million over five years.

While some positions will be eliminated due to the transaction, significant efforts are being made to minimize the impact on individual staff members. For example, vacancies have been held for many positions at YNHH since the beginning of the year, to increase opportunities to transition HSR employees whose positions are being lost. Further, the Teamsters are being recognized as the bargaining agent of more than 1,000 current Hospital of Saint Raphael employees on that campus. As we continue to invest in both campuses, we expect to grow job opportunities and continue to serve as an economic driver for New Haven, the region and the State of Connecticut.

But, what is most critical about our common vision is the ability to advance access to high quality care more efficiently and effectively. This is absolutely essential to our long-term ability to adapt to a rapidly evolving healthcare environment. In Connecticut, with an aging population, demand will be compounded as the Baby Boom generation is entering retirement with high expectations for a comprehensive level of healthcare and supportive services. In fact, according the U.S. Census Bureau, Connecticut's population over age 65 is already 14.2%, which exceeds the U.S. average of 13.0%.

And while the demand for services will continue to challenge our capacity, we also understand that the reimbursements received by hospitals will not grow concomitantly. In fact, in its support of healthcare reform, the American Hospital Association, on behalf of its member hospitals, committed to a $155 billion reduction of Medicare over the next decade and that number continues to grow as economic pressures continue to intensify. So we clearly understand that we must do everything in our power to continue to advance quality, address demand through expanded access, and to do it all in the most efficient manner possible.

OHCA is tasked with the statutory mandate to evaluate proposals against certain guiding principles. We believe that this transaction satisfies these principles – by advancing our common vision of increasing access to high quality care in the most cost-efficient manner possible. This opportunity to integrate the resources of these two institutional providers positions us to meet the expectations of our patients more efficiently and effectively. It is clear that together we are healthier and only together can we overcome the pressing challenges facing both of our organizations, and healthcare in general. I urge you to approve this CON application.

Now I would like to introduce Dr. Peter Herbert, Chief Medical Officer of Yale-New Haven Hospital to provide an overview of YNHH's growth, capacity issues, and plans to integrate our medical staffs.

The foregoing is my sworn testimony.

Marna Borgstrom
Chief Executive Officer
Yale-New Haven Hospital

Yale-New Haven Hospital
Saint Raphael Healthcare System
Hospital of Saint Raphael

Yale-New Haven Hospital's Acquisition of SRHS and HSR
DN: 12-31747-CON

Pre-file Testimony of Peter Herbert, MD
Chief of Staff & Senior Vice President for Medical Affairs, Yale-New Haven Hospital

Hearing Officer Yandow and members of the OHCA staff, thank you for the opportunity to speak about this historic Certificate of Need (CON) application before you for Yale-New Haven Hospital (YNHH) to acquire the assets of the Saint Raphael Healthcare System (SRHS), including the Hospital of Saint Raphael (HSR). I am Dr. Peter Herbert, Chief of Staff and Senior Vice President, Medical Affairs at YNHH.

My testimony will focus on the following key points:

- YNHH's growth and evolution as a Destination Hospital;
- YNHH's significant inpatient capacity issues and the need for additional beds; and
- Plans and efforts to integrate the medical staffs of YNHH and HSR.

YNHH Growth and Evolution as a Destination Hospital

YNHH has evolved into a destination hospital attracting patients from all over the globe who seek out the institution's highly specialized services. YNHH has many specialized and unique services that are not offered at the same level of expertise elsewhere in the state or region, or in many cases are not offered at all. Some of the Hospital's distinctive clinical services include:

- Cardiac services:
  - Heart valve program
  - Implantable ventricular assist devices (VADs)
  - Percutaneous aortic valve replacement (investigational)
  - Less-invasive (mini-sternotomy) aortic valve replacement

  - Percutaneous pulmonic valve replacement (investigational)
  - Less-invasive (mini-thoracotomy) mitral valve replacement/repair
  - Valve-sparing aortic root replacement
- Connecticut's only bi-plane hybrid MRI Operating Room
- Neuro-interventional Center:
  - Neurological Intensive Care Unit staffed specifically with neurointensivists
  - Intracranial aneurysms-GDC therapy
  - Arteriovenous malformations (AVMs)
  - Dural arteriovenous fistula (DAVFs)
  - Pre-operative tumor embolization
  - Emergency stroke therapy
  - Carotid artery angioplasty & stenting
  - Vertebroplasty
  - Hemangioma treatment
- Connecticut's only liver transplant program
- Level I trauma center, one of only two in the State of Connecticut
- Cancer treatment:
  - Molecular profiling for cancer
  - Bone marrow & stem cell transplants
  - Rare and complex cancer treatment (recognized by United/Optum Health as a Center of Excellence for a dozen tumor sites)

These tertiary and quaternary services are regional or national referral services, and will increasingly serve patients from within and outside Connecticut.

YNHH has recruited numerous clinical physician leaders in tandem with Yale University whose specialized capabilities, expertise, and advanced skills have expanded the clinical services available at the Hospital, particularly in each of our five major service lines: pediatrics, oncology, heart and vascular, neurosciences and transplant. Attachment I includes a listing of recent and planned physician recruitments between 2009 and 2015. The availability of these specialized services has and will contribute to

increases in inpatient volume and has been incorporated into our inpatient volume projections. The majority of these recruitments are incremental to our medical staff as opposed to replacements.

In FY 2011, YNHH established the Y Access Line, a centralized resource to facilitate rapid access to our specialized physicians and if necessary the admission and/or transfer of patients in need of YNHH's specialized services. Inpatient cases transferred to YNHH totaled 2,996 the year before the Y Access Line was initiated and are projected to increase to approximately 4,500 based on actual statistics through the first four months of this fiscal year. YNHH's transfer cases as a percentage of all cases has been increasing steadily as shown in the table below.

YNHH Inpatient transferred cases – all services*	**FY 2010**	**FY 2011**	**FY 2012 Oct-Jan**
Transfer Cases	3,449	4,165	1,508
Transfers as % of All Cases	6.1%	7.3%	8.0%

Patients referred through the Y Access line are high acuity and in FY 2011 had an average length of stay (ALOS) of 10.81 days; more than double that of the 5.24 ALOS for all YNHH inpatients. The significant growth in transfer cases and their longer length of stay adds to the demand on inpatient beds. We project the Y Access Line volume to continue to increase as the population ages, patient acuity increases and economic challenges prevent many smaller hospitals from being able to offer highly specialized care to these patients.

Inpatient Capacity Issues at YNHH

As a result of YNHH's steady inpatient volume growth due in large part to its Destination Hospital status, the Y Access Line growth and its specialized services, the hospital is faced with significant capacity issues. I would like to describe in greater detail our present inpatient capacity challenges which will only become worse as our volume continues to increase. I will also discuss how the acquisition of HSR, although not a complete solution, provides much needed relief.

YNHH is one of few hospitals throughout Connecticut and the country that operates all of its licensed beds. Inpatient discharges totaled 57,451 in FY 2011 and have grown steadily (on average 3% per year) since FY 2005, while many other hospitals have experienced declines. Patient days reached just under 301,000 in FY 2011. The majority of our admissions are urgent or emergent. In fact, in FY 2011, 73% of YNHH's admissions were categorized as emergent and this figure increases to 76% if you exclude maternity, pediatrics and psychiatry. With approximately three quarters of our admissions arriving to YNHH with little or no advance notice, we are faced with significant bed management challenges when our occupancy is so high.

The average monthly census (based on discharge data) at YNHH increased from 766 in FY 2009 - to 780 in FY 2010 - and to 825 for FY 2011. Medical and surgical areas have experienced the most significant growth. The average monthly census increased from 511 in FY 2009 to 577 in FY 2011, a 13.1% increase. Our medical/surgical beds are operating above 90% occupancy. There is significant patient movement in and out of the hospital's beds and between 20 and 40 additional patients (beyond the midnight census) occupy a bed at some point during each day. This is referred to as the contact census and is tracked most days. When the contact census is at its peak, all overflow spaces are in use and on average there are 5-6 patients using an overflow space. On average, the same number of patients is also waiting in the Emergency Department for an inpatient bed.

We have aggressively managed our length of stay, but patient acuity continues to increase, in large part, because we attract many of the most acutely ill patients from other Connecticut hospitals and beyond. Inpatient growth and increasing patient acuity are major contributors to our capacity issues. The results of such high occupancy and so little bed availability are numerous and strain our staff, physicians and patients. There are sixteen overflow areas that include single rooms converted to doubles, doubles converted to triples, and solariums and other clinical support rooms converted to patient rooms, that we are forced to use on a regular basis. The need for private

rooms has grown over the years, in large part, due to infection control needs, but also as part of family oriented care and patient privacy needs. Patients with drug-resistant organisms require a private room or must be cohorted with like colonized/infected patients. Private rooms are also used for patients who have a contagious condition such as chicken pox or influenza. The lack of private rooms at YNHH contributes to the daily challenges of meeting current inpatient demand.

Marna Borgstrom discussed the cost implications of having to build a new bed tower to meet our inpatient bed needs. YNHH's proposal to acquire HSR will significantly improve our capacity issues. HSR has 511 licensed beds, physical space for 499, with some renovations, and is currently operating approximately 420. YNHH has identified locations to operationalize the remaining 12 beds so that all of HSR's 511 beds can be put into use at either the York Street or Saint Raphael campus. The combined patient census from both institutions along with all of each hospital's licensed beds, will result in a reduction of the occupancy level overall to 79-83% and for medical/surgical areas 80-83% overall between 2013 and 2016. Please refer to Attachment I of the second set of completeness responses (Applicant pages 294-298) for more detail. Although this does not allow YNHH to reach its target occupancy of 80%, it will provide much needed relief and as stressed by Ms. Borgstrom, can be done at a substantially lower cost than the construction of a new bed tower. This is truly the most financially feasible solution to YNHH's capacity issues.

Medical Staff Integration

I would like to now address some of the significant efforts that have been underway to permit the smooth integration of the medical staffs at each institution. I have the privilege of working, along with my colleague Dr. Kliger, on the imperative for medical staff transition and clinical integration on the campuses of Yale-New Haven Hospital and the Hospital of Saint Raphael. Dr. Kliger will address more specifics on clinical program integration.

With respect to the integration of our respective medical staffs, we have undertaken a careful and deliberate approach to ensure that services are provided without disruption on both campuses. More than 400 doctors, physician assistants and APRNs/midwives are being added to the YNHH medical staff. Over the past several months there have been meetings with physicians to share perspectives on clinical integration and discuss the transition process for the medical staff. Dr. Kliger and I have convened several meetings with medical staff leaders, departmental chiefs, medical directors, hospital based physicians and community physicians to continue planning the clinical integration. We have met with all employed physicians at HSR to provide them information on benefits and explain how the combined organization will function. We have also held several open forums for the medical staff to encourage interaction, information sharing and to address questions regarding the transaction. Medical staff leadership at both organizations has focused on "Day One Readiness" to ensure continuity of patient care upon the closing of the transaction. Virtually all employed physicians at HSR have agreed to employment within the Yale New Haven Health System including emergency medicine physicians, intensivists, traumatologists, and hospitalists. Yale-New Haven has agreed to accept assignment of the contracts of physicians and physician groups providing service in the primary care and specialty clinics at HSR. Site medical directors have been identified for all the clinical services, and the hospital-based services (radiology, pathology, therapeutic radiology, and anesthesiology) have agreed to assign their contracts to YNHH. Extensive discussions have taken place with the leadership of the graduate medical education programs who, together with other faculty, will remain in place. In summary, physician services on "Day One" are assured.

Through an integrated medical staff, patients will benefit from better coordinated care with better access to specialists and specialty care. Patients will also have enhanced access to clinical trials coordinated through the Yale School of Medicine. In addition, we expect that YNHH will continue its success in recruiting renowned leaders in key clinical areas and that the breadth of our combined medical staff will contribute to improved quality care to patients in our community.

The Applicants are extremely confident that following the close of the proposed acquisition, a new clinical environment will be created that better meets the inpatient bed demands of our collective patient populations and provides two state-of-the-art facilities for our physicians and their patients. For all of these reasons, and for the embedded opportunities to advance our clinical quality at the lowest possible cost, clinical leadership firmly believes that this transaction allows us to provide a healthier future for our community. I urge you to approve this CON application.

The foregoing is my sworn testimony.

Peter N. Herbert, M.D.

Peter N. Herbert, M.D.
Chief of Staff and Senior Vice President, Medical Affairs
Yale-New Haven Hospital

Attachment I
YNHH – Recent and Planned Physician Recruitments

Department/Division	Recent Physician Recruitments (FY 2009, 2010, 2011)	Planned Physician Recruitments (FY 2012-2015)
Surgery	1 GI Surgeon 2 Breast Surgeons 2 ENTs 2 Plastic Surgeons 1 Urologist	1 Plastic Surgeon* 5 Urologists
Orthopedics	3 Orthopedic Surgeons	1 Orthopedic Surgeon*
Neurosciences	1 Gen'l Neurology 2 MS 1 Neuromuscular 1 Pedi Neurosurgery 1 Gen'l Neurosurgery 3 Epilepsy 1 Neurovascular 1 Neuro-oncologist*	2 Epilepsy* 2 Pedi Epilepsy 1 Neuro- Degenerative* 1 Stroke* 1 Neurointerventionalist 1 Neuro-ophthalmologist 1 Movement Disorders
Internal Medicine	2 Thoracic Intervention(* for 1) 1 GI 3 Infectious Disease	
Heart & Vascular	1 VAD* 1 Pedi Card Chief 1 Peripheral Vascular* 1 Heart Failure 1 CV Medicine 1 Noninvasive Surg* 1 Thoracic Surgery 1 Electrophysiology* 1 Interventional Radiology	1 Vascular* 1 Heart Failure* 1 Pedi CT Surgery Chief*
OB/GYN	2 OB/GYNs	
Pediatrics	1 Emergency Med 1 Nephrologist 3 Neonatologists 1 Pedi Surgery 1 Hematology 1 GI 1 Neurology	
Oncology	2 Thoracic* 2 Breast* 2 GI* 1 Hematology*	2 Urology-Oncology*
Ophthalmology	1 Ophthalmologist	

Yale-New Haven Hospital
Saint Raphael Healthcare System
Hospital of Saint Raphael

Yale-New Haven Hospital's Acquisition of SRHS and HSR
DN: 12-31747-CON

Pre-file Testimony of Alan Kliger, MD
Senior Vice President, Chief Medical & Quality Officer

Hearing Officer Yandow and members of the OHCA staff, thank you for the opportunity to speak about this critically important Certificate of Need (CON) application before you for Yale-New Haven Hospital (YNHH) to acquire the assets of the Saint Raphael Healthcare System (SRHS), including the Hospital of Saint Raphael (HSR). I am Dr. Alan Kliger, Senior Vice President and Chief Medical and Quality Officer at the Hospital of Saint Raphael.

My testimony will focus on the following key points:

- Clinical integration for the two campuses;
- Benefits of a shared clinical information system (Epic); and
- The integration of Graduate Medical Education programs between HSR and YNHH.

I would like to begin my remarks by highlighting the tremendous history of our two institutions, which dates back almost 200 years. When the General Hospital Society of Connecticut was founded in 1826, rickets, small pox, measles, mumps, polio and whooping cough were widespread and deadly. To meet that challenge, ten members of the New Haven community came together to form the fourth voluntary hospital in the nation which would someday be known as Yale-New Haven Hospital. In 1906, Dr. William Verdi and 13 local physicians identified the need for a hospital to serve the sick and needy without regard to race, faith or ability to pay. An Italian-born Yale Medical College graduate, Verdi shared that vision with the Sisters of Charity of Saint Elizabeth

and together they formed the Hospital of Saint Raphael, named after the patron saint of healing. Both hospitals have been serving the community and investing and evolving to meet the health care challenges that exist. As the world of healthcare has changed, so too have both hospitals. Yet, one thing has remained constant – the dedication and focus of our two exceptional organizations. Change is a clear and fundamental part of our modern world, and together we believe we can best meet the changes ahead.

Clinical Integration

The goal of our clinical integration is to offer the safest, highest quality of care to our patients, their families, and our community. To do this, we must take into consideration our current capabilities, historical investments, and opportunities for future investments. From a patient's point of view, we aim to deliver care that is easy to navigate and patient-centered, without the inefficiencies of care, waste, and duplication of tests and procedures that all too frequently characterize routine care today.

We recognize that this process of clinical integration will take some time to complete, as care is organized around patient needs and efficient use of resources rather than around classical clinical departments and services. As described in more detail in our previous submissions, certain services are expected to be focused on one campus or the other, while others will be on both campuses or in several outpatient locations.

Planning for the implementation of such integrated care will require input from hospital administrators, medical leaders, nurses, physicians, and patients from both organizations. Dr. Peter Herbert and I have been working with other clinical leaders at both institutions to move this process along. Although there still is much work to be done in partnership with these "content experts," at this time we have identified the following plan for clinical integration.

The YNHH Campus is in our opinion best suited to deliver care in the following programs: trauma; oncology, specifically medical, thoracic, gynecologic, surgical and breast oncology; pediatrics; and high risk obstetrics. As described in our CON

application, these areas have been selected for the YNHH campus due to the highly specialized nature of these services and the established presence of physician experts, strong support services and the necessary technology at the YNHH campus. With all high risk obstetrical cases being located at YNHH, the need to transport sick newborns from HSR to YNHH will be minimized, thus reducing costs and stress on patients. YNHH is currently completing renovations to its emergency department, which will provide improved access and greater capacity. A single trauma destination in New Haven will simplify patient transport from the field, and reduce duplication of an expensive resource.

The HSR campus has been identified for the establishment of a musculoskeletal institute including orthopedics, pain management, spine, rehabilitation, and podiatry. The HSR campus includes acute rehabilitation in the Hospital and subacute rehabilitation at the Grimes Health Center, allowing this campus to offer the full continuum of care for musculoskeletal disorders. The elderly have always been identified as a special population within the mission of HSR. Musculoskeletal disorders are common in the elderly, representing a fast-growing need in our community, so a musculoskeletal institute with particular focus on diseases of aging is a natural fit on the HSR campus. The HSR campus may also be a focus for bariatric surgery and a primary family oriented birthing program (including a birthing center).

Certain services will be offered at both campuses due to community need, high volume and the interrelationship of these services. These services include general medicine and surgery, cardiology, vascular surgery, urology, psychiatry gynecology, low risk obstetrics, dentistry, emergency services (non-trauma), and essential support services including anesthesia, pathology, laboratory medicine and radiology.

Clinical integration of the HSR and YNHH campuses will offer future opportunities to minimize the purchase of expensive medical equipment. Historically, Yale-New Haven and the Hospital of Saint Raphael have both sought to advance their clinical enterprise by investing in medical technology and state-of-the-art equipment. Both hospitals

invested in overlapping, and even duplicative, equipment in order to remain current with medical developments and stay competitive with other area hospitals. By integrating the clinical services, we can employ a more rational approach to investment, better utilize technology and expertise, lower costs, advance quality and ultimately strip redundancy out of the Delivery System.

Our clinical integration plan will continue to evolve and the ultimate decisions will be based on our collective expertise, patient demand, access and the most cost-effective solutions.

Clinical Information Technology Integration

A major benefit of the proposed acquisition is the opportunity to expand the use of Epic, a comprehensive electronic medical record and information system, to the YNHH and HSR campuses, outpatient service areas and physicians. Such integrated electronic information systems are required to measure processes and outcomes of care, real costs of care, and opportunities to improve the efficiency of care delivery. Systems such as Epic allow us to measure and compare the quality of care delivery and show us ways we need to improve care and the patient's experience of care. Hospitals across the country are struggling to meet the federal government's expectations for electronic medical records and to reap some of the financial benefits for implementing such systems. The cost of such systems would be prohibitive to HSR standing alone given its current financial condition.

The benefit of any enterprise-wide electronic medical record is the ability to access consistent clinical information across the health care continuum, including the physician office, emergency departments, inpatient and outpatient locations, laboratories, radiology and other ancillary service areas. Access to a patient's clinical record by any YNHH provider in any of these settings significantly enhances the coordination of patient care, reduces the need for duplicate tests and procedures, and even offers patients access to their clinical records. Most importantly, it improves the safety of patients. As a single patient record, a patient on Epic has a common list of current medications, allergies,

medical conditions, and both medical and surgical histories. By having this information as structured data and by employing large databases of clinical information, Epic is able to flash alerts to caregivers when a patient could have a reaction to a drug or radiology contrast agent based on their allergies or current medications. Epic also improves safety, reduces nursing clerical work, and minimizes potential errors by feeding patient monitoring data (heart rate, pulse oximetry, blood pressure) directly into the patient's electronic record without the time and potential errors of having a clinician write then type the information. Finally, use of bedside barcode medication authentication (with mobile barcode scanners and patient bar-coded wristbands) allows nurses to verify right does, right patient, right drug, and right time each time they deliver medications.

A good example of the opportunity is reflected in those patients who currently choose to use both hospitals' emergency departments. The clinician's ability to immediately access prior test results, medication records and provider assessments will improve the clinical and financial efficiency of that care.

The use of Epic for all patients at both the YNHH and HSR campuses will be a significant enhancement to the quality of patient care we can deliver. This technology will propel our organization into the future of accountable care and help us deliver the best care at the lowest cost.

Graduate Medical Education

I would like to shift my testimony to the topic of graduate medical education. Both YNHH and HSR have been strongly committed to educating the next generation of physicians. The proposed acquisition will allow us to integrate the graduate medical education programs of both institutions into a stronger, more coordinated whole. We will ensure that all residents and fellows currently enrolled in the HSR programs have the opportunity to complete their training programs, with wider opportunities for education on both campuses. Future enrollees will find stronger programs with wider opportunities for patient care and teaching. All current HSR training programs will be integrated into YNHH's programs, with training available on both campuses, and,

consistent with existing residency affiliation agreements, at other hospitals and outpatient centers. Substantially all of the teaching staff at HSR will continue their teaching duties. Program Directors at HSR will work with Program Directors at YNHH to ensure uninterrupted training for residents and fellows.

HSR's residency and/or fellowship programs in the areas of Surgery, Diagnostic Radiology, Geriatrics, Nephrology, Cardiology and Oral and Maxillofacial Surgery will be transferred to and integrated with YNHH's ACGME accredited programs. In addition, HSR's Internal Medicine residency program will be integrated with YNHH's Primary Care residency program. All programs will be sponsored by YNHH.

The proposed acquisition will permit the reduction of duplicative functions in the support areas for graduate medical education. Streamlining our staff and processes associated with ongoing operation of graduate medical education will enable the combined organization to be more efficient and operate all of these programs more cost effectively.

YNHH and HSR share a vision of the future that will enhance the delivery of healthcare services in our region. Recognizing and respecting the strengths of each institution, we see the value of coming together to form an integrated care delivery system that understands that great healthcare can be made even better. I urge you to approve this CON application.

The foregoing is my sworn testimony.

A S Kliger

Alan Kliger, M.D.

Senior Vice President, Chief Medical & Quality Officer

Hospital of Saint Raphael

Yale-New Haven Hospital
Saint Raphael Healthcare System
Hospital of Saint Raphael

Yale-New Haven Hospital's Acquisition of SRHS and HSR
DN: 12-31747-CON

Pre-file Testimony of Christopher O'Connor
President and Chief Executive Officer, Saint Raphael Healthcare System and Hospital of Saint Raphael

Hearing Officer Yandow and members of the OHCA staff, thank you for the opportunity to speak about this vitally important Certificate of Need (CON) application before you for Yale-New Haven Hospital (YNHH) to acquire the assets of the Saint Raphael Healthcare System (SRHS), including the Hospital of Saint Raphael (HSR). My name is Christopher O'Connor and I am President and Chief Executive Officer of the Saint Raphael Healthcare System and the Hospital of Saint Raphael.

I will focus my testimony on the current condition of the Hospital of Saint Raphael, the many efforts undertaken to improve the situation and finally the important reasons why the Hospital of Saint Raphael is pursuing acquisition by Yale-New Haven Hospital. Our founders and sponsors – the Sisters of Charity of Saint Elizabeth, our Board of Trustees, and our leadership team firmly believe that acquisition by and full integration with Yale-New Haven Hospital represents the very best way to address the needs of the Saint Raphael campus, our patients, employees, physicians and the community.

Current Condition

The present day challenges are many but are particularly significant with regard to cash flow and debt coverage, as well as our inability to retain and recruit the talent necessary to manage the organization, and fulfill our commitments to those who have served with distinction.

The Hospital suffered through five consecutive years of significant operating losses between fiscal years 2005 and 2009, including a staggering $17 million loss in FY 2008. About 70 percent of our patients – a number that is growing – are currently insured by

either Medicare or Medicaid. As Ms. Borgstrom pointed out during her testimony, the economic pressure on government reimbursement will only intensify in the years ahead and our ability to shift those losses to other payors, given our existing payor mix is – and will remain – extremely limited. These painful and deepening financial pressures required us to make extremely difficult choices to preserve the organization's viability.

Currently our Days Cash on Hand is perilously low at 23.5 days as of April 30, 2012. At that level we have very limited ability to manage through business interruptions. Even if we were to somehow triple the number of Days Cash on Hand, it would still be well below national benchmarks. From a capital perspective, a lack of available funds for capital investment has placed us at a competitive disadvantage vis-à-vis other hospitals in the State and given the current state of our long-term debt, borrowing is simply not a possibility. As a result of the financial pressures we have encountered, we have been spending well below depreciation levels and, as a result, the average age of the Hospital of Saint Raphael campus has increased from 16.5 years in 2008 to 26.2 years in 2011 – making us the oldest in the State of Connecticut. With our curtailment in 2010 of all post-retirement pension benefit contributions, the Hospital can no longer compete effectively for the staff and physicians.

Saint Raphael's financial performance has put it out of compliance with the majority of its bond covenants, specifically those pertaining to days cash, long-term debt to capitalization and minimum fund balance. This has resulted in a "going concern" opinion on each of the annual audits conducted by Ernst &Young since 2009. The Hospital of Saint Raphael still faces a significant amount of long-term debt, a pension fund deficit, a deteriorating payor mix and as I've noted the physical plant is aging rapidly. It is now more than two and a half times older than the national average.

Efforts Undertaken

I want to emphasize that much has been done to try and improve the organization. The Sisters, Board and senior leadership determined back in 2008 – prior to my arrival as CEO – that Saint Raphael's rapidly deteriorating financial position jeopardized its future

as a standalone hospital. The decision was made to explore, identify and prioritize potential strategic partners. Simultaneously, the Hospital also did what most would do facing similar circumstances and management and staff worked hard to drive down costs and to seek opportunities to expand revenue.

These actions, which continue to this day, include but are not limited to:

a. Cuts to existing employee benefits, most significantly ceasing contributions to the employee defined benefit pension plan, defined contribution pension plan, and employer matching funds to participants' 401(k) plans;
b. Use of value engineering to achieve efficiencies in the way we operate, including "right sizing" our organization. This involved labor and non-labor cost savings initiatives in essentially all departments, including reducing FTE levels.
c. Deferred investments in our capital infrastructure, including our physical plant, new technology and information systems.

In addition, Saint Raphael's has taken deliberate steps to improve our revenue cycle.

a. We have engaged third party payers to negotiate the most competitive rates possible given the circumstances.
b. We have improved enrollment of Medicaid-eligible patients, are better capturing Medicaid usage which results in higher DSH payments, and have pursued various appeals related to Medicare reimbursement, such as those involving area wage indices.
c. We have improved medical record documentation to ensure appropriate reimbursement for medically necessary services, improved charge capture oversight, streamlined collections, and diminished payment denials.

Unfortunately all of these actions have not been enough. Today, Saint Raphael's is at a unique moment in time when it must set a new course as its current operation as an independent hospital is unsustainable for the future. Despite all of our best efforts and despite all of the challenging decisions we've made, we remain very concerned about

our ongoing viability. It is clear that we can no longer exist as a standalone provider of medical services. If we must remain as a standalone hospital, we will not be able to invest in facilities, talent and equipment, and will suffer continued volume decline, loss of staff and physicians and ultimately demise.

Acquisition by YNHH

The significant economic pressures which have only intensified over the course of the last five years, led us to the conclusion that is critically important for us to seek a partner or buyer that would enable the continued provision of high quality care on the Saint Raphael campus, and particularly to maintain our commitment to the most vulnerable populations. The Sisters, Board and prior leadership began this process in 2008, initially reaching out to national Catholic healthcare organizations as a way to stabilize our financial footing while preserving our mission. As those conversations progressed, however, it became clear that the combination of our organization's financial issues and the national economic conditions were serving as real and direct obstacles to our ability to consummate a working partnership that would address both our long-term capital and operating needs.

Following our leadership transition in 2009, and given our continuing fragility, we restarted the search for a strategic partner in 2010 with a very strong sense of urgency. We considered national, state, for profit, Catholic and secular options. Through that process, we established a series of criteria that would be essential to an affiliation. These criteria included:

- Retaining a Catholic identity;
- A strong preference to remain non-profit;
- A commitment to providing high quality, accessible healthcare;
- An ongoing commitment to the local community, our physicians and employees, and;
- Access to capital that would allow us to address our longstanding financial needs.

Ultimately, our national evaluation led us back home to New Haven. By the Spring of 2011, we recognized that acquisition by Yale-New Haven Hospital would allow us to meet all of our primary objectives and could serve as a unique and exciting opportunity to align and better coordinate care in our region. The benefits of this acquisition could not be matched by any other acquirer, including:

- Recognition of our Catholic heritage, even though secular ownership does not allow continuation of the Catholic designation;
- Retention of non-profit status;
- Retention of local decision making;
- An ability to improve the quality and delivery of care;
- The elimination of our long-term debt;
- A narrowing of our pension fund deficit;
- A capital investment in HSR's campus infrastructure, and;
- Implementation of the Epic electronic medical record system.

You have heard all of the reasons today that motivated our decision to align with Yale-New Haven. This is about advancing high quality care. It is about preserving access. It's about continuing to give patients and the community the option to receive care consistent with Catholic tradition on the Saint Raphael campus. And it is about doing so in a cost efficient manner. The promise of this transaction is unlimited and the benefits to the community would be immediate. As important, this acquisition is essential to the patients cared for on the Saint Raphael campus, the physicians who practice here, the almost 4,000 employees who come from all over Connecticut and even beyond, and the retirees who are anxious about their pension benefit.

Saint Raphael's is at a crossroads. We must see this transaction to a close by July 27th, 2012 due to the continuing erosion of Saint Raphael's financial performance and the related escalating risk to the organization. We have pursued and are confident will have the support of other regulatory and related entities considering this acquisition. The Vatican has already provided its authorization to relinquish our official Catholic designation. Rulings are pending from the Connecticut Attorney General and Federal

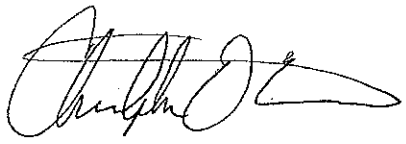
Trade Commission and we are optimistic based on meetings and conversations as part of this process. This acquisition is the only pathway to financial stability and long-term viability for the Saint Raphael campus, and is imperative for the economic vitality of the entire region.

We need the support of OHCA because the immediate viability of our hospital is at stake. Each month, as volume declines, and as staff and physicians seek alternative employment, our future gets darker. Potential actions by our bondholders, insolvency and bankruptcy are real and present threats. It is a very challenging, stressful time for our patients, our physicians and our staff.

The Hospital of Saint Raphael was founded more than a century ago on the presumption of access and quality. That mission can continue and be furthered with our acquisition by Yale-New Haven Hospital. On behalf of all stakeholders, we urge your strong consideration and your approval of this transaction. Time is of the essence.

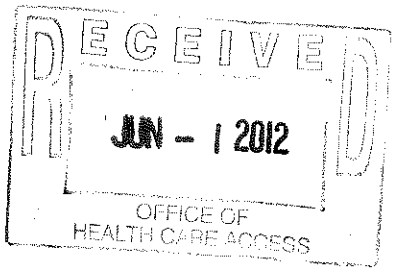
Thank you very much.

The foregoing is my sworn testimony.



Christopher O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System and
Hospital of Saint Raphael

FAX COVER



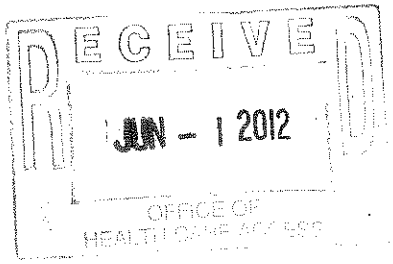
DATE: June 1, 2012

TO: Kim Martone, OHCA

FROM: Jean Ahn, YNHH

The attached pages were inadvertently left out of the packet of prefile testimony that was delivered today. Please include.

Attachment



Docket Number 12-31747-CON

Attachments to Marna Borgstrom Prefile Testimony

Attachment I

CANNONDESIGN

March 12, 2012

Brad Bevers
Yale New Haven Hospital
TE 102
New Haven, CT 06504

Dear Brad,

Thank you for contacting Cannon Design regarding industry planning standards for inpatient bed unit occupany rates. The chart below contains the mean occupancy rates for select inpatient bed types assuming a bedded care model of 80-100% private beds, and a bedded care model in which semi-private beds, less than 50% private are utilized.

Bed Type	Planned Occupancy Rate Private Bed Model	Planned Occupancy Rate Semi-Private Beds
Medical-Surgical Beds	80-85%	85-75%
Step Down/ Telemetry Beds	80-85%	85-75%
Intensive Care Beds	60-70%	60-70%
Pediatric	65-75%	80-65%
Postpartum	70-80%	85-65%
Medical & Geriatric Psychiatric	75-85%	80-65%
Behavioral Psychiatric*	80-90%	80-95%

Note: Contemporary models assumes double occupancy for behavioral health patients.

Based upon Cannon Design's research, for semi-private beds we recommend a lower utilization rate to reflect patient compatibility issues such as patient gender, infection contol and prevention and patient personality incompatibility, which can limit the utilization of the second bed within a semi-private patient room.

For select specialty bed types, Cannon Design recommends a slightly lower occupany rate, when compared to medical-surgical beds, to reflect variations in specialty bed utilization due to seasonalties or inconsistent demand in patient services, e.g. pediatric and intensive care. To accommodate demand variations, a lower occupany rate is recommened to allow for flexibility in bed capacity, to accommodate the service demand volatility.

Please do not hesitate to contact me should you have questions.

Sincerely,

Mike Puksaris
Principal

St. Louis
Baltimore
Boston
Dallas
Calgary
Chicago
Houston
Los Angeles
Miami
New York
Phoenix
San Francisco
Shanghai
Toronto
Washington
Wichita
Abu Dhabi, UAE

1700 Clark Avenue
St. Louis, Missouri
63103
T: 314.241.2600
F: 314.241.2670
www.cannondesign.com

HEERY design

March 6, 2012

C. Bradford Severs, Director
Facilities, Construction and Design
Yale-New Haven Hospital
20 York St, Rm TE 105
New Haven, CT 06504

RE: Inpatient Occupancy Rates

Dear Brad:

As part of the programming and planning process, Heery utilizes target occupancy rates to determine the proposed bed need. The occupancy rates vary depending on the type of unit and the availability of similar beds in alternate locations. Units with little flexibility (such as critical care and obstetric units) are planned with a lower desired occupancy to accommodate peaks and valleys in demand. Units for which alternate areas are available (such as general medical / surgical units) are planned for higher occupancy levels. The factors below are industry standards that have been adjusted for academic medical center inpatient facilities with mostly private beds.

Target Occupancy Rates	
Medical / Surgical	80%
Critical Care	75%
Pediatrics	80%
PICU	75%
NBSCU	70%
Obstetrics	70%
Psych	80%
Pediatric Psych	80%
Other	80%

The target occupancy rates listed above are the guidelines we use as a starting point. These factors can fluctuate 5-10% up or down depending on the institution's efficient and private/semi-private bed mix.

Sincerely,

Heery International, Inc.

Doug Infelt, AIA, LEED AP

DI/drs

Heery International, Inc.
A group of professional services practices
625 South Quebec Street, Suite 500, Iowa City, Iowa 52240-4008
Telephone 319 354-4900 Fax 319 354-4207
Offices Nationwide

Attachment II
DN: 04-30410-CON (Smilow Cancer Hospital CON) Projections Compared to Actuals

Clinical Service Inpatient Volume Smilow Cancer Hospital CON to Actual

Clinical Service Inpatient Volume									
	Cancer Hospital CON Projections (DN 04-30410-CON)							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	29,298	30,108	30,503	31,551	32,699	33,339	34,093	16.4%	2.7%
Pediatrics	6,645	6,797	7,402	7,230	7,519	7,910	8,082	21.6%	3.6%
OB	9,466	9,660	9,553	9,314	9,040	8,987	8,798	-7.1%	-1.2%
Psych	2,591	2,646	2,688	2,703	2,752	2,797	2,827	9.1%	1.5%
Total	48,000	49,211	50,146	50,798	52,010	53,033	53,800	12.1%	2.0%
	Actual							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	30,172	31,396	32,856	34,088	36,432	38,998	39,608	31.3%	5.2%
Pediatrics	6,507	6,770	6,832	6,506	6,221	6,349	6,702	3.0%	0.5%
OB	9,485	9,604	9,200	8,892	8,763	8,439	8,539	-10.0%	-1.7%
Psych	2,451	2,592	2,543	2,535	2,815	2,813	2,602	6.2%	1.0%
Total	48,615	50,362	51,431	52,021	54,231	56,599	57,451	18.2%	3.0%
	Difference from Original Projections							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	874	1,288	2,353	2,537	3,733	5,659	5,515	14.9%	2.5%
Pediatrics	-138	-27	-570	-724	-1,298	-1,561	-1,380	-18.6%	-3.1%
OB	19	-56	-353	-422	-277	-548	-259	-2.9%	-0.5%
Psych	-140	-54	-145	-168	63	16	-225	-2.9%	-0.5%
Total	615	1,151	1,285	1,223	2,221	3,566	3,651	6.1%	1.0%

Patient Days Smilow Cancer Hospital CON to Actual

Patient Days									
	Cancer Hospital CON Projections (DN 04-30410-CON)							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	161,699	166,245	169,486	173,508	180,584	184,020	187,419	15.9%	2.7%
Pediatrics	41,929	41,850	42,924	42,455	42,746	44,212	44,804	6.4%	1.4%
OB	26,146	27,083	27,401	27,242	25,884	26,020	25,850	-1.1%	-0.2%
Psych	25,225	25,640	25,961	26,025	26,437	26,823	27,065	7.3%	1.2%
Total	254,999	260,818	265,772	269,230	275,651	281,075	285,138	12.1%	2.0%
	Actual							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	164,272	166,166	169,598	181,074	186,399	193,015	210,786	28.3%	4.7%
Pediatrics	42,518	44,218	42,413	38,800	41,166	41,562	38,493	-9.5%	-1.6%
OB	27,398	27,024	26,100	26,119	25,649	24,459	24,508	-10.5%	-1.8%
Psych	24,346	25,225	26,237	26,853	26,389	25,665	27,202	11.7%	2.0%
Total	258,534	262,633	264,448	272,846	279,603	284,701	300,989	16.4%	2.7%
	Difference from Original Projections							Growth Rate	
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Cum.	Avg Ann.
Med/Surg.	2,573	-79	212	7,566	5,815	8,995	23,367	12.4%	2.1%
Pediatrics	1,189	2,368	-511	-3,655	-1,580	-2,650	-6,311	-17.9%	-3.0%
OB	1,252	-59	-1,301	-1,123	-235	-1,561	-1,342	-9.4%	-1.6%
Psych	-879	-415	276	828	-48	-1,158	137	4.4%	0.7%
Total	4,135	1,815	-1,324	3,616	3,952	3,626	15,851	4.3%	0.7%

Source: YNHH Department of Financial Planning
Note: Statistics from Smilow Cancer Hospital CON have been grouped into four service areas as noted above.

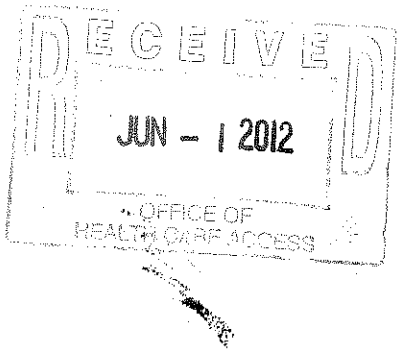
WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com

June 1, 2012



VIA HAND DELIVERY

Joanne Yandow, Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application; Docket Number 12-31747-CON
Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Yandow:

Enclosed please find Notices of Appearance of Wiggin and Dana LLP and Jones Day filed on behalf of the applicants in the above-referenced proceeding. Also enclosed is an Application to Admit Attorney Geoffrey D. Oliver *Pro Hac Vice*, pursuant to which the applicants request that Mr. Oliver, a member in good standing of the bars of the District of Columbia and Massachusetts, be permitted to participate in the above-referenced proceeding as co-counsel on behalf of Yale-New Haven Hospital. An Affidavit of Mr. Oliver in support of this Application is attached to the Application.

We appreciate your consideration of the enclosed Application. Should you need any additional information prior to the hearing on Tuesday, June 5, 2012, please do not hesitate to contact me.

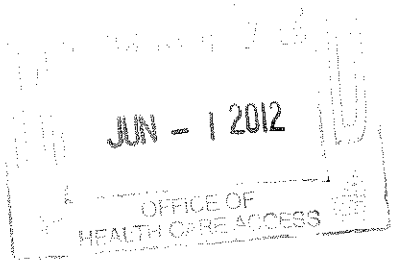
Sincerely,

Rebecca A. Matthews

cc: Lisa Davis, MBA, BSN, RN, Deputy Commissioner, Department of Public Health, Office of Health Care Access

STATE OF CONNECTICUT

BEFORE THE DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	DOCKET NO. 12-31747-CON
	:	JUNE 1, 2012
IN RE APPLICATION OF YALE-NEW HAVEN HOSPITAL (YNHH), SAINT RAPHAEL HEALTH CARE SYSTEM (SRHS) AND HOSPITAL OF SAINT RAPHAEL (HSR) FOR THE ACQUISITION BY YNHH OF SRHS AND HSR	:	



NOTICE OF APPEARANCE

Please enter the appearance of Wiggin and Dana LLP on behalf of Yale-New Haven Hospital, Saint Raphael Health Care System and Hospital of Saint Raphael.

The undersigned plans to attend the hearing on Tuesday, June 5, 2012 on behalf of our clients.

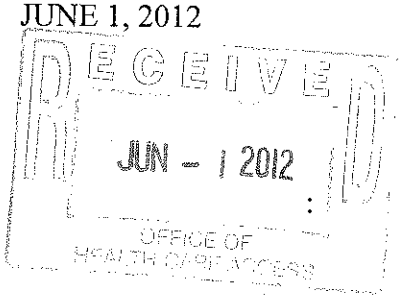
Respectfully submitted,

YALE-NEW HAVEN HOSPITAL
SAINT RAPHAEL HEALTH CARE SYSTEM
HOSPITAL OF SAINT RAPHAEL

By: Rebecca A. Matthews
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832
203-498-4400 (Telephone)
203-782-2889 (Fax)
rmatthews@wiggin.com
Their Attorneys

STATE OF CONNECTICUT

BEFORE THE DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	DOCKET NO. 12-31747-CON
	:	JUNE 1, 2012
IN RE APPLICATION OF YALE-NEW HAVEN HOSPITAL (YNHH), SAINT RAPHAEL HEALTH CARE SYSTEM (SRHS) AND HOSPITAL OF SAINT RAPHAEL (HSR) FOR THE ACQUISITION BY YNHH OF SRHS AND HSR	:	



NOTICE OF APPEARANCE

Please enter the appearance of Jones Day on behalf of Yale-New Haven Hospital.

The undersigned plans to attend the hearing on Tuesday, June 5, 2012 on behalf of our client.

Respectfully submitted,

YALE-NEW HAVEN HOSPITAL

By: Geoffrey D. Oliver

Jones Day
51 Louisiana Avenue, N.W.
Washington, D.C. 20001-2113
202-879-3939 (Telephone)
202-626-1700 (Fax)
gdoliver@jonesday.com
Its Attorneys

STATE OF CONNECTICUT

BEFORE THE DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	DOCKET NO. 12-31747-CON
	:	JUNE 1, 2012
IN RE APPLICATION OF YALE-NEW HAVEN HOSPITAL (YNHH), SAINT RAPHAEL HEALTH CARE SYSTEM (SRHS) AND HOSPITAL OF SAINT RAPHAEL (HSR) FOR THE ACQUISITION BY YNHH OF SRHS AND HSR	:	

APPLICATION TO ADMIT
ATTORNEY GEOFFREY D. OLIVER *PRO HAC VICE*

Pursuant to Connecticut Practice Book § 2-16, the undersigned, a member in good standing of the Connecticut Bar, on behalf of Yale-New Haven Hospital, Inc., Saint Raphael Health Care System and the Hospital of Saint Raphael, hereby requests that the Department of Public Health's Office of Health Care Access admit Geoffrey D. Oliver, an attorney in good standing at the bar of the District of Columbia, *pro hac vice* to represent Yale-New Haven Hospital, Inc. (the "Applicant") in connection with all proceedings in this action. In support hereof, the undersigned represents that there is good cause to permit Mr. Oliver to appear *pro hac vice* on the Applicant's behalf, as follows:

1. Attorney Oliver is a partner in the law firm of Jones Day, resident in its offices located at 51 Louisiana Avenue, N.W., Washington, D.C. 20001-2113. Jones Day is counsel to the Applicant and has a relationship with the Applicant that predates the filing of the Certificate of Need in this matter.

2. As a consequence of this prior relationship with the Applicants, Mr. Oliver has knowledge and experience in representing the Applicant in matters such as the one now pending before the Department. Mr. Oliver's involvement in this action will add substantially to the

efficiency and effectiveness of the Applicant's representation in this matter. Because of this prior relationship, the Applicant has requested that Mr. Oliver represent it in this matter, with the ongoing presence and assistance of Connecticut counsel.

3. The Connecticut law firm of Wiggin and Dana LLP will represent the Applicant and be present at all proceedings in this action, and will assume full responsibility for all papers filed with the Department and for the conduct of the case and of the attorney admitted *pro hac vice*.

4. Attached to this Application is an affidavit from Mr. Oliver setting forth the information required by Practice Book § 2-16.

WHEREFORE, the undersigned, on behalf of the Applicants, respectfully requests that Mr. Oliver be admitted *pro hac vice* to represent the Applicant in connection with all proceedings in this matter.

Respectfully submitted,

YALE-NEW HAVEN HOSPITAL
SAINT RAPHAEL HEALTH CARE SYSTEM
HOSPITAL OF SAINT RAPHAEL

By: Rebecca A. Matthews
Wiggin and Dana LLP
One Century Tower
New Haven, CT 06508-1832
203-498-4400 (Telephone)
203-782-2889 (Fax)
rmatthews@wiggin.com
Their Attorneys
Juris No. 409688

STATE OF CONNECTICUT

BEFORE THE DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	DOCKET NO. 12-31747-CON
	:	MAY 31, 2012
IN RE APPLICATION OF YALE-NEW HAVEN HOSPITAL (YNHH), SAINT RAPHAEL HEALTH CARE SYSTEM (SRHS) AND HOSPITAL OF SAINT RAPHAEL (HSR) FOR THE ACQUISITION BY YNHH OF SRHS AND HSR	:	

AFFIDAVIT OF GEOFFREY D. OLIVER
IN SUPPORT OF HIS APPLICATION FOR ADMISSION *PRO HAC VICE*

WASHINGTON)
) ss.: Washington, DC May 31, 2012
DISTRICT OF COLUMBIA)

I, Geoffrey D. Oliver, being first duly sworn, depose and say as follows:

1. I am over the age of eighteen years, understand the meaning and obligations of an oath, and am competent to testify to the matters set forth in this affidavit.

2. I make this affidavit in support of a motion by counsel for Yale-New Haven Hospital, Inc., Saint Raphael Health Care System and the Hospital of Saint Raphael in the above-captioned matter to permit me to appear *pro hac vice* as co-counsel for Yale-New Haven Hospital (the "Applicant") in all proceedings in this matter.

3. I am a partner in a partner in the law firm of Jones Day, resident in its offices located at 51 Louisiana Avenue, N.W., Washington, D.C. 20001-2113. Jones Day is counsel to Applicant and has a relationship with the Applicant that predates the filing of the Certificate of Need in this matter. As a consequence of this prior relationship with the Applicant, I have knowledge and experience in representing the Applicant in matters such as the one now pending before the

Department of Public Health's Office of Health Care Access. My involvement in this action will add substantially to the efficiency and effectiveness of the Applicant's representation in this matter. Because of this prior relationship, the Applicant has requested that I represent them in this matter, with the ongoing presence and assistance of Connecticut counsel.

4. I am an attorney and member in good standing of the bars of the District of Columbia and Commonwealth of Massachusetts.

5. I have paid the client security fund fee for 2012;

6. I hereby designate the Commissioner of the Department of Public Health as my agent upon whom process and service of notice may be served.

7. I agree to register with the Statewide Grievance Committee in accordance with the provisions of Chapter 2 of the Connecticut Practice Book while appearing in this matter in this State and for two years after the completion of this matter. I also agree to notify the Statewide Grievance Committee of the expiration of the two-year period.

8. I have not been denied admission or disciplined by any court.

9. No grievances are currently pending against me in any jurisdiction.

10. I have never been reprimanded, suspended, placed on inactive status, or disbarred. I have never resigned from the practice of law.

11. I have not previously appeared *pro hac vice* in the State of Connecticut.

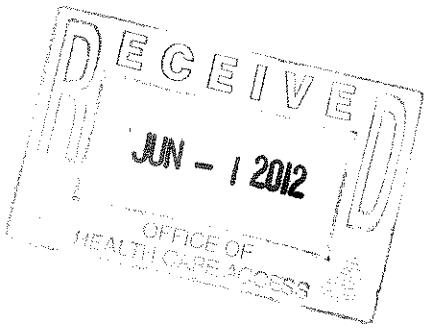
Geoffrey D. Oliver

Subscribed and sworn to
before me this 31st day of May, 2012.

Notary Public
My Commission Expires on:

ELLEN L. OWENS
Notary Public, District of Columbia
My Commission Expires August 31, 2015

YALE-NEW HAVEN HOSPITAL



June 1, 2012

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

Re: Yale-New Haven Hospital (YNHH)
Saint Raphael Healthcare System (SRHS) & Hospital of Saint Raphael (HSR)
YNHH's Acquisition of SRHS and HSR
Docket Number: 12-31747-CON

Dear Ms. Martone:

Please find enclosed some additional letters of support received by the Applicants in reference to the above mentioned CON application.

Please do not hesitate to contact me with any questions or concerns. I can be reached at (203) 688-7541.

Thank you for your time and attention.

Sincerely,

Jean Ahn
Director, Planning & Business Development
YNHH

Enclosures

20 York Street
New Haven, CT 06504

TOWN OF WOODBRIDGE
11 MEETINGHOUSE LANE
WOODBRIDGE, CONNECTICUT 06525

Telephone: (203) 389-3401
FAX: (203) 389-3480
E-mail: emsheehy@ci.woodbridge.ct.us

EDWARD MAUM SHEEHY
FIRST SELECTMAN

RECEIVED
MAY 10 2012
Marna P. Borgstrom
President & CEO

May 1, 2012

Marna P. Borgstrom
Chief Executive Officer of
Yale-New Haven Hospital and
President and CEO of
Yale-New Haven Health System
40 York Street
New Haven, CT 06510

RECEIVED
JUN - 1 2012
OFFICE OF

Dear Ms. Borgstrom:

As First Selectman of the Town of Woodbridge and a member of the South Central Regional Council of Governments I fully support the proposed merger of Yale-New Haven Hospital and St. Raphael Healthcare System.

The merger of these large medical institutions will benefit the citizens of Woodbridge and the other towns in the New Haven area by providing a stable health care system for the future.

Sincerely,

Edward Maum Sheehy
First Selectman

EMS/gs

cc: Woodbridge Board of Selectmen

The Eastern Bag & Paper Group
200 Research Drive
Milford, CT 06460
1-800-972-9622

April 3, 2012

JUN - 1 2012
OFFICE OF
HEALTH CARE ACCESS

Ms. Marna P. Borgstrom
President & CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna,

I would like to express my firm support for the proposal to integrate Yale-New Haven Hospital and the Hospital of Saint Raphael. I believe the integration is absolutely necessary to improve access and quality of care in our statewide community. The proposal to purchase the assets of the Hospital of Saint Raphael promises more opportunity to provide exceptional care in a cost effective manner.

As a major employer in the State, we feel it is important to support and encourage innovative solutions that drive down costs and create efficiency within our healthcare delivery system. Our employees deserve the very best quality of care available, delivered in the most efficient way possible. I strongly believe that this proposed transaction between the two hospitals represents the type of innovative approach that will allow us to meet those needs well into the future. Our employees recognize the value that Yale-New Haven provides throughout the State of Connecticut. I fully endorse this proposal and urge its approval.

Sincerely,

Meredith Reuben
CEO
Eastern Bag & Paper Group

Bilco®

Since 1926

May 3, 2012

RECEIVED

MAY – 3 2012

Marna P. Borgstrom
President & CEO

Marna Borgstrom, President and CEO
Yale-New Haven Hospital
789 Howard Ave.
New Haven, CT 06519

Christopher O'Connor, President and CEO
Hospital of Saint Raphael and St. Raphael Healthcare System
1450 Chapel St.
New Haven, CT 06511

RECEIVED

JUN – 1 2012

OFFICE OF HEALTH CARE ACCESS

Dear Marna and Chris,

On behalf of The Bilco Company, which just observed its 85th year as a corporate citizen in the Greater New Haven area, I am pleased to endorse and support the acquisition of the Hospital of Saint Raphael by Yale-New Haven Hospital. As community leaders, Bob Lyons, Sr., Roger Joyce and I believe that the integration of Saint Raphael's into Yale-New Haven will be beneficial to the New Haven Community. We also recognize and see merit in the business objectives of this combination, in that Yale-New Haven Hospital will gain additional space for growth and expansion, while the Hospital of Saint Raphael's financial challenges will be resolved.

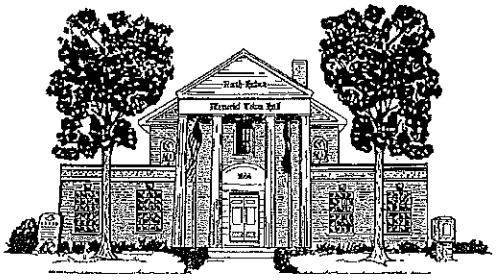
As a colleague of yours on the Connecticut Hospital Association Board, I have had decade-long visibility of the developing challenges faced by hospitals in the State. The New Haven region needs a thoughtful, planned approach to combining the resources and expertise of both institutions to provide extraordinary health care to the community. Enhanced efficiency and reduced duplication of services will result from the integration, improving the cost equation as well.

We look forward to the successful integration, and offer our support and encouragement as you work to create this new health care model in New Haven.

Sincerely,

Robert J. Lyons, Jr.
President

RJL:bss



TOWN OF NORTH HAVEN

MEMORIAL TOWN HALL / 18 CHURCH STREET

NORTH HAVEN, CONNECTICUT 06473

First Selectman
Michael J. Freda

Tel. (203) 239-5321
Fax (203) 985-9009

RECEIVED
MAR [illegible] 2012
Marna P. Borgstrom
President &

RECEIVED
JUN - 1 2012
OFFICE OF

March 1, 2012

Ms. Marna Borgstrom
Chief Executive Officer
Yale New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna,

I wanted to take a moment to express my firm support for the proposal to integrate Yale New Haven Hospital and the Hospital of Saint Raphael. As you are well aware, we have been working with representatives of Yale New Haven Hospital in an effort to locate a new ambulatory facility here in North Haven. During the course of the last two years I have been impressed by the efforts of Yale New Haven Hospital to improve access and improve the quality of care in our community. The proposal to purchase the assets of the Hospital of Saint Raphael promises more opportunity to provide exceptional care in a cost effective fashion.

Although there may be a few who challenge the nature of the integration of two well respected hospitals in our region, it is clear that it will not dampen the competitive atmosphere in our state.

Yale New Haven Hospital is viewed as a statewide resource which, in many respects, was why it was challenged by Hartford Health Care and Midstate Hospital when it made plans for the ambulatory facility in North Haven.

As a result of the fact that the people in our region recognize the strong value that Yale New Haven can provide in our part of the state, the support for the facility was, and is, overwhelmingly strong.

I believe that the same can be said of the proposal to integrate with the Hospital of Saint Raphael. I wanted to write to you to give you my total support for the proposed integration of Yale New Haven Hospital and the Hospital of Saint Raphael.

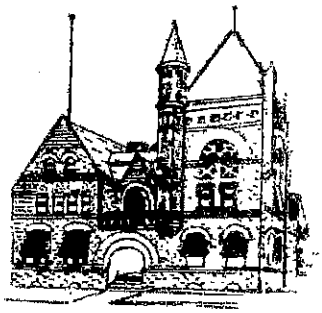
Sincerely,

Michael J. Freda
First Selectman

MJF/vg

Office of the Mayor

City of West Haven
355 Main Street
West Haven, Connecticut 06516



City Hall
1896 - 1968

John M. Picard
Mayor

RECEIVED
DEC 5 - 2011
Marna P. Borgstrom
President & CEO

RECEIVED
JUN - 1 2012
OFFICE OF HEALTH CARE ACCESS

November 2011

Dear Marna and Chris:

I would like to express my support for the proposal to integrate Yale-New Haven Hospital and the Hospital of Saint Raphael. As you know, we have a longstanding relationship with Yale-New Haven and the Hospital of Saint Raphael. Each has served the citizens of West Haven in a very responsive manner.

Over the years, I have been impressed by the efforts of the hospitals to reach out and serve our communities. Under the proposed integration, I fully believe that access and quality would be continued in an even more efficient manner for the benefit of their patients.

We are proud of being home to the new scientific research campus of Yale University and we are encouraged by the promise of this plan because I believe it will allow patients to receive better access to the discoveries that will occur in our region. I fully support the proposal of Yale-New Haven Hospital to acquire the assets of the Hospital of Saint Raphael and wholeheartedly endorse its approval.

Sincerely,

John Picard
Mayor

SCRCOG
SOUTH CENTRAL REGIONAL COUNCIL OF GOVERNMENTS
Planning for Our Region's Future

RECEIVED
JUN - 1 2012
OFFICE OF HEALTH CARE ACCESS

Bethany Branford East Haven Guilford Hamden Madison Meriden Milford
New Haven North Branford North Haven Orange Wallingford West Haven Woodbridge

Carl J. Amento, Executive Director

Resolution Supporting the Merger of Yale New Haven Hospital and the Hospital of Saint Raphael

WHEREAS: The mayors and first selectmen of the 15 cities and towns of the region have determined that the merger of Yale New Haven Hospital and the Hospital of St. Raphael will be beneficial to the citizens of the region.

NOW, THEREFORE, BE IT RESOLVED by the South Central Regional Council of Governments that:
The South Central Regional Council of Governments hereby supports the merger of Yale New Haven Hospital and the Hospital of St. Raphael.

Certificate:

The undersigned duly qualified and acting Secretary of the South Central Regional Council of Governments certifies that the foregoing is a true and correct copy of a resolution adopted at a legally convened meeting of the South Central Regional Council of Governments on April 25, 2010.

Date: April 25, 2012

by: _____
Scott Jackson, Secretary
South Central Regional Council of Governments

127 Washington Avenue, 4th Floor West, North Haven, CT 06473

www.scrcog.org T (203) 234-7555 F (203) 234-9850 camento@scrcog.org

We Will Only Accept Deliveries from UNION Carriers! All Other Deliveries Will Be Refused!

RECEIVED
JUN – 1 2012
OFFICE OF
HEALTH CARE ACCESS

CHAUFFEURS, TEAMSTERS, WAREHOUSEMEN AND HELPERS
LOCAL 443
AFFILIATED WITH THE INTERNATIONAL BROTHERHOOD OF TEAMSTERS

ROBERT E. BAYUSIK
Secretary-Treasurer / Principal Officer

DANIEL J. FLANAGAN
President and Business Representative

200 Wallace Street
P.O. Box 1710
New Haven, Connecticut 06507

Phone (203) 624-5185
Toll Free No. 1-888-JOIN-443
Fax (203) 624-0145

February 28, 2012

Marna Borgstrom
President and CEO
Yale - New Haven Hospital, Yale - New Haven Health System
20 York Street
New Haven, CT 06510-3202

Dear Mrs. Borgstrom,

The Teamsters are pleased to support the Saint Raphael Healthcare System / Yale - New Haven Hospital Definitive Agreement. As you know, we represent approximately 1,200 Saint Raphael employees which is about a third of its workforce. We are also pleased that the proposed integration would save jobs and provide employment stability to the Saint Raphael workforce and that Yale-New Haven Hospital has agreed to recognize Teamsters Local 443 as the collective bargaining representative for the Hospital of Saint Raphael and Grimes Center union employees.

More importantly, the Teamsters, who represent approximately 15,000 members in the state of Connecticut, are confident that the integration of Saint Raphael's and Yale-New Haven Hospital would result in a coordinated, streamlined healthcare system while also improving access and reducing overall healthcare costs. Although our Saint Raphael members have primarily utilized Saint Raphael services, they, along with our other Teamster members, would still have the option of receiving care on the Saint Raphael campus that is provided consistent with Catholic teaching, or they can receive care at other Catholic or secular hospitals in Connecticut.

We have had a productive and collegial working relationship with Saint Raphael's, and we look forward to the opportunity to work closely with Yale - New Haven Hospital management. We commend you on this exciting venture-we believe it is a positive step to ensure Saint Raphael's future and the future of its employees and their families. We look forward to our ongoing collaboration and urge approval of the Saint Raphael / Yale - New Haven Hospital Definitive Agreement.

Very truly yours,

Robert E. Bayusik
Secretary-Treasurer / Principal Officer
Teamsters Local 443

CC: Christopher O'Connor - President and CEO, Hospital of Saint Raphael
Elizabeth Conrad - Vice President, Human Resource, Hospital of Saint Raphael

REB/jmd

CURE

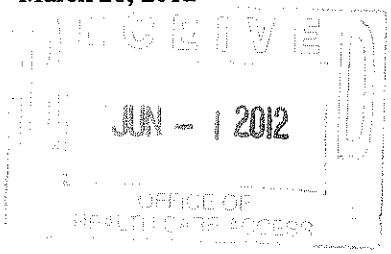
Connecticut United for Research Excellence, Inc.

RECEIVED

APR - 3 2012

Marna P. Borgstrom
President & CEO

March 28, 2012



Ms. Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Re: Integrating Yale New Haven Hospital and the Hospital of Saint Raphael

Dear Marna:

I would like to express our strong support for the proposal to integrate Yale-New Haven Hospital (YNHH) and the Hospital of Saint Raphael (HSR). As an association dedicated to the advancement of the biotech industry, we recognize the value of both hospitals and firmly believe that the acquisition provides a unique opportunity to strengthen the State's growing biotech industry.

With YNHH facing significant capacity issues, the need for additional clinical space is critical to meet patient needs and to fortify an important clinical research endeavor. From a patient's perspective, the acquisition will provide enhanced quality, improved access and do so in the most efficient and effective manner.

We strongly believe that there is a clear opportunity to position Connecticut as a national biotech center. Yale-New Haven Hospital has established itself as a destination hospital with the Smilow Cancer Hospital and Yale University is pushing forward the frontiers of scientific research on its new West Haven campus. The creation of an efficient, two-campus hospital that provides the capacity necessary to deliver innovative translational research at the bedside makes sense for the community and will serve as a catalyst for future biotech development in the State. As a result, we believe this integration is critically important and we strongly seek its approval.

Please do not hesitate to contact me with any questions, for more information or to amplify any of the points made above.

Sincerely,

Paul R. Pescatello
President/CEO

c: Peter R. Farina, Ph.D., CURE Co-Chair
David Keiser, CURE Co-Chair

THE CHAPIN & BANGS COMPANY

FOUNDED 1888
INCORPORATED 1902

165 RIVER ST.
BRIDGEPORT, CT 06604
TEL: (203) 333-4183
(800) 972-9615
FAX: (203) 334-8538

RECEIVED
JUN - 1 2012
OFFICE OF
HEALTH CARE ACCESS

February 7, 2012

Marna P. Borgstrom
President & CEO
Yale New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna,

I am writing to express my appreciation and strong support for your acquisition of the Hospital of Saint Raphael. Your courage and vision are needed at a time when our Nation's health care system faces tremendous challenges. The needs are great and growing and the costs are clearly not sustainable. The combination of the two hospitals will provide needed access for surrounding communities, synergies and cost savings and with Yale's leadership, continuing improvement in patient care and outcomes.

Changes are needed and this new partnership can start us down a road to establish a system that provides quality care and prevention at a cost that America can afford.

Thank you,

Dick

Richard M. Hoyt
President & CEO
The Chapin & Bangs Co.

RECEIVED
FEB - 9 2012
Marna P. Borgstrom
President & CEO

Jeffrey A. Klaus
Regional President

Webster Bank, N.A.
80 Elm Street
New Haven, CT 06510
Business 203.782.4529
Cell 203.233.9803
Fax 203.782.4577
jklaus@websterbank.com
WebsterOnline.com

WebsterBank

RECEIVED
FEB - 6 2012
Marna P. Borgstrom
President & CEO

February 2, 2012

RECEIVED
JUN - 1 2012
OFFICE OF

Ms. Marna P. Borgstrom
President and CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna:

I would like to express my strong support for the proposal to integrate Yale-New Haven Hospital (YNHH) and the Hospital of Saint Raphael (HSR). As a major employer in New Haven and throughout the state of Connecticut, our employees have come to count on the high quality and accessible care provided by Yale-New Haven and the Hospital of Saint Raphael. The integration of YNHH with the HSR provides a unique opportunity to carry forward that quality and access in a new, more cost efficient manner.

Webster Bank has a strong tradition of service in Connecticut. It is a trait that we share with both Yale-New Haven and the Hospital of Saint Raphael. As you know, the financial industry has long been served by the efficiencies of combining operations for the benefit of our customers. Similarly, this transaction makes sense because it provides the opportunity to strip out duplicative and costly capital and programmatic investments.

We seek value in all that we do. We are encouraged that both hospitals are doing the same through creativity and innovation. As a result, we fully support Yale-New Haven Hospital's proposal to acquire the assets of the Hospital of Saint Raphael.

Sincerely,

Jeffrey A. Klaus
Regional President

RECEIVED
MAR 2 1 2012
Marna P. Borgstrom
President & CEO

MATT GATTUSO
PRESIDENT, GLOBAL HEALTH SYSTEMS

COVIDIEN

March 2012

RECEIVED
JUN – 1 2012
OFFICE OF

Ms. Marna P. Borgstrom
Chief Executive Officer
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna:

On behalf of Covidien and its 41,000 employees, we are proud to lend our support to the proposal to integrate Yale-New Haven Hospital and the Hospital of Saint Raphael. As a partner, supplier and major employer in the State of Connecticut, we understand the significant pressures on hospitals and healthcare systems to provide high quality care in the most efficient manner possible. We believe the approach being outlined by this acquisition will provide the opportunity to fulfill these important goals.

The transaction offers a unique opportunity to coordinate care for patients throughout the state of Connecticut. As Yale-New Haven Hospital experiences significant capacity constraints and the Hospital of Saint Raphael faces historic economic challenges, the proposal allows for a cost-effective way to expand capacity and establish financial stability, preserving access for thousands of patients who seek medical services from these hospitals every year. As an employer the importance of finding innovative approaches to drive down cost is vital and we understand that this integration will achieve this by reducing redundancy and better coordinating care.

We look forward to working with a newly integrated Yale-New Haven Hospital in the future and we offer our support for your efforts to ensure this transaction is approved.

Sincerely,

Matt Gattuso
President, Global Health Systems

15 HAMPSHIRE STREET
MANSFIELD, MA
02048

508-452-4845 [T]
508-261-8562 [F]

GREATER NEW HAVEN
Chamber *of* Commerce

Bethany Branford Cheshire East Haven Guilford Hamden Milford New Haven North Branford North Haven Orange Wallingford West Haven Woodbridge

November 21, 2011

RECEIVED
JUN – 1 2012

Marna P. Borgstrom
President & CEO
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510

Dear Marna:

On behalf of the Greater New Haven Chamber of Commerce, which represents more than 2000 businesses in our region, I am writing to support the proposal to integrate the Hospital of Saint Raphael and Yale-New Haven Hospital. The proposed acquisition by Yale-New Haven Hospital provides a unique opportunity to transform the delivery of high quality healthcare to employees of companies in our region in the most cost effective manner possible.

We recognize the enormous pressure on hospitals in Connecticut and across the nation. These pressures require creative and innovative solutions. We believe this proposal is exactly the right approach. These two exceptional hospitals will be able to find greater efficiencies in the delivery system if the acquisition is approved. The opportunity to drive down costs through program integration and capital avoidance is critically important in this economy and that is why we are so supportive of this initiative.

Additionally, healthcare represents a significant part of the Greater New Haven economy and we believe that addressing the financial needs of the Hospital of Saint Raphael along with the capacity needs of Yale-New Haven Hospital will position the unified hospital for long-term growth.

We enthusiastically endorse the proposal for Yale-New Haven Hospital to acquire the Hospital of Saint Raphael.

Sincerely,

Anthony P. Rescigno

Anthony Rescigno
President
Greater New Haven Chamber of Commerce

RECEIVED
NOV 23 2011
Marna P. Borgstrom
President & CEO

900 Chapel Street 10th Floor New Haven, Connecticut 06510-2811 Tel: (203) 787-6735 Fax: (203) 782-4329
info@gnhcc.com www.gnhcc.com

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2941
RECIPIENT ADDRESS	912034591601
DESTINATION ID	
ST. TIME	06/01 14:37
TIME USE	01'53
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KAREN BANOFF

FAX: 203-459-1601

AGENCY: KMB CONSULTING

FROM: KIMBERLY MARTONE

DATE: 6/1/12 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

Attached is information regarding Tuesday's hearing for DN 12-31747. Please contact Kimberly Martone at (860-418-7029 with any questions

PLEASE PHONE Barbara Olejarz IF THERE ARE ANY TRANSMISSION

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Tentative Agenda

PUBLIC HEARING

Certificate of Need Application, Docket Number 12-31747

Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Gateway Community College, Room 160
60 Sargent Drive, New Haven, Connecticut

June 5, 2012, at 10:00 am

10:00 Convening of the Public Hearing

10:05 Applicant's Presentation of the CON Proposal

11:00 OHCA's Questions

12:00 Lunch Break

1:00 Public Testimony ***(each person will be limited to 3 minutes)***

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael**

DOCKET NUMBER: **12-31747-CON**

PUBLIC HEARING: **June 5, 2012 at 10:00 a.m.**

PLACE: **Gateway Community College, Room 160**
60 Sargent Drive, New Haven, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicants dated February 1, 2012, enclosing the Certificate of Need ("CON") application under Docket Number 12-31747, received by the Office of Health Care Access ("OHCA") on February 9, 2012.
B	Letter of support dated February 16, 2012 from members of the legislator in the matter of the CON application under Docket Number 12-31747, received by OHCA on February 16, 2012.
C	Verification of posting on OHCA's website of receipt of the CON application in the matter of the CON application under Docket Number 12-31747 dated March 13, 2012.
D	OHCA's letter to the Applicants dated March 8, 2012, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31747.
E	Letter in opposition dated March 2012 from the Committee to Preserve an Independent Hospital of St. Raphel in the matter of the CON application under Docket Number 12-31747, received by OHCA on March 21, 2012.
F	Applicants' responses to OHCA's letter of March 8, 2012, dated April 12, 2012, in the matter of the CON application under Docket Number 12-31747, received by OHCA on April 12, 2012.
G	OHCA's letter to the Applicants dated May 9, 2012, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31747.

H	Applicants' responses to OHCA's letter of May 9, 2012, dated May 11, 2012, in the matter of the CON application under Docket Number 12-31747, received by OHCA on May 11, 2012. Hardcopy received May 14, 2012.
I	OHCA's letter to the Applicants dated May 14, 2012 informing them that the application has been deemed complete in the matter of the CON application under docket Number 12-31747.
J	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for June 5, 2012, in the matter of the CON application under Docket Number 12-31747, dated May 16, 2012.
K	Designation letter, dated May 22, 2012, designating Attorney Joanne V. Yandow as hearing officer in the matter of the CON application under Docket Number 12-31747.
L	OHCA's letter to the Applicants dated May 24, 2012, requesting prefile testimony in the matter of the CON application under Docket Number 12-31747.
M	Letter from the Applicants enclosing Prefile Testimony dated June 1, 2012 in the matter of the CON application under Docket Number 12-31747, received by OHCA on June 1, 2012.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

JUNE 5, 2012
PUBLIC COMMENT

Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

INFORMATIONAL SHEET FOR PERSONS SIGNING UP TO SPEAK FROM THE GENERAL PUBLIC

Any and all persons are welcome to make a comment on the record at the public hearing for Docket Number 12-31747-CON. All those who wish to speak must sign up prior to speaking.

- Please make sure you have signed up on OHCA's Sign-Up Sheet for the General Public.
- Please only sign up for yourself.
- Those individuals who have signed up to speak will be called in the order they appear on the sign-up sheet.
- Your comments should be your own personal opinion.
- Your comments should be limited to **three (3) minutes** or less.
- If you do not wish to speak on the record and would instead like to submit a written comment by mail please do so at your earliest convenience. Such written comments are part of OHCA's administrative record in this matter and have the same weight as all verbal comments made at the hearing. Please address your comments to:

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

- **Agenda for this Proceeding**:
  - Convening of the Proceeding
  - Summary by the Applicant
  - OHCA Questions
  - Comments from the Public Officials and General Public
  - Public Hearing Recessed

WIGGIN AND DANA

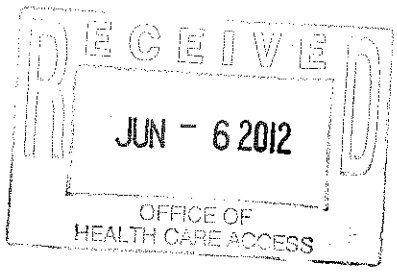
Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Rebecca A. Matthews
203.498.4502
203.782.2889 fax
rmatthews@wiggin.com

353

June 6, 2012



VIA HAND DELIVERY

Joanne Yandow, Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P. O. Box 340308
Hartford, CT 06134

Re: Certificate of Need Application; Docket Number 12-31747-CON Proposal for Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and Hospital of Saint Raphael

Dear Ms. Yandow:

On behalf of Yale-New Haven Hospital, the Saint Raphael Healthcare System, Inc. and the Hospital of Saint Raphael (the "Applicants"), we thank you for your time yesterday and careful consideration of this important proposal.

As requested at yesterday's public hearing, we hereby submit an original and six (6) copies of the financial statements as of April 30, 2012 of each of Yale-New Haven Hospital and the Hospital of Saint Raphael as a late-file exhibit in the proceeding.

Sincerely,

Rebecca A. Matthews

cc: Lisa Davis, MBA, BSN, RN, Deputy Commissioner, Department of Public Health, Office of Health Care Access
Kimberly Martone, Director of Operations, Office of Health Care Access
William J. Aseltyne, Esq., General Counsel, Yale-New Haven Hospital
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael

Yale-New Haven Hospital
Statement of Revenue and Expenses
April 30, 2012 (Month)
$ in thousands

	FY 2012		Bud vs Act		FY 2011	Act vs Act	
	Budget	Actual	Over (Under)	%	Actual	Over (Under)	%
Net Revenue -							
I/P Net Patient Revenue	$ 81,431	$ 80,701	$ (730)		$ 76,923	$ 3,778	
O/P Net Patient Revenue	57,816	61,645	3,829		42,982	18,663	
Total Net Patient Revenue	139,247	142,346	3,099		119,905	22,441	
Other Operating Revenue	3,448	3,571	123		3,583	(12)	
Total Revenue	142,695	145,917	3,222	2.3%	123,488	22,429	18.2%
Expenses:							
Salaries and benefits	62,853	60,460	(2,393)		56,363	4,097	
Supplies and other expenses	60,355	59,963	(392)		51,752	8,211	
Depreciation	6,177	6,036	(141)		5,670	366	
Insurance, Bad debts & Interest	6,126	5,861	(265)		4,964	897	
Total Expenses	135,511	132,320	(3,191)	-2.4%	118,749	13,571	11.4%
Operating Gain	7,184	13,597	6,413		4,739	8,858	
Non-operating (loss) gains	2,083	(3,856)	(5,939)		11,274	(15,130)	
Net Gain/(Loss)	$ 9,267	$ 9,741	$ 474		$ 16,013	$ (6,272)	

YALE-NEW HAVEN HOSPITAL

Yale-New Haven Hospital
Statement of Revenue and Expenses
April 30, 2012 (Year to Date)
$ in thousands

	FY 2012		Bud vs Act		FY 2011	Act vs Act	
	Budget	Actual	Over (Under)	%	Actual	Over (Under)	%
Net Revenue -							
I/P Net Patient Revenue	$ 570,800	$ 581,794	$ 10,994		$ 526,914	$ 54,880	
O/P Net Patient Revenue	358,407	374,316	15,909		292,421	81,895	
Total Net Patient Revenue	929,207	956,110	26,903		819,335	136,775	
Other Operating Revenue	23,535	24,436	901		25,319	(883)	
Total Revenue	952,742	980,546	27,804	2.9%	844,654	135,892	16.1%
Expenses:							
Salaries and benefits	435,434	430,330	(5,104)		392,785	37,545	
Supplies and other expenses	401,637	413,033	11,396		355,011	58,022	
Depreciation	43,241	42,497	(744)		39,518	2,979	
Insurance, Bad debts & Interest	41,269	38,525	(2,744)		34,689	3,836	
Total Expenses	921,581	924,385	2,804	0.3%	822,003	102,382	12.5%
Operating Gain	31,161	56,161	25,000		22,651	33,510	
Non-operating (loss) gains	14,583	23,410	8,827		48,570	(25,160)	
Net Gain/(Loss)	$ 45,744	$ 79,571	$ 33,827		$ 71,221	$ 8,350	

YALE-NEW HAVEN HOSPITAL

Yale-New Haven Hospital
Assets
As of April 30, 2012 and September 30, 2011

Long-term investments		
Deferred financing costs		
Other assets		
Property, plant and equipment:		
Land and land improvements	**20,464**	19,467
Buildings and fixtures	**964,201**	952,346
Equipment	**397,117**	419,565
	1,381,782	1,391,378
Less accumulated depreciation	**575,396**	566,850
	806,386	824,528
Construction in progress	**74,864**	43,207
	881,250	867,735
Total assets	**$ 2,118,743**	$ 2,061,160

Yale-New Haven Hospital, Inc.
Liabilities and Net Assets
As of April 30, 2012 and September 30, 2011

	(in thousands) April 30 2012	September 30 2011
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 97,561	$ 99,381
Accrued expenses	117,955	120,959
Other liabilities	19,093	17,361
Current portion of long-term debt	18,185	10,185
Short-term capital lease obligation (Lot E - $851; Park Street - $1,429)	2,280	2,862
Total current liabilities	255,074	250,748
Long-term debt, less current portion	500,524	509,022
Long-term capital lease obligation (Lot E - $53,605; Park Street - $52,858)	106,463	107,529
Accrued pension and postretirement benefit obligations	229,172	240,901
Other long-term liabilities	230,633	230,552
Deferred revenue	47,332	48,321
Total liabilities	1,369,198	1,387,073
Net assets:		
Unrestricted	681,121	604,617
Temporarily restricted	41,694	43,947
Permanently restricted	26,730	25,523
Total net assets	749,545	674,087
Total liabilities and net assets	$ 2,118,743	$ 2,061,160

Yale-New Haven Hospital
Statement of Changes in Net Assets
Seven Months ended April 30, 2012 and 2011
(in thousands)

	FY 2012	FY 2011
Unrestricted Net Assets April 30		
Excess Revenue over Expenses	$ 79,571	$ 71,221
Transfer to Yale-New Haven Health Services Corporation-Clinical Development Fund	(4,500)	(6,000)
Transfer from Yale-New Haven Network Corporation	-	250
Transfer from Yale-New Haven Health Services Corporation for Fixed Assets	1,692	1,450
Funding for Yale-New Haven Hospital NEMG Community Practice	(650)	-
Transfer from Temporary Restricted Net Assets for Plant Assets	142	155
Transfer from Temporary Restricted Net Assets for Smilow	-	464
Contributions to Endowments	251	187
Increase in Unrestricted Net Assets	76,606	67,727
Temporarily Restricted Net Assets April 30		
Income from Investments	239	331
Realized Gains on Investments	58	1,601
Change in Unrealized Gains and Losses on Investments	5,526	5,145
Bequests, Contributions, and Grants	1,585	1,564
Net Assets Released from Restriction for Plant Assets	(142)	(464)
Net Assets Released from Restriction for Free Care	(234)	(393)
Net Assets Released from Restriction for operations	(1,800)	(2,363)
Net Assets Released from Restriction for clinical programs	(7,487)	(9,645)
Decrease in Temporarily Restricted Net Assets	(2,255)	(4,224)
Permanently Restricted Net Assets April 30		
Change in beneficial interest in perpetual trust	1,207	794
Increase in Permanently Restricted Net Assets	1,207	794
Total Increase in Net Assets	75,458	64,297
Net Assets at beginning of year	674,087	642,312
Net Assets at end of year	$ 749,545	$ 706,609

Yale-New Haven Hospital
Statements of Cash Flow
(in thousands)

	Year to Date Period Ended	
	April 30 2012	September 30 2011
Cash Flow From Operating Activities		
Increase in net assets	$ 75,458	$ 31,775
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	42,497	67,948
Net realized and change in net unrealized gains and losses on investments	(45,109)	(21,801)
Change in fair value of interest rate swap	428	(4,444)
Amortization of long-term debt premium	(498)	(885)
Amortization of deferred financing cost	148	317
Bad Debt	19,404	26,390
Change in perpetual trusts	(1,207)	733
Transfer to Yale-New Haven Health Services Corporation-Clinical Development Fund	4,500	12,000
Transfers from Yale-New Haven Health Services Corporation	-	(2,900)
Transfer from YNH Network Corporation	-	(6,250)
Bequests, contributions and grants, net of pledges	(1,303)	(16,941)
Pension and other postretirement liability adjustments	-	28,727
Changes in operating assets and liabilities:		
Accounts receivable, net	(37,867)	(58,328)
Other receivables	(16,246)	(20,152)
Other assets	(15,636)	(56,621)
Accounts payable	(1,820)	(1,597)
Accrued expenses	(3,004)	12,574
Other liabilities	(11,279)	37,987
Net cash provided by operating activities	8,466	28,532
Investing Activities		
Acquisitions of property, plant and equipment	(58,202)	(79,667)
Capitalized Interest	2,190	3,054
Net change in investments	(8,867)	(27,189)
Amounts deposited with trustee in debt service fund	(7,390)	(1,696)
Assets whose use is limited	25,664	(65,079)
Transfer to Yale-New Haven Health Services Corporation-Clinical Development Fund	(4,500)	(12,000)
Transfers from Yale-New Haven Health Services Corporation	-	2,900
Transfer from YNH Network Corporation	-	6,250
Net cash used in investing activities	(51,105)	(173,427)
Financing Activities		
Proceeds from long-term debt	-	145,436
Repayments of long-term debt	-	(13,577)
Deferred financing costs	-	(1,956)
Payments on capital lease obligations	(1,648)	(2,622)
Bequests, contributions and grants, net of pledges	1,303	16,941
Net cash (used in) provided by financing activities	(345)	144,222
Net decrease in cash and cash equivalents	(42,984)	(673)
Cash and cash equivalents at beginning of the year	65,883	66,556
Cash and cash equivalents end of period	$ 22,899	$ 65,883

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.
CONSOLIDATED NET INCOME (LOSS) BY ENTITY
FOR THE SEVEN MONTHS ENDED APRIL 30, 2012

(Dollars in 000's)

Month-to-Date				
Ongoing Operations	Budget	Variance Fav(Unfav)		
[A]	[B]	[A]-[B]=[C]		
$ (1,325)	$ 21	$ (1,346)	Hospital of Saint Raphael	
39	-	39	Lukan Indemnity Company, Ltd.	
(45)	-	(45)	Caritas Insurance Company, Ltd.	
(1,331)	21	(1,352)	Consolidated Hospital	
(122)	(197)	75	SR Affiliated Physicians	
(10)	(6)	(4)	Auxiliary	
(150)	(155)	5	SAVG Health Center	
(83)	(50)	(33)	Saint Raphael Foundation **	
(12)	(12)	-	Parent DePaul}	
14	(21)	35	Dialysis Venture}	
258	83	175	MRI Venture}	
(2)	-	(2)	VNA Services}	
258	50	208	DePaul Health Services Corp.}	
-	-	-	Xavier Services Corporation	
(19)	(18)	(1)	SRHS Parent	
$(1,457)	**$ (355)**	**$(1,102)**	***Consolidated SRHS operations***	
Other Items				
125	-	125	Unrealized chg in mkt value- investments	
$(1,332)	**$ (355)**	**$ (977)**	***Consolidated SRHS***	
$ 742	$ 146	$ (596)	POTENTIAL AFFILIATION costs included above	
			** Note: Foundation restricted net income not included above of.....	
$ 53	$ 3		Restricted gifts & bequests	
(16)	42		Restricted realized & unrealized gains (losses)	
$ 37	$ 45	$ (8)	TOTAL	

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.
CONSOLIDATED NET INCOME (LOSS) BY ENTITY
FOR THE SEVEN MONTHS ENDED APRIL 30, 2012

(Dollars in 000's)

	Year-to-Date			Prior Year
	Ongoing Operations	Budget	Variance Fav(Unfav)	Ongoing Operations
	[A]	[B]	[A]-[B]=[C]	
Hospital of Saint Raphael	$ (665)	$ 5,950	$ (6,615)	$ 808
Lukan Indemnity Company, Ltd.	550	(1)	551	259
Caritas Insurance Company, Ltd.	(219)	1	(220)	(180)
Consolidated Hospital	(334)	5,950	(6,284)	887
SR Affiliated Physicians	(1,848)	(1,734)	(114)	562
Auxiliary	(43)	(42)	(1)	(55)
SAVG Health Center	(1,044)	(946)	(98)	(932)
Saint Raphael Foundation **	(241)	(312)	71	(165)
Parent DePaul}	(84)	(84)	-	(61)
Dialysis Venture}	(174)	(149)	(25)	(85)
MRI Venture}	841	583	258	562
VNA Services}	145	-	145	(145)
DePaul Health Services Corp.}	728	350	378	271
Xavier Services Corporation	-	-	-	-
SRHS Parent	68	(124)	192	(112)
Consolidated SRHS operations	**$ (2,714)**	**$ 3,142**	**$ (5,856)**	**$ 456**
	Other Items			Other Items
Unrealized chg in mkt value- investments	2,824	-	2,824	1,667
Consolidated SRHS	**$ 110**	**$ 3,142**	**$ (3,032)**	**$ 2,123**
POTENTIAL AFFILIATION costs included above	$ 2,569	$ 1,021	$ (1,548)	

** Note: Foundation restricted net income not included above of.....

Restricted gifts & bequests	$ 598	$ 531	
Restricted realized & unrealized gains (losses)	1,905	292	
TOTAL	$ 2,503	$ 823	$ 1,680

Saint Raphael Healthcare System, Inc. and Subsidiaries
Consolidated Statement of Operations
For the seven months ended April 30, 2012
(Dollars in 000's)

Line #		Actual [A]	Budget [B]	Fav(Unfav) Variance [C]	Line #
	Revenues				
501	Net patient service revenues	$ 275,503	$ 284,919	$ (9,416)	501
502	Other revenues	13,478	13,222	256	502
503	Net assets released from restrictions	3,491	3,491	-	503
504	Total unrestricted revenues	292,472	301,632	(9,160)	504
	Expenses				
505	Salaries and wages	143,383	143,575	192	505
506	Fringe benefits	35,068	32,965	(2,103)	506
507	Professional Fees	24,350	27,760	3,410	507
508	Staff Replacement	1,834	1,643	(191)	508
509	Supplies and other nonsalary costs	71,826	75,031	3,205	509
510	Hospital Malpractice	2,376	3,876	1,500	510
511	Hospital Worker Compensation	2,943	2,213	(730)	511
512	Depreciation and amortization	8,553	8,595	42	512
513	Interest	1,627	2,143	516	513
514	Total operating expenses	291,960	297,801	5,841	514
515	Operating gain (loss)- ***before one-time costs***	512	3,831	(3,319)	515
516	Affiliation costs	2,569	1,021	(1,548)	516
517	Severance costs	1,508	-	(1,508)	517
518	Operating gain (loss)- ***after one-time costs***	(3,565)	2,810	(6,375)	518
519	Non-operating gains (losses), net	851	332	519	519
520	Net income (loss) before change in unrealized appreciation (depreciation) of investments	(2,714)	3,142	(5,856)	520
521	*Unrealized* change in appreciation (depreciation) of investments	2,824	-	2,824	521
522	**Net income (loss)**	**$ 110**	**$ 3,142**	**$ (3,032)**	522
523	Net income (loss) before one time costs	$ 4,187	$ 4,163	$ 24	523

Saint Raphael Healthcare System, Inc. and Subsidiaries

Consolidated Statements of Operations

For the seven months ended April 30, 2012 and April 30, 2011

(Dollars in 000's)

Line #		4/30/12 [A]	4/30/11 [B]	Increase (Decrease) Change [C]	Line #
	Revenues				
601	Net patient service revenues	$ 275,503	$ 272,575	$ 2,928	601
602	Other revenues	13,478	12,874	604	602
603	Net assets released from restrictions	3,491	2,543	948	603
604	Total unrestricted revenues	292,472	287,992	4,480	604
	Expenses				
605	Salaries and wages	143,383	140,872	2,511	605
606	Fringe benefits	35,068	31,517	3,551	606
607	Professional Fees	24,350	24,874	(524)	607
608	Staff Replacement	1,834	889	945	608
609	Supplies and other nonsalary costs	71,826	71,828	(2)	609
610	Hospital Malpractice	2,376	4,401	(2,025)	610
611	Hospital Worker Compensation	2,943	2,107	836	611
612	Depreciation and amortization	8,553	7,956	597	612
613	Interest	1,627	1,694	(67)	613
614	Total operating expenses	291,960	286,138	5,822	614
615	Operating gain (loss)- ***before one-time costs***	512	1,854	(1,342)	615
616	Affiliation costs	2,569	1,681	888	616
617	Severance costs	1,508	149	1,359	617
618	Operating gain (loss)- ***after one-time costs***	(3,565)	24	(3,589)	618
619	Non-operating gains (losses), net	851	432	419	619
620	Net income (loss) before change in unrealized appreciation (depreciation) of investments	(2,714)	456	(3,170)	620
621	*Unrealized* change in appreciation (depreciation) of investments	2,824	1,667	1,157	621
622	**Net income (loss)**	**$ 110**	**$ 2,123**	**$ (2,013)**	622
623	Net income (loss) before one time costs	$ 4,187	$ 3,953	$ 234	623

Saint Raphael Healthcare System, Inc. and Subsidiaries
Consolidated Balance Sheets
As of April 30, 2012 and September 30, 2011
(Dollars in 000's)

Line #			4/30/12 [A]	9/30/11 [B]		Line #
	Assets					
701	Cash	23.5	$ 27,655	$ 33,763	28.1	701
702	Short term investments		2,332	1,157		702
703	Patient receivables, net		47,522	45,453		703
704	Due from third-party payers		8,546	6,665		704
705	Other receivables		3,157	3,483		705
706	Inventory		7,213	7,466		706
707	Current portion assets limited to use		3,241	1,206		707
708	Other current assets		6 6	241		708
709	Due from affiliates		-	-		709
710	Total current assets		100,322	99,434		710
711	Long term investments		1,765	2,204		711
712	Assets limited to use:					712
713	Tax-exempt bonds		9,620	7,585		713
714	Self-insurance liabilities		7,272	7,504		714
715	Other		90,218	81,861		715
716	Less current portion		(3,241)	(1,206)		716
717			103,869	95,744		717
718	Property & Equipment, net		95,602	96,935		718
719	Other long-term assets (incld due from 3rd parties)		20,837	21,830		719
720	Total assets		**$ 322,395**	**$ 316,147**		720
	Liabilities and Net Assets					
721	Current portion of long-term debt		$ 5,321	$ 5,261		721
722	Long-term debt classified as payable in one year		68,085	68,776		722
723	Current portion postretirement benefits		1,700	1,700		723
724	Interest payable		428	314		724
725	Payables and accruals	49.5	61,700	58,534	50.5	725
726	Due to third-party payers		1,572	4,864		726
727	Due to affiliates		-	-		727
728	Total current liabilities		138,806	139,449		728
729	Self-insurance		6,965	6,981		729
730	Long-term debt, net of short term portion		-	661		730
731	Postretirement benefits		143,444	140,965		731
732	Other long-term liabilities (incld due to 3rd parties)		55,841	53,010		732
733	Total liabilities		345,056	341,066		733
734	Net assets		(22,661)	(24,919)		734
735	Total liabilities and net assets		**$ 322,395**	**$ 316,147**		735

Saint Raphael Healthcare System, Inc. and Subsidiaries
Consolidated Statements of Cash Flows
For the seven months ended April 30, 2012 and year ended September 30, 2011
(Dollars in 000's)

Line #		4/30/12 [A]	9/30/11 [B]	Line #
	Cash flows from operating activities:			
801	Change in NET ASSETS	$ 2,258	$ (25,102)	801
	Adjustments to reconcile to cash			
802	provided by (used in) operations			802
	Non-Cash items:			
803	Depreciation	8,553	14,006	803
804	Change in mkt value investments	(4,997)	(981)	804
805	Restricted gifts	(2,695)	(5,697)	805
806	Restricted investment income	(222)	73	806
807	Post-retirement benefits	-	27,208	807
808	Nonoperating (income) loss, net	(851)	(654)	808
	Changes in operating assets/liabilities			
	Decrease (increase) in:			
809	Patient care receivables	(2,069)	3,543	809
810	Other receivables	(1,555)	(424)	810
811	Other assets	(1,204)	1,609	811
	Increase (decrease) in:			
812	Payables and accruals	(12)	5,084	812
813	Estimated WC liabilities	(16)	552	813
814	Post retirement liabilities	2,479	1,231	814
815	Other long-term liabilities	2,831	3,066	815
816	Net cash provided by (used in) operations	2,500	23,514	816
	Cash flows from investing activities:			
817	(Increase) decrease in investments	(736)	1,141	817
818	(Increase) decrease in assets LTU	(3,128)	(109)	818
819	Nonoperating income (loss), net	851	654	819
820	Restricted investment income	222	(73)	820
821	Capital expenditures, net	(7,220)	(10,187)	821
822	Net cash provided by (used in) investing	(10,011)	(8,574)	822
	Cash flows from financing activities:			
823	Restricted gifts	2,695	5,697	823
824	Principal payments on debt	(1,292)	(5,032)	824
825	Net cash provided by (used in) financing	1,403	665	825
826	Net increase (decrease) in cash & equivalents	(6,108)	15,605	826
827	Cash & equivalents, beginning	33,763	18,158	827
828	Cash & equivalents, ending	**$ 27,655**	**$ 33,763**	828

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 7, 2012

VIA FACSIMILE ONLY

Ms. Jean Ahn
System Director
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 06504

Ms. Terrie Estes
Director of Planning and Business Development
Saint Raphael Healthcare System & Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

RE: Certificate of Need Application; Docket Number: 12-31747-CON
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Closure of the Public Hearing

Dear Ms. Ahn and Ms. Estes:

On June 6, 2012, the Office of Health Care Access ("OHCA") received the information requested by OHCA as late file submissions from the public hearing held in this matter on June 5, 2012. With the receipt of the late file submissions, the hearing on the above application is hereby closed.

If you have any questions regarding this matter, please feel free to contact Steven W. Lazarus at (860) 418-7012.

Sincerely,

Joanne V. Yandow, Esq.
Hearing Officer

JAY:swl

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2946
RECIPIENT ADDRESS	912038675665
DESTINATION ID	
ST. TIME	06/07 09:03
TIME USE	00'37
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Terrie Estes

FAX: (203) 867-5665

AGENCY:

FROM: Steven Lazarus

DATE: 6/7/12 TIME: 8:50 a

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Letter closing the Hearing in the matter of DN. 12-31747 enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2945
RECIPIENT ADDRESS	912036885013
DESTINATION ID	
ST. TIME	06/07 08:58
TIME USE	00'55
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Jean Ahn

FAX: (203) 677-5013

AGENCY:

FROM: Steven Lazarus

DATE: 6/7/12 TIME: 8:50 am

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:
Letter closing Hearing in the matter of DN - 12-31747-CON Enclosed

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	2941
RECIPIENT ADDRESS	912034591601
DESTINATION ID	
ST. TIME	06/01 14:37
TIME USE	01'53
PAGES SENT	5
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KAREN BANOFF

FAX: 203-459-1601

AGENCY: KMB CONSULTING

FROM: KIMBERLY MARTONE

DATE: 6/1/12 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

Attached is information regarding Tuesday's hearing for DN 12-31747. Please contact Kimberly Martone at (860-418-7029 with any questions

PLEASE PHONE Barbara Olejarz IF THERE ARE ANY TRANSMISSION

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: KAREN BANOFF

FAX: 203-459-1601

AGENCY: KMB CONSULTING

FROM: KIMBERLY MARTONE

DATE: 6/1/12 **TIME:**

NUMBER OF PAGES: 5
(including transmittal sheet

Comments:

Attached is information regarding Tuesday's hearing for DN 12-31747. Please contact Kimberly Martone at (860-418-7029 with any questions

PLEASE PHONE Barbara Olejarz IF THERE ARE ANY TRANSMISSION PROBLEMS.

Phone: (860) 418-7001 *Fax: (860) 418-7053*

410 Capitol Ave., MS#13HCA
P.O.Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Tentative Agenda

PUBLIC HEARING

Certificate of Need Application, Docket Number 12-31747

Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Gateway Community College, Room 160
60 Sargent Drive, New Haven, Connecticut

June 5, 2012, at 10:00 am

10:00 Convening of the Public Hearing

10:05 Applicant's Presentation of the CON Proposal

11:00 OHCA's Questions

12:00 Lunch Break

1:00 Public Testimony (*each person will be limited to 3 minutes)*

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: **Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael**

DOCKET NUMBER: **12-31747-CON**

PUBLIC HEARING: **June 5, 2012 at 10:00 a.m.**

PLACE: **Gateway Community College, Room 160**
60 Sargent Drive, New Haven, Connecticut

EXHIBIT	DESCRIPTION
A	Letter from the Applicants dated February 1, 2012, enclosing the Certificate of Need ("CON") application under Docket Number 12-31747, received by the Office of Health Care Access ("OHCA") on February 9, 2012.
B	Letter of support dated February 16, 2012 from members of the legislator in the matter of the CON application under Docket Number 12-31747, received by OHCA on February 16, 2012.
C	Verification of posting on OHCA's website of receipt of the CON application in the matter of the CON application under Docket Number 12-31747 dated March 13, 2012.
D	OHCA's letter to the Applicants dated March 8, 2012, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31747.
E	Letter in opposition dated March 2012 from the Committee to Preserve an Independent Hospital of St. Raphel in the matter of the CON application under Docket Number 12-31747, received by OHCA on March 21, 2012.
F	Applicants' responses to OHCA's letter of March 8, 2012, dated April 12, 2012, in the matter of the CON application under Docket Number 12-31747, received by OHCA on April 12, 2012.
G	OHCA's letter to the Applicants dated May 9, 2012, requesting additional information and/or clarification in the matter of the CON application under Docket Number 12-31747.

H	Applicants' responses to OHCA's letter of May 9, 2012, dated May 11, 2012, in the matter of the CON application under Docket Number 12-31747, received by OHCA on May 11, 2012. Hardcopy received May 14, 2012.
I	OHCA's letter to the Applicants dated May 14, 2012 informing them that the application has been deemed complete in the matter of the CON application under docket Number 12-31747.
J	OHCA's request for legal notification in the *New Haven Register* and OHCA's Notice to the Applicant of the public hearing scheduled for June 5, 2012, in the matter of the CON application under Docket Number 12-31747, dated May 16, 2012.
K	Designation letter, dated May 22, 2012, designating Attorney Joanne V. Yandow as hearing officer in the matter of the CON application under Docket Number 12-31747.
L	OHCA's letter to the Applicants dated May 24, 2012, requesting prefile testimony in the matter of the CON application under Docket Number 12-31747.
M	Letter from the Applicants enclosing Prefile Testimony dated June 1, 2012 in the matter of the CON application under Docket Number 12-31747, received by OHCA on June 1, 2012.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

JUNE 5, 2012
PUBLIC COMMENT

Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

INFORMATIONAL SHEET FOR PERSONS SIGNING UP TO SPEAK FROM THE GENERAL PUBLIC

Any and all persons are welcome to make a comment on the record at the public hearing for Docket Number 12-31747-CON. All those who wish to speak must sign up prior to speaking.

- Please make sure you have signed up on OHCA's Sign-Up Sheet for the General Public.
- Please only sign up for yourself.
- Those individuals who have signed up to speak will be called in the order they appear on the sign-up sheet.
- Your comments should be your own personal opinion.
- Your comments should be limited to **three (3) minutes** or less.
- If you do not wish to speak on the record and would instead like to submit a written comment by mail please do so at your earliest convenience. Such written comments are part of OHCA's administrative record in this matter and have the same weight as all verbal comments made at the hearing. Please address your comments to:

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

- **Agenda for this Proceeding:**
  - Convening of the Proceeding
  - Summary by the Applicant
  - OHCA Questions
  - Comments from the Public Officials and General Public
  - Public Hearing Recessed

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Agenda

PUBLIC HEARING

Certificate of Need Application, Docket Number 12-31747

Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Gateway Community College, Room 160
60 Sargent Drive, New Haven, Connecticut

June 5, 2012, at 10:00 am

10:00 Convening of the Public Hearing

10:05 Applicant's Presentation of the CON Proposal

11:00 OHCA's Questions

12:00 Lunch Break

1:00 Public Testimony (*each person will be limited to 3 minutes)*

An Equal Opportunity Employer
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Toll-Free: 1-800-797-9688
Fax: (860) 418-7053

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Elected Officials sign up sheet

Print Name	Phone	Fax	POSITION HELD
Dr. Alan Kliger			CMO - HSR
John Burke			CIO - HSR
Martha Judd	203 789 3252		Director, Community Gov't Relations - HSR
Terrie Estes			Director, Planning & Business Development - HSR
Pete Duffy			VP / Facilities - HSR
Cindy von Beren	203 789 4133		VP / Corporate Affairs - HSR
Suzanne Lubin Szafranski, Esq	203 789 3336		VP / Legal Services - HSR
Bill Bedye	203-688-8097		SVP - YNHHS
Ed Fisher	203-688-5873		VP INFORMATION TECHNOLOGIES

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Elected Officials sign up sheet

Print Name	Phone	Fax	POSITION HELD
Anthony Rescigno	203-782-4340	203-782-4329	Pres. Chamber of Commerce ✓

PUBLIC HEARING
LEGISLATIVE/MUNICIPAL OFFICIALS
SIGN UP SHEET

JUNE 5, 2012
10:00 a.m.

Applicant: Docket Number: 12-31747-CON
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Print Name	Phone	Fax	POSITION HELD
John Picard	203937-3510		Mayor City of W. Haven

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
public sign up sheet

PRINT NAME	REPRESENTS
TOM DeSTE	CITY YNH

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Elected Officials sign up sheet

Print Name	Phone	Fax	POSITION HELD
Nancy Stroman			Consultant
Karen Banoff			Consultant
Pete Duffy	7893968		HSC
JOHN BURKE	789-3694		HSR

PUBLIC HEARING
APPLICANTS
SIGN UP SHEET

JUNE 5, 2012
10:00 a.m.

Applicant: Docket Number: 12-31747-CON
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

Print Name	Phone	Fax	POSITION HELD
Joe Bisson	203-789-2975		VP/Business Development - HSR
Elizabeth Conrad	203-789-4171		VP/Human Resources - HSR
Jim Rude	203-789-3575		AVP/Finance - Interim CFO - HSR
Mary Kunces	203-789-4032		VP/Patient Services - HSR
Chris O'Connor	203 788-3120		CEO - SRHS + HSR

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Elected Officials sign up sheet

Print Name	Phone	Fax	POSITION HELD
Marna Borgstrom	688-2608		CEO - YNHH
Peter Herbert, MD	688-2606		Chief Medical Officer - YNHH
Richard D'Aquila	688-2606		President - YNHH
Victor Morris, MD	688-2606		Assoc Chief Medical Officer - YNHH
William Gedge			SVP - YNHHS
Brad Bevers			Administrative Director YNHH
Gerald Defelice			" " "
Lisa Stamp			" " "
William Aseltyne	688-2201		Chief Legal Counsel - YNHH
Vincent Tammaro	688-2612		SVP - Yale New Haven Health

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
public sign up sheet

PRINT NAME	REPRESENTS
Curtenia McDonald	Hospital of Saint Raphael ✓

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
public sign up sheet

PRINT NAME	POSITION HELD
Rose MAJestic	Ex. DIR. WHEAT, INC. ✓
John Dye	Hill South Management Team ✓

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
public sign up sheet

PRINT NAME	REPRESENTS
REP. PATRICIA DILLON	C69 - 92

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
public sign up sheet

PRINT NAME	REPRESENTS
KATRINA CLARK	FAIR HAVEN COMM HEALTH CENTER
Representative Dillon	

PUBLIC HEARING

PUBLIC (must represent themselves)

SIGN UP SHEET

JUNE 5, 2012
10:00 a.m.

Applicant: Docket Number: 12-31747-CON
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

PRINT NAME	REPRESENTS	
JAMESINA HENDERSON	CORNELL SCOTT - HILL HEALTH CENTER	✓
Cathey Szeto	Patient Advisory Council — YNHH	✓
John Courtney	Self	✓
Kevin O'Brien	S.I.P	✓

Public Hearing
Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael
Elected Officials sign up sheet

Print Name	Phone	Fax	POSITION HELD
Stacy A. Spell	203 777 2192		President, West River Neighborhood Services Corp.
Donna B. Fedus	203-789-7645		Gerontologist, The Consultation Center, Yale University.

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Yale New Haven Hospital, Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

DN: 12-31747-CON

Hearing Date: June 5, 2012

Time: 10:00 a.m.

Proposal: Proposal for Yale New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc. and the Hospital of Saint Raphael

OHCA Exhibit #	Description
1	Month End + YTD Financial Statements
2	
3	
4	
5	

OHCA Public Hearing
June, 2012

Public Testimony

Name of Attendee	Comments/Action	Time
Mayor John DeStefano	Confirmed	3:30 PM
Representative Dillon	Confirmed	2 or 3 o'clock
West Haven Mayor John Picard	Confirmed	1:00 PM
~~North Haven First Selectman Michael Freda~~	~~Confirmed~~	~~1:30 PM~~
Tony Rescigno, GNH Chamber of Commerce	Confirmed	2:00 PM
Stacy Spell, West River Neighborhood Services Corp.	MJ/CvB - Contacted; confirming availability	1:30 PM
Curlena McDonald, Greater Dwight Central Management Team	Confirmed	3:15 PM
John Dye (Hill South Management Team)	Confirmed	2:00 PM
Nesya Stallmann Guerino, Agency on Aging	Dorothy/Martha - Tentative yes	5:30
Consultation Center re: geriatric services	Confirmed Donna Fedus	1:45 PM
Rose Majestic, W.H.E.A.T. re: Project Mother Care	Confirmed	2:30 PM
Jae Henderson, Cornell Scott Hill Health Center	Confirmed	1:00 PM
Katrina Clark, Fair Haven Community Health Center	Confirmed	3 or 4 o'clock
Kevin O'Brien, Patient Advisory Speaker	Confirmed	1:30 PM
Cathey Szeto, Patient Advisory Speaker	Confirmed	1:00 PM
~~Pete Kenyon, Patient Advisory Speaker~~	~~Confirmed~~	

Rev. 6/4/12 LS

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION
DOCKET NUMBER 12-31747

YALE-NEW HAVEN HOSPITAL, SAINT RAPHAEL HEALTHCARE SYSTEM, INC. AND THE HOSPITAL OF SAINT RAPHAEL

PROPOSAL FOR YALE-NEW HAVEN HOSPITAL'S ACQUISITION OF THE SAINT RAPHAEL HEALTHCARE SYSTEM, INC. AND THE HOSPITAL OF SAINT RAPHAEL

JUNE 5, 2012

GATEWAY COMMUNITY COLLEGE
60 SARGENT DRIVE
NEW HAVEN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the Department of Public Health, Office of Health Care Access, held at Gateway Community College, Room 160, 60 Sargent Drive, New Haven, Connecticut, on June 5, 2012 at 10:09 a.m. . . .

HEARING OFFICER JOANNE YANDOW: Good morning. Before we begin, would everyone please turn off or silence your cell phones and beepers, please?

This is a public hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access. I am Joanne V. Yandow, the Hearing Officer in this matter, and I was designed by the DPH Commissioner, Dr. Jewel Brown. I'm sorry. Dr. Jewel Mullen.

Docket No. 12-31747-CON is being held today, June 5, 2012, to consider Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated and the Hospital of Saint Raphael's CON application for the proposal of Yale-New Haven Hospital's acquisition of the Saint Raphael Healthcare System, Incorporated and the Hospital of Saint Raphael.

This public hearing is being held pursuant to Connecticut General Statute, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, Uniform Administrative Procedures Act.

Again, I'm Joanne V. Yandow, the Hearing Officer in this matter. Assisting me today with the public hearing is Kimberly Martone to my right, Director of Operations for the Office of Health Care Access. To my left is the Department of Public Health Legal Director, Marianne Horn.

The hearing is being recorded today by Post Reporting Services. Following the hearing, I will issue a proposed final decision, in accordance with General Statute 4-179.

I will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

In accordance with the General Statutes, Department of Public Health, Deputy Commissioner Lisa Davis, shall issue a final decision.

The applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated, and Hospital of Saint Raphael, have been designed as parties

to this proceeding.

Could I please have counsel for the applicants identify themselves for the record? And I'll start here.

MS. REBECCA MATTHEWS: Okay. Good morning. I'm Rebecca Matthews with Wiggin and Dana. I'm here on behalf of the applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System and the Hospital of Saint Raphael.

HEARING OFFICER YANDOW: For all three applicants?

MS. MATTHEWS: Yes.

HEARING OFFICER YANDOW: Any other counsel on the table? And, Attorney Matthews, who is it that will be offering testimony on behalf of the applicant today?

MS. MATTHEWS: I have with me today Marna Borgstrom, the CEO of Yale-New Haven Hospital, Chris O'Connor, the CEO of the Hospital of Saint Raphael, and Drs. Peter Herbert and Alan Kliger, who are the Chief Medical Officers of each of the hospitals.

HEARING OFFICER YANDOW: And are there -- is there anyone also here today, who wishes to offer testimony or make a statement in this case, other than the individuals representing the applicant? The record can

show that no one has come forward.

Okay. At this time, I would like all the individuals, who are going to testify on behalf of the applicants, to stand and raise your right hand to be sworn.

(Whereupon, the parties were sworn.)

HEARING OFFICER YANDOW: Okay and I will note for the record there are also people, who plan to testify on behalf of the applicant in the audience.

With counsel at the applicant’s table we have -- you identified the people that have filed pre-filed testimonies?

MS. MATTHEWS: Yes, correct. There may be some questions that they would like to consult with some other folks here, so they have been sworn in, if that’s okay. We’ll have each of them introduce themselves and their titles when they come up.

HEARING OFFICER YANDOW: Okay. For those individuals, who just took the oath, please state your full name the first time you speak and adopt any written testimony you’ve submitted on the record.

We have Ms. Marna Borgstrom, Dr. Peter Herbert, Dr. Alan Kliger. Am I pronouncing that right?

DR. ALAN KLIGER: Yes.

HEARING OFFICER YANDOW: And Christopher O'Connor all present. Ms. Borgstrom, do you want to adopt the testimony that you have filed as pre-filed testimony?

MS. MARNA BORGSTROM: Yes, I do.

HEARING OFFICER YANDOW: Mr. Herbert, do you -- I'm sorry. Mr. Herbert, do you adopt the document that has been filed as pre-filed testimony with your signature?

DR. PETER HERBERT: I do.

HEARING OFFICER YANDOW: Dr. Kliger, do you adopt the testimony that has been filed as pre-filed testimony under your signature?

DR. KLIGER: Yes, I do.

HEARING OFFICER YANDOW: Mr. O'Connor, do you adopt the testimony that has been filed under your signature?

MR. CHRIS O'CONNOR: I do.

HEARING OFFICER YANDOW: Also, for everyone else that stood to be sworn, please make sure that you have printed your name and affiliation on the sign-up sheet that has been made available for the hearing.

At this time, I will ask Ms. Martone to read into the record those documents already appearing in OHCA's Table of Record in this case. All documents have

been identified in the Table of Record for reference purposes.

MS. KIMBERLY MARTONE: Good morning. Kimberly Martone for this proposal, Docket Number 12-31747. We have Exhibits A through M, and we also have an additional exhibit, which we'll label Exhibit N, and those are the letters of support that were received by the office on June 1st.

HEARING OFFICER YANDOW: Okay. Have you seen the record of exhibits?

MS. MARTONE: Yes, I have.

HEARING OFFICER YANDOW: Any objection?

MS. MARTONE: We don't have any objection to any of the items listed. I would just like to note on the record a couple of matters with respect to Exhibit E, which is a letter from the physicians.

I'd just like to note that that letter was submitted anonymously. Obviously, OHCA can consider whatever evidence it thinks is relevant. I just wanted to have you consider that when determining how much weight to give to it.

The authors did not send a representative to participate in this proceeding, and since the time that it was submitted, there have been various discussions

regarding medical staff integration that Drs. Herbert and Kliger will give you more detail on.

We're obviously happy to answer any questions you have about any of that.

HEARING OFFICER YANDOW: Okay. In Record Exhibit N, which came along with the pre-filed testimony, is a motion for pro hac vice.

MS. MARTONE: Yes.

HEARING OFFICER YANDOW: And --

MS. MARTONE: I think you can consider that application withdrawn at this point.

HEARING OFFICER YANDOW: You're going to withdraw that?

MS. MARTONE: Yes.

HEARING OFFICER YANDOW: So the motion pro hac vice is withdrawn at this point?

MS. MARTONE: Correct.

HEARING OFFICER YANDOW: And does not need a ruling. Okay. At this time, the applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated, and Hospital of Saint Raphael may proceed with their testimony.

MS. MARTONE: Okay, thank you. With your permission, I'll turn it over to Mrs. Borgstrom.

MS. BORGSTROM: Good morning, and thank you. My name is Marna Borgstrom, and I am the Chief Executive Officer of Yale-New Haven Hospital and the President and Chief Executive Officer of the Yale-New Haven Health System.

On behalf of all of our employees, our Boards and our affiliated physicians, I want to offer our appreciation to OHCA for your careful deliberation of this historic integration.

We recognize the challenges that are facing you in this evolving health care environment, and we're grateful for your time and consideration of this.

I have the distinct privilege of introducing and highlighting the importance of this proposed acquisition, and I'll provide you with an overview of a few of the reasons that we're seeking your regulatory approval for this transaction. And, as noted earlier, you're also going to be hearing from my colleagues at this table.

So let me take a few minutes, just to outline the reasons why this transaction is so vital to our future and to the provision of high-quality health care to the people of Connecticut for years to come, we believe.

The concept of this acquisition was founded on three broad principles. One is to continue to advance quality and safe care that we already provide, two is to preserve and extend access to that care, and three is to provide that care in the most cost-effective manner possible.

Underlying these goals are two real imperatives. One are the financial challenges currently being faced by the Hospital of Saint Raphael, and you'll hear more about that from Mr. O'Connor, and the second are the extraordinary capacity restraints faced by Yale-New Haven, which have reached a point, where this acquisition is absolutely essential to increasing our ability to effectively take care of patients.

The acquisition will help us immediately relieve our crowded conditions. I will note that this morning our contact census was 956 patients at Yale-New Haven Hospital, and it will allow us to do that much more quickly than building a new bed tower, which comes at significant cost.

We were also pleased to find out, on June 1st, on Friday, that after reviewing thousands of documents, the Connecticut Attorney General and the Federal Trade Commission recognized these imperatives and

announced that they would not be taking any action to oppose this acquisition.

This transaction represents a unique opportunity for us to better manage and coordinate care on behalf of the patients we serve. Supported by an integrated electronic medical records system, we can engage various health care providers to assist, track and influence the use of the very best evidence-based practices across the campuses.

Imagine a fully integrated patient care network, that empowers patients by providing them access to their medical records.

For anyone, who has left a caregiver and wondered if they heard the directions or instructions they were given clearly, or for anyone, who has had to rely on the memory of an older family member to proceed with the next steps of their care, having access to this will be a wonderful safety net.

Through this acquisition, we also believe that we can have a real impact on influencing downward the health care cost curve.

We can avoid duplicative investments in medical technology and talent, and we can spread our infrastructure costs over a wider base of operations,

achieving the efficiencies that couldn't be attained under any other scenario, other than bringing these organizations together.

The transaction also gives Yale-New Haven Hospital the ability to avoid a 622-million-dollar capital investment and a new patient care tower, which we had already begun to plan. That includes the cost of the building, establishing a new chiller plant, because we've run out of chilled water capacity, putting in a new parking garage, because the City of New Haven has requirements for additional parking as new spaces bought, is built, adding or renovating space in buildings that patient care beds may be moved from in order to consolidate focused service line patient care in a new building, and, of course, the capitalized interest associated with a project like that.

So this allows us to increase our capacity in a much more cost-effective way, using the existing beds and the operating room time and space on the Saint Raphael campus.

As a result of growth and demand at Yale-New Haven Hospital, our existing bed utilization is over 80 percent, and, most significantly, medical surgical occupancy is over 90 percent. Our volume projections

forecast and occupancy rate of 93 percent by 2016, and that is simply unsustainable to operate a good organization with that kind of demand.

Yale-New Haven is unique in the state for the level of care we provide, from acutely ill patients, a level one trauma service, to high acuity referrals from other institutions.

In 2011, we instituted the Y Access line, which is a single-source phone referral system, where a physician can make one call, and all the arrangements for a patient, from transportation to the hospital, to admission, to insurance clearance, can be done.

As a result of that, the increased number of referrals has been growing substantially, and it affords an opportunity for better access for some of the most critically ill patients in Connecticut and from beyond.

So we’re not just a state resource. We have become a regional resource, and having capacity is going to be critical to managing. Most of that is unexpected demand. People obviously don’t book those in advance, and we have to be able to handle the demand when the calls are made.

To manage our resources most effectively,

we need to reach a maximum occupancy target of 80 percent, and, as I said earlier, the acquisition allows us to do that.

And we're convinced that the need for additional beds on the Yale-New Haven Hospital campus will remain clear, as well. Recognizing the extraordinary demands that you have, a great deal of work, we withdrew an application for additional capacity on the Yale-New Haven campus until after we've completed this acquisition, but that withdrawal is predicated on the assumption that you will approve all 511 beds in Saint Raphael's license to come into this integrated organization.

So what's this ultimately going to mean for Yale-New Haven and for the Hospital of Saint Raphael? First and foremost, this transaction will allow us to address the real and very pressing financial challenges that Saint Raphael's is facing, and, as I mentioned earlier, it provides a creative and cost-effective approach to addressing capacity challenges at Yale-New Haven.

It preserves existing commitments to charitable care and investments in our community. Last year alone, Yale-New Haven Hospital provided more than 160 million dollars in free and charitable and under-

reimbursed care, and our charitable policies, which are among the most liberal we've heard of, including free care and sliding scale to those in need, will prevail after this acquisition.

As part of the acquisition, we've also agreed to honor the heritage of the hospital of Saint Raphael, including the recognition of the Catholic ethical and religious directives of the care provided on that campus, and this will essentially preserve health care as it is currently provided in New Haven.

The transaction provides an opportunity to invest in one of the really great hospitals in the State of Connecticut, and, as you've read under this proposal, Yale-New Haven has a commitment to strongly support the Hospital of Saint Raphael by investing in capital infrastructure and insuring that organization as a healthy, vibrant resource in the health care community for the Greater New Haven region.

The opportunity to integrate clinical services will support improvements in quality of care and the creation of centers of excellence on the Saint Raphael's campus, so we're not looking to just use it for overflow. We're looking to make very focused patient care investments.

The transaction permits the two hospitals to integrate clinical services and support functions, and, as I mentioned earlier, achieve cost savings that are estimated to be up to 300 million dollars over five years.

While some positions will be eliminated, due to the transaction, already significant efforts have been made to minimize the impact on individual staff members.

For example, since the beginning of the year, vacancies have been held at the Yale-New Haven campus to increase the opportunity that we can transition Saint Raphael employees, whose positions are being lost, into other positions.

In the long run, as we continue to invest on both campuses, we expect that job opportunities will continue to grow, and that New Haven will continue to serve as an economic driver for the State of Connecticut.

But what is most important and most critical about our common vision is the ability to advance access to high-quality care efficiently and effectively.

This is absolutely essential to our long-term ability to adapt to a changing health care environment.

In Connecticut, with an aging population,

demand is going to be compounded in Connecticut as the baby boom generation is entering retirement with high levels of expectations for health care and support services.

In fact, Connecticut's population over 65 is already 14.2 percent, which exceeds the U.S. average of 13 percent.

And while the demand for services will continue to challenge our capacity, we also understand that reimbursements received by hospitals are going to continue to be contained, hence, the importance of operating as effectively and efficiently as we can.

In fact, the American Hospital Association committed, on behalf of its member hospitals in both Yale-New Haven and Saint Raphael, supported this to 155 billion dollars in cost reductions over the next 10 years, and we expect that number will continue to grow as the federal government's economic challenges intensify.

So we clearly understand that we have to do everything in our power to advance quality care, to advance access, and to do it in a cost-effective way.

OHCA, as you know, is tasked with a statutory mandate to evaluate proposals against certain guiding principles, including increasing access to high-

quality care in the most cost-effective manner.

That is, obviously, the core of this proposal, and that is our promise. It allows us to creatively manage change in a way that's going to enhance access and quality, and it will have a lasting and positive impact on our state.

This opportunity to integrate the resources of these two institutional providers provides us the opportunity to meet the expectations of our patients, and it is clear that we are healthier, and only together can we overcome the pressure of the challenges facing both of our organizations and health care in general, so I obviously urge you to approve this Certificate of Need application.

It's now my pleasure to introduce Dr. Peter Herbert, who is the Chief Medical Officer at Yale-New Haven Hospital, to provide an overview of the clinical opportunities that this transaction provides to the communities we serve.

DR. HERBERT: Thank you, Marna. As Marna mentioned, I'm the Chief Medical Officer for Yale-New Haven Hospital and Yale-New Haven Health System.

I've had the privilege over the last several months of working with my friend and colleague,

Dr. Alan Kliger, on the implementation of clinical integration between our two campuses.

I think it's noteworthy that between 1990 and 1999 I spent virtually the decade as Chairman of the Department of Medicine at Hospital of Saint Raphael, and when I moved from Hospital of Saint Raphael to Yale-New Haven Hospital, Dr. Kliger took over in my position as Chief of Medicine at Hospital of Saint Raphael and since has become the Chief Medical Officer and the Chief Quality Officer.

Alan was also a full-time member of the Yale faculty for several years before he joined the community, and both of us are still clinical professors of medicine at Yale.

I want to expand a bit on Marna's testimony, as it relates to both what we have done to deal with the census challenge at Hospital of Saint Raphael and how we have prepared for the integration of our two medical staffs.

Yale-New Haven Hospital right now is one of very few hospitals in the State of Connecticut that fundamentally operates all of its beds. Actually, probably one of the few in the country, and that relates to the fact that between 2005 and the present we yearly

have increased discharges from the hospital by roughly three percent.

We work very hard on controlling our length of stay. In medicine, our biggest department, for instance, we've reduced length of stay from roughly 5.4 days to 5.0 days and change now.

Mr. Richard D'Aquila, our President, has led a very important safe patient flow initiative that has resulted in the average discharge time of patients being moved from roughly 3:00 to 1:00, the average number of patients being discharged by 11:00 in the morning, increasing from roughly seven percent to up to close to 25 percent, and it's only changes like this that have permitted us to function effectively with the number of licensed beds that we have at the current time.

Marna mentioned the Y Access patients that have come. The number of patients coming through Y Access the year before we implemented was in the range of 3,000. That number this year will grow by roughly 70 percent, so more than 4,500 patients will be transferred to us from other hospitals in the State of Connecticut.

That transfer is driven by a lot of special services that Yale-New Haven Hospital offers. Many of them were mentioned in my pre-filed testimony, and they

include cardiac services, transplant services, trauma services and so forth.

The problem with the patients that come to us through the Y Access line is they are the sickest of the sick, and whereas our patients typically stay overall for the hospital around 5.24 days, these patients stay 11.8 days in the hospital.

If you look at the number of patients that we classify as emergent, who are admitted to Yale-New Haven Hospital, that number a year ago was roughly 73 percent. It's now about 76 percent.

So, as Marna mentioned, these patients come to us without a lot of advance information, and we're challenged with looking for places to place these patients when they come.

Marna mentioned a number of patients that were in the hospital this morning, and we've had days when the census in the hospital has exceeded 1,000. That's contact census.

So on the Department of Medicine and Surgery, where we have had pretty much steady 90 percent occupancy, the number of patients, on average on that service, has increased from 511 to 577.

So when you work with such an extremely

high census, we're forced often to put patients into what we consider to be overflow areas, and what are they?

They're one-bed patient rooms that have two patients in them. They're two patient rooms that end up with three patients in them. They are solariums.

And the consequence of this, you know, to the fragile and very ill patients that we admit is you have two or three people sharing the same bathroom, and patients tell us how they like that experience when we have patient census, and we get letters, and, you know, it's just not a great experience, when we're forced to use overflow beds.

We're fairly certain that our care is safe in these sites, but it's not, obviously, the kind of care that patients expect from us.

We have spent a lot of time, Alan and I, dealing with the issue of clinical integration. We've held meetings at both hospitals with clinical leadership, with members of the general staff.

We have discussed what we think are good plans for the new institution, and we spent a lot of time looking at the rationale and the logistics of accomplishing this clinical integration.

A big question, of course, that arises is

will we have problems with staffing from a physician point of view when the clinical integration begins, and I can assure you we're in a very good position right now.

Of the physicians, who are privileged at Hospital of Saint Raphael, roughly 80 percent of them already have privileges at Yale-New Haven Hospital.

That left approximately 400 physicians and mid-level physicians, mid-level practitioners, many of them employed by Hospital of Saint Raphael that we needed to privilege.

We worked extremely hard in the last three months to accomplish this, and I'm certain that virtually every vital caregiver at Hospital of Saint Raphael will be privileged at Yale-New Haven Hospital on day one.

We have dealt with the issue of the hospital-based services. We have agreed to accept the contracts that the hospital-based services, services like radiology, pathology, anesthesia and so forth, have at Hospital of Saint Raphael, and those services will all be fully functioning on day one.

So we're very confident that we will be able to manage both campuses if OHCA grants this request for an asset purchase agreement.

Obviously, the other part of this is very

important, is integrating the clinical services, themselves, and my colleague, Dr. Kliger, will address much of that in his testimony.

I'll be happy to answer questions later, and, at this point, Alan, I turn the microphone over to you.

DR. KLIGER: Thank you, Peter. I'm Alan Kliger, the Chief Medical Officer and the Chief Quality Officer for the Hospital of Saint Raphael.

You've heard about the capacity issues facing Yale-New Haven from Peter, and you've heard about the benefits of this transaction from Marna Borgstrom.

I really want to make three major points. First of all, this acquisition is going to further the mission of both hospitals to deliver care more effectively and efficiently and to integrate services to that end.

The second point I want to talk about is the value of a single comprehensive information system that we intend to use, and, thirdly, the importance of this transaction to graduate medical education.

When we began to explore the possibility of these two hospitals coming together, we knew there would be challenges, but we also knew that there would be opportunity to plan and deliver services more effectively

and more efficiently.

In particular, we knew that we'd have opportunities to avoid duplication of services and redundant investments in technology and infrastructure, and avoiding duplication of services is critical, not only to the business of hospitals, but to the experience of patients, for patients to be able to know that they can get the right care at the right time and not to have duplication of services or redundancy in their care.

Yale-New Haven Hospital and the Hospital of Saint Raphael share a vision of the future that will enhance the delivery of health care services in our region, recognizing and respecting the strengths of both of the institutions.

We see the value of coming together to form an integrated system that understands that great health care can be made even better.

When we integrate these services, the goal of integration is to offer the safest, highest quality of care to our patients and their families and our whole community.

To do this, we have to look carefully at what our current capabilities are, what investments we've made before, and then what opportunities for future

investments we have.

But also importantly, we have to examine this from the patient's point of view, and, from a patient's point of view, we aim to deliver care that's easy to navigate, is patient-centered, without the inefficiencies of care and waste and duplication of tests and procedures that all too frequently characterize routine care.

Now this process of clinical integration that Peter and I have started to talk about will take some time to complete, because our goal is to organize care around patient needs and efficient use of resources, rather than around this sort of traditional departmental organization of care that we've had before.

Certain services we know will be focused on one campus or the other, while other services will be on both campuses or in several outpatient locations.

And Peter Herbert and I have been working with hospital administrators, medical leaders, nurses and doctors from both organizations to start soliciting input from them to facilitate that clinical planning.

At this time, we believe that the Yale-New Haven campus is best suited to deliver care in several clinical programs, trauma, in oncology care and its

subspecialty areas, pediatrics, high-risk obstetrics.

These are all areas that the Yale-New Haven campus right now is very deep and rich in, and they've been selected, because of their highly specialized nature, the depth of physician expertise on the Yale-New Haven campus, and the very strong support services in technology that are present on the Yale-New Haven campus.

The Hospital of Saint Raphael's campus has been identified for the establishment of a musculoskeletal institute, which will include orthopedics, pain management, spine care, rehabilitation, podiatry.

The Saint Raphael's campus now has an established intensive rehabilitation service on campus and, also, sub-acute rehabilitation in our Grimes Center, allowing Saint Raphael's campus, therefore, to offer this full continuum of care, from acute care, to rehabilitation, to sub-acute care.

The Hospital of Saint Raphael's campus might also be a focus for bariatric surgery and, also, for a primary family-oriented birthing center.

High-volume services we think will be offered at both campuses to meet community need, including general medicine, surgery, cardiology, vascular surgery, urology, psychiatry, low-risk obstetrics, dentistry and

emergency services, as well as essential support services for the hospital locate services, such as anesthesia, pathology, laboratory medicine and radiology.

At the end of the day, we are confident that we can integrate these services under one license to provide access to exceptional care in a cost-efficient manner.

We can envision a future, where quality, safety and value for our patients are really at the center of everything that we do.

Let me move to my second point, the importance of a single electronic information system. A comprehensive electronic record and information system will transform, we believe, the way that we provide care across our integrated network, reducing redundant tests and procedures and facilitating continuous quality improvement.

Hospitals across the country are struggling to meet the federal government’s expectation for medical records and to reap some of the benefits for implementing those systems.

If the cost of these systems would be prohibited to the Hospital of Raphael’s, were we to stand alone, given our current financial condition, this merging

of our two hospitals will allow both campuses to deploy an integrated single electronic medical record.

Yale-New Haven Hospital has chosen a really wonderful comprehensive electronic information system, called Epic. Epic will connect inpatient to outpatient settings, connect physician offices, laboratories, diagnostic centers, and provide patients with direct access to their own medical records.

Access to a patient's clinical record by any Yale-New Haven provider will significantly enhance the coordination of patient care and reduce duplicative tests and procedures, but probably most importantly that single system improves the safety for our patients.

Epic provides a common list of current medications that all of our patients are on, so that all caregivers have access to that same list of medications and any changes to those medications that are made, a list of allergies, a list of medical conditions and past history as a single unified record accessed by all caregivers.

It will be able to flash alerts to caregivers when there might be a reaction to a drug, or an allergy to a medicine, or a problem with a radiological contrast material.

Probably a good example of how a system like Epic can be so useful across both campuses is reflected even today in the fact that many patients seek care in the Emergency Department at both hospitals.

It’s not at all unusual for a patient to be at the Yale-New Haven Emergency Room and get care there and be discharged, and five days later, or a week later come to the Saint Raphael’s Emergency Room, either with a similar complaint, or continued problems.

Right now, those two hospitals don’t have a uniform record. Understanding what tests were done, understanding what medicines were given is something that we currently do only with a difficulty of telephone calls, telephone calls at 3:00 a.m., trying to get additional information.

Often, the same tests that have been done only a week earlier will be repeated in the other emergency room a week later, so that the doctors can be assured that all of those are normal.

A single integrative medical information system really helps save that type of evaluation and that type of duplication.

This system of integrated care and a single information system we think can deliver us to the future

of accountable care, that concept that all of us are striving for, to deliver the best care at the lowest cost.

The last point I want to raise has to do with the training of future doctors, an important part of what both hospitals currently do.

A full integration of the graduate medical education program from Yale-New Haven Hospital and Saint Raphael provides us with the unique opportunity to broaden the medical education, by bringing together the best components of each institution to teach that next generation of doctors.

Under the terms of this acquisition, all residents and fellows currently enrolled in our Saint Raphael’s programs will have the opportunity to complete their training with a wider opportunity for education on both campuses.

Future enrollees will find stronger programs with wider opportunities for patient care and teaching. The teaching staff at Saint Raphael’s will be working with the program directors at Yale-New Haven Hospital to insure uninterrupted training of our residents and fellows, and, as a result, the acquisition will permit the reduction of duplicative functions in the support areas for this graduate medical education.

Saint Raphael residency and fellowship programs in surgery, diagnostic radiology, geriatrics, nephrology, cardiology, oral and maxillofacial surgery all will be transferred to and integrated with the Yale-New Haven graduate education accredited programs.

Our internal medicine residency program will be integrated into Yale-New Haven primary care program.

We believe strongly that these changes will create a more patient-centered, safe and quality-driven care for our community than ever before.

While change can cause anxiety and uncertainty, it can also inspire and transform. Together, we believe we can deliver high-quality care to more people in a more efficient manner.

So thanks, and let me, then, turn over the microphone to Chris O'Connor.

MR. O'CONNOR: Good morning. Thank you, Alan. My name is Christopher O'Connor. I'm the President and Chief Executive Officer of the Saint Raphael Health Care System and the Hospital of Saint Raphael.

I believe the testimony you've already heard from Marna, Peter and Alan articulates why this makes so much sense, given the extraordinary benefits it

can provide to our patients, employees, physicians and our community.

This morning, I'd like to thank OHCA for your time and consideration of this exceptionally important question.

I'd also like to discuss the important reasons why the Hospital of Saint Raphael is pursuing acquisition by Yale-New Haven Hospital and why our timing is so critical in achieving our goals.

I can offer a unique perspective about the value of this transaction, especially with respect to the mounting challenges faced by Saint Raphael.

Our founders and sponsors, the Sisters of Charity of St. Elizabeth, our Board of Trustees, our leadership team firmly believe that this acquisition by and the full integration with Yale-New Haven Hospital represents the very best way to address the needs of the Saint Raphael's community.

I will try to provide you with a sense of our deliberations and how we concluded that this transaction is absolutely the right thing to do.

Today, Saint Raphael's is at a unique moment in time, when it must set a new course. As its current operation as an independent hospital is

unsustainable for the future, here's where we are.

The hospital has suffered through five consecutive years of significant operating losses between fiscal years 2005 and 2009, including a staggering 17-million-dollar loss in fiscal year 2008.

These painful and deepening financial pressures required us to make extremely difficult choices to preserve the organization's solvency.

Saint Raphael's financial performance has put it out of compliance with a number of its bond covenants, specifically, those pertaining today's cash, long-term debt to capitalization and minimum fund balance.

It's with this background that the Sisters, the Board and senior leadership determined back in 2008, prior to my arrival as CEO, that Saint Raphael's rapidly deteriorating financial position jeopardized its future as a standalone hospital.

A strategic partner had to be found. Simultaneously, the hospital also did what most would do facing similar circumstances. We turned to ourselves and worked hard to drive down costs and seek opportunities to expand revenue.

These actions, which continue to this day, fall within a magnitude of categories. In the expense

reduction area, actions included, but certainly not limited to, cuts to existing employee benefits, most significantly ceasing contributions to the employee defined contribution plan, pension plan, defined contribution pension plan, as well as the employer matching funds to participants of 401K plans, use of value engineering to achieve efficiencies in the way that we operate, including right sizing our organization.

This involved labor and non-labor savings, initiatives in essentially all departments, including reducing the number of employees.

Deferred investments in our capital infrastructure as a result of financial pressures we have encountered, we have been spending well below depreciation levels, and, as a result, the average age of plant for the Hospital of Saint Raphael campus has increased from 16.5 years in 2008 to 26.2 years in 2011, making us the oldest in the State of Connecticut, a deferred investment in new technology, as well as information systems.

In addition, Saint Raphael’s has taken deliberate steps to improve our revenue cycle. We have engaged third party payers to negotiate the most competitive rates possible, given our circumstances.

We have improved enrollment in Medicaid-

eligible patients and are better capturing Medicaid usage, which results in higher DSH payments, and have pursued various appeals related to Medicare reimbursement, such as those relating to the area of wage indices.

We have improved medical record documentation to insure appropriate reimbursement for medically necessary services, improved charge capture oversight, streamline collections and diminished payment denials.

Unfortunately, all of these actions have not been enough. Despite all of our best efforts and despite all of the challenging decisions we have made, we remain very concerned about our ongoing viability.

It is clear that we can no longer exist as a standalone provider of medical services. The Hospital of Saint Raphael's still faces a significant amount of long-term debt, an enormous pension fund deficit, and deteriorating payer mix, as I've noted -- payer mix, as I've noted the fiscal plan is aging rapidly. It is now more than two and a half times older than the national average.

With our curtailment in 2010 of all post-retirement pension benefit contributions, the hospital can no longer compete effectively for the talent necessary to

manage the organization, nor fulfill our commitments to those who have served with distinction.

Our day's cash on hand is perilously low at 23.5 days, as of our April 30, 2012 financials. At that level, we have a very limited ability to manage through business interruptions.

Even if we were to somehow triple the number of day's cash on hand, it would still be well below national averages.

COURT REPORTER: One second.

MR. O'CONNOR: From a capital perspective, a lack of available funds has placed us at a competitive disadvantage, vis-à-vis other hospitals in the state. Given the current state of our long-term debt, borrowing is simply not a possibility.

Compounding this are the volume declines experienced by the Hospital of Saint Raphael in the recent years. Our volume this year is down about eight percent, with that decline expected to continue if we remain as a standalone hospital.

Absent the ability to invest in our facilities, talent and equipment, we do not see this as a reversible trend.

About 70 percent of our patients, a number

that is growing, are currently insured by either Medicare or Medicaid.

As Marna pointed out during her testimony, the economic pressures on government reimbursement will only intensify in the years ahead, and our ability to shift those losses to other payers, given our existing payer mix, is and will remain extremely limited.

So under the veil of that economic pressure, which has only intensified over the course of the last five years, it has become critically important for us to seek a partner or a buyer that would enable the continued provision of high-quality care on the Saint Raphael campus, particularly to maintain our commitment to the most vulnerable populations.

The Sisters, Board and prior leadership began this process in 2008, initially reaching out to national Catholic health care organizations as a way to stabilize our financial footing while preserving our mission.

As those conversations progressed, however, it became clear that the combination of our organization's financial issues and the national economic conditions were serving as real and direct obstacles to our ability to consummate a working partnership that would address both

our long-term capital and operating needs.

Following the leadership transition in 2009 and given our continuing fragility, we restarted the search for a strategic partner in 2010, with a very strong sense of urgency.

We chartered a path toward affiliation, which resulted in considering national, state, for-profit, Catholic and secular options.

Through that process, we established a series of criteria that would be essential to affiliation. These criteria included retaining our Catholic identity, a strong preference to remain not-for-profit, a commitment to providing high-quality accessible health care, an ongoing commitment to the local community, our physicians and employees, as well as access to capital that would allow us to address our longstanding financial needs.

Ultimately, our national evaluation led us right back home to New Haven. By the spring of 2011, we recognized that the acquisition by Yale-New Haven Hospital would allow us to meet all of our primary objectives and can serve as a unique and exciting opportunity to align and better coordinate care in our region.

The benefits of this acquisition cannot be matched by any other acquirer, including recognition of

our Catholic heritage, retention of our not-for-profit status, retention of local decision making, an ability to improve the quality of care we deliver, the elimination of our long-term debt, a narrowing of our pension fund deficit, a capital investment in our infrastructure, and, as you heard from Alan, an implementation of Epic, an electronic medical record system.

Saint Raphael's is at a crossroads. We must see this transaction closed by the end of July. The Vatican has provided its authorization to relinquish our official Catholic designation.

As you heard from Marna, the Connecticut Attorney General and Federal Trade Commission have stated that they will not oppose this transaction.

We need the support of OHCA, because the immediate liability of our hospital is at stake.

You've heard all the reasons today that motivated our decision to align with Yale-New Haven. This is about advancing high-quality care. It is about preserving access. It's about continuing to give patients in the community the option to receive care consistent with the Catholic tradition on the Saint Raphael's campus, and it is about doing so in a cost-efficient manner.

The promise of this transaction is

unlimited, and the benefits to this community would be immediate.

As important, this acquisition is essential to the patients cared for on the Saint Raphael's campus, the physicians, who practice here, the almost 4,000 employees, who come from all over Connecticut and even beyond, and the retirees, who are anxious about their pension benefit.

This acquisition is the only pathway to financial stability, long-term viability for the Saint Raphael campus, and it is imperative for the economic vitality of this entire region.

We need your support, and we need it as soon as you can provide it. Each month, as volume declines, as the staff and physicians seek alternative employment, our future gets cloudier.

Potential actions by our bond holders and solvency and bankruptcy are real and present threats. It is a very challenging, stressful time for our patients, our physicians, and our staff.

The Hospital of Saint Raphael was founded more than a century ago on the presumption of access and quality. That mission can continue and be furthered with the acquisition by Yale-New Haven Hospital.

On behalf of all the stakeholders, we urge your strong consideration and approval of this transaction. Time is of the essence. Thank you very much, and we'd be pleased to answer your questions.

HEARING OFFICER YANDOW: We can have some questions. When answering the question, if there's any reference you have to the application that's been filed, or any of the completeness responses, it would certainly assist OHCA with your answers, so when we go back to review the record, we can also take a look at what you filed already.

MS. MATTHEWS: Okay.

MS. MARTONE: This is Kimberly Martone again. Okay. My first question is application page 35. The applicants state that this proposal is an opportunity to focus on key strategies, such as primary care development, to enhance access to services for patients in the region.

I was just wondering if you could, you know, expound on that statement and really provide us with more evidence, in terms of how this proposal will address access to services of primary care development.

MS. BORGSTROM: Let me start and ask some of our colleagues to provide additional information. Both

organizations currently provide primary care in the form of clinics on campus, and we both operate ambulatory satellites.

We may not have covered the precise geographies from which our patients come as comprehensively, and what this allows us to do is an inventory of the services provided, match that with the needs in the community as we know, working, also, collaboratively with other providers in the community, including the federally-qualified health centers, and try and make investments and decisions in the placement of ambulatory satellites and the recruitment of physicians that can enhance patient access to both ambulatory and related services.

And let me ask Alan or Peter Herbert to expand on that.

DR. HERBERT: So one of the major challenges in Connecticut is access to primary care physicians, and they include pediatricians, general practitioners and internal medicine specialties.

We have traditionally at both hospitals had categorical internal medicine training programs, but what we have seen in the last decade is the majority of graduates of these programs seek fellowships that leads

them to specialization.

We intend, if this application is successful, to convert the categorical internal medicine program and Hospital of Saint Raphael's to a primary care internal medicine program, with the focus more on ambulatory training than on inpatient medicine, and hope, through actual education and creating our own, we will develop the physicians that will populate the offices of the internists associated with our hospitals and actually continue and expand the availability of general internal medicine.

Right now, if you came to us and asked for a name of a vibrant internal medicine specialist that has openings in the practice, the only way we would succeed is personally calling them on your behalf and saying will you take this patient into your practice, because these practices right now are full?

Obviously, we are also at Yale-New Haven Hospital and system through the Northeast Medical Group, offering employment to physicians, who are primary care physicians, a stress on this in the New Haven environment, and this provides security against some of the vicissitudes of funding for physicians, which is another way to help stabilize the population of primary care

physicians that we have.

DR. KLIGER: I just want to add a quick word to that. When I trained, and I did my training in the 1970s, everyone knew that the best doctors were the specialists. I mean I said everyone knew in quotation marks, or the best doctors are the specialists, and, in fact, New Haven and Yale University grew as a place that became remarkably strong in specialty and sub-specialty medicine, and the result of that in the year 2012 is that we have a remarkably strong medical community in specialty and sub-specialty medicine and a relatively anemic primary care setting.

We have great primary care doctors here, but we don't have enough of them, and we don't have the kind of system planning to make primary care the center of a health care delivery system.

What this acquisition and new hospital will allow is for that kind of strategic thinking and planning for really establishing a strong primary care system to partner with our very strong specialty system here in our area.

MS. MARTONE: Okay. Thank you. Has the employee ED staff at Saint Raphael's reached terms yet with Northeast?

DR. HERBERT: We are in the process now of credentialing all, virtually all of the employed physicians with Northeast Medical Group.

We have met with them, we have explained the benefits to them, we have assured them that we will accept, without knowledge, their current terms of employment, and we are in the process, both of credentialing them to Northeast Medical Group and credentialing them with payers, so, hopefully, shortly after the 1st of August, we will be able to bill and collect for them, as well.

And this group includes some 20 physicians, who are in emergency medicine at Hospital of Saint Raphael, so it has gone well, and it’s accepted, because the hospitalist physicians, some 60 strong at Yale-New Haven Hospital and an equal number of mid-levels, made the transition a year ago from Yale-New Haven Hospital employment to Northeast Medical Group employment, so people feel very secure and like the benefits that are offered.

MS. MARTONE: Okay, thank you. Now, on page 36, sort of somewhat similar. If you have anything additional, please let me know.

It also states that the acquisition of

Hospital of Saint Raphael's will position Yale for success as the health care environment focuses more on prevention and wellness. Any additional information you can provide on that, unless it's the same?

MS. BORGSTROM: I think that we're still going to have people, who are going to require inpatient utilization, but I think more and more care is provided on an ambulatory basis, and I think the expansion of primary care that Peter and Alan had talked about is going to be the best way to help manage and integrate that care and cooperation with other providers in the Greater New Haven community.

MS. MARTONE: Okay.

DR. HERBERT: I would also add that we are now developing systems that are beginning with our employees to address preventative care for high-risk conditions, like chronic obstructive pulmonary disease, asthma and diabetes.

This year, we have begun employing care coordinators and have recruited patients to this program. This is something very new for us, something that we're going to be developing expertise to do.

And, certainly, as Alan mentioned, with the hopes some day that our care will be completely

accountable, we'll have to address preventive care, as well as acute and episodic care.

DR. KLIGER: Just, again, if I can, a quick addition? When you talk about or when we talk about wellness, it's isolating the early care before people develop disease.

The vision that we've had is a much more comprehensive one of engaging people in the community at a time of wellness through a time of disease, management of that disease appropriately, involvement of patients in the management of their own health, so, really, the idea of a much more comprehensive way of thinking about care than we've had before.

MS. MARTONE: Okay and that would be for both campuses I'll say at this point. There will be an overall strategic program addressing prevention and wellness, or continuing to, I should say. Okay.

Then, on page 36, again, it addresses the definitive asset purchase agreement that was executed in September 2011. When does that actually take effect, and if it did already, and have there been any amendments or modifications to that agreement?

MS. BORGSTROM: So the asset purchase agreement allowed us to begin the regulatory review

processes with the federal government and the state and OHCA, and, as soon as we complete this process of review and get your approval, we will begin to move to close this transaction.

There have been, as we've learned more about one another, we've gotten a more refined plan, but the overall terms of the asset purchase agreement remain in effect.

MS. MARTONE: Okay, so, the agreement, the signed agreement that was provided with the application, is that the complete agreement? There hasn't been any additions to that?

MS. BORGSTROM: We have not executed any legal changes to any agreements.

MS. MARTONE: Okay. On page 28 -- will there be any changes to Yale-New Haven's Board or governance structure that will take place as a result of the transaction?

MS. BORGSTROM: We have agreed, as part of this transaction, that the Yale-New Haven Hospital Board will not grow in its size. It can be up to 28 members.

We have held vacancies, and, as part of this transaction, we will bring over four nominees from the Hospital of Saint Raphael, and then they will go into

our self-perpetuating governance process.

MS. MARTONE: Okay. Is it expected that charges for Yale-New Haven Hospital services will go up as a result of the transaction?

MS. BORGSTROM: We do not have any plans to raise charges as a result of this transaction, and, in fact, have been working with the payers on this matter. And if you have additional questions, we'd be happy to introduce William Gedge, who is the Senior Vice President for Payer Relations, to discuss that, but the short answer is, no, the prices won't go up as a result of this transaction.

MS. MARTONE: Okay. If you would like him to, if he can discuss any steps that Yale-New Haven has taken to assure that there's no adverse financial impact on health care consumers?

HEARING OFFICER YANDOW: I know we did have -- I don't know if you stood before.

MR. WILLIAM GEDGE: I did.

HEARING OFFICER YANDOW: You did, okay. So could you state your name and spell your last name?

MR. GEDGE: Yes. I'm Bill Gedge, Senior Vice President, Yale-New Haven Health System, and responsible for the payer relationships.

With respect to the payer relationships, we've reached agreement with all the payers to move into the transaction on a budget-neutral basis.

We, obviously, do not have access to the Hospital of Saint Raphael's contracts or their rates, but the anticipation is that when the transaction is completed, that we would then sit down with the payers and work out a new agreement, which would be budget-neutral and from a financial aspect, and we would merge together the provisions of the agreement, and that would probably take three to four months.

In the meantime, services provided on the Hospital of Saint Raphael's campus would be billed under their current billing system and paid under their current contracts, so there would be no adverse financial impact to the payers while that process of melding the two agreements occurs.

And then, once that's completed, then we'll move to a new agreement that we have negotiated with the payers on a budget-neutral basis forward from that point.

MS. MARTONE: Okay. Doesn't the application also say there's a letter of agreement that was worked out with Aetna? Is that true?

MR. GEDGE: Yes, that's correct.

MS. MARTONE: Okay. What does the agreement provide for? Is there any more specifics on that?

MR. GEDGE: No. It was essentially a budget. It was as we presented in the CON. It was a budget neutrality, in terms of pulling together the both hospitals' agreements, so that there's no financial impact to the payer when those two agreements are put together.

MS. MARTONE: Okay. All right, thank you.

HEARING OFFICER YANDOW: I just want to make sure. Did you get the last name? Okay.

MR. GEDGE: Thank you.

MS. MARTONE: On page 39, the applicants have stated that the detailed transition plan to assure continuity of services and the integration of services was still in the process, with a target closing date very soon. Can you update OHCA on that plan?

MS. BORGSTROM: Yes. As you can imagine, this is taking a great deal of time, because it's important to us that we do this very well and as my colleague, Rick D'Aquila, the President at Yale-New Haven, would describe flawlessly, so I'm going to ask Rick to come forward and describe the process.

MS. MARTONE: Okay.

HEARING OFFICER YANDOW: And you took the oath earlier?

MR. RICHARD D'AQUILA: I did.

HEARING OFFICER YANDOW: Okay and could you say and spell your last name, please, and your title?

MR. D'AQUILA: Sure. It’s Richard D’Aquila, D, apostrophe, capital A-Q-U-I-L-A, and I’m President and Chief Operating Officer, Yale-New Haven.

So let me start maybe with just a general framework, and then, if you have specifics that you want to hear more about, I can focus on them.

MS. MARTONE: Okay.

MR. D'AQUILA: But it is a kind of a massive effort to integrate services over time, but to really focus on four critical things as of August 1st. We’re contemplating an August 1st transition date.

The real focus is, and it’s going to sound kind of basic, but there are a huge number of steps, getting all the employee transitions made, getting the employees from the Hospital of Saint Raphael to the Yale-New Haven Hospital payroll, getting all that right, which is extraordinarily difficult, because there’s a lot of information we don’t have access to.

And if you think of all the things that

need to happen, employee testing, employee training, employee orientation, it’s a massive undertaking under normal circumstances, compounded in a short period of time.

Getting the hospital to function, integration enough to function seamlessly for State of Connecticut, Joint Commission and CMS standards and requirements, so a seamless integration to operate as one provider, getting the bills out and getting contracts transitioned and payable.

So we have a -- we’re using the support of an outside consulting firm. They are supporting about 20 executive teams that are made up of executives and managers responsible for key functional areas. They broke into this massive undertaking into 25 or 30 activity tracks, and, you know, the work is ongoing with a culmination date for the transition as of August 1st, so that’s the basic framework of what we’re doing and how we’re doing it.

MS. MARTONE: Okay. Does that include the clinical integration?

MR. D'AQUILA: It does not. It really, and as Peter and Alan testified, the clinical integration really needs to play out over time. It needs to be done

deliberately.

Physicians need to be engaged, services need to be thought through. On August 1st, the focus is really on existing operations, absolute continuity, employee and licensure issues, and then, over time, we'll integrate clinical services and, particularly, those services that, you know, we've agreed upfront will be focused on the Yale-New Haven campuses, the trauma, the cancer, pediatrics and others.

MS. MARTONE: Okay and you're talking about the process, so is there an actual or will there be an actual written document, any type, about the integration?

MR. D'AQUILA: In terms of the process that we're following or the milestones?

MS. MARTONE: Process and then outcome.

MR. D'AQUILA: Yeah. Right now, there are good documents that memorialize the work of the transition teams.

MS. MARTONE: Okay.

MR. D'AQUILA: So we have, we can provide kind of high-level dashboards that track the basic activity tracks of employee transition, employee training, licensure, payer notifications, you know, the actual aggregate transactional components that get us through

August 1st, and then there's kind of a longer term project schedule, which would have the clinical integration.

MS. MARTONE: And will you be updating those dashboards as the integration evolves?

MR. D'AQUILA: The dashboard is our tracking tool as an executive team for staying on track for August 1st, and that dashboard is updated weekly.

MS. MARTONE: Oh, weekly.

MR. D'AQUILA: And it identifies areas of vulnerability, areas where, you know, where we need to put additional focus and effort to stay on track, but that's our real time monitoring of an effective transition as of August 1st.

MS. BORGSTROM: And let me add, and Rick I think will agree with this. There isn't a document that says the plan. This is something that's really a very dynamic document, and it's a way of tracking something that is evolving, and we want to know, as Rick said, where we need to put our shoulder in a little bit harder, but, you know, it's changing as frequently as it needs to.

HEARING OFFICER YANDOW: Okay, so, is there some point at the end that there will be a summary of what the whole transition plan was, and when do you expect that transition to be complete?

MS. BORGSTROM: I think the transition --

HEARING OFFICER YANDOW: Taking if all goes as you hope and August 1 is the date, is there some date out there you would see that to be complete?

MS. BORGSTROM: I think the end of July/August 1 is a transaction date. I think the transition and the integration is ongoing, and it will take a long time to ultimately get these integrated, because there's also the process of culturally integrating the employees and the physicians and the two organizations.

We have a lot of milestones along the way. We want to get as much of the clinical integration started, so that we have a defined way of approaching that in the first 100 days, but then that's going to happen sequentially, so we don't have an ending, say, as of four years from now, it's going to be 100 percent.

MR. D'AQUILA: And that's really by design, because we wanted to, we certainly want to focus on the transaction. The transaction is really a July 29th/August 1st transaction, and, you know, that's got very focused nuts and bolts.

What does it take to seamlessly operate the new organization and comply with all requirements and

minimize employee disruption? That's very detailed and very focused.

And then, at the second level, are the things we've agreed will be the focus, that we won't duplicate trauma, children's hospital, but then the rest really needs to play out, you know, like your question on ambulatory. It really needs to play out much more deliberately.

Ambulatory we're immediately looking at starting a planning process that's going to, back to your earlier question, look at all of the outpatient services in the community, identify where we have duplication, identify where we have gaps and opportunities to expand access, and then how do we reconfigure the system accordingly?

That's the right way to focus, you know, on ambulatory. It takes time and engagement to do that, and it's a bit premature, until we're through this whole process.

Plus, as you probably know, until we're one organization, we don't have access to a lot of information. We still have to function like competitors, so we'd be planning in a vacuum, and when the transaction is done, then, you know, then that stuff can really

proceed in a deliberate way, and the right people can be engaged.

MS. MARTONE: Okay and I appreciate that, and the questioning behind that is really related to, you know, a department will be publishing a statewide facility plan very shortly, and the hospital's long-range plan, strategic plan, is supposed to coincide with that plan, so it's important that we, you know, collect, and we have documents, or any type of summaries to make sure that they do coincide.

MR. D'AQUILA: Sure. We're happy, as we always have, we're happy to participate in that and share what we have.

MS. MARTONE: Okay. All right. In terms of Epic, it's not scheduled to be installed at the Hospital of Saint Raphael's until 11 months after closing, so could you explain how Yale-New Haven will provide for exchanges of medical record information between the campuses until that point?

MS. BORGSTROM: I'm going to ask Lisa Stump, who is here as a Senior Executive in the health system with Information Technology, and we've had, before we planned the acquisition of Saint Raphael's, we had a very detailed plan to role Epic out among physician

practices, Greenwich Hospital, Bridgeport and Yale-New Haven, and, as Greenwich has already gone live, there are already ways to integrate some of the information between campuses, and, Lisa, you can talk more about that and the schedule.

HEARING OFFICER YANDOW: Did you take the oath earlier?

MS. LISA STUMP: I did.

HEARING OFFICER YANDOW: Okay and if you could state your name for the record, spell your last name, and your title, also?

MS. STUMP: Lisa Stump. I'm the Vice President of the Epic project, and it's S-T-U-M-P.

So, as Marna said, we have, with the understanding that the acquisition of the Hospital of Saint Raphael's was a potential, closely looked at the timing for the potential to bring both campuses live on the same information system, being our Epic EMR.

In the interim, my colleagues in Information Technology have also done, where we can, gain as much information about the technology and use on the campus today, and we will integrate key pieces of the Information Technology systems through interfaces, so that operations, billing operations can flow, as well as

clinical information, where appropriate, until the time that we can bring the Hospital of Saint Raphael campus live on Epic, as well.

MS. MARTONE: Okay, thank you.

MS. STUMP: Thank you.

MS. MARTONE: On page 52, it's indicated that the installation of the Epic EMR system can be done at approximately 30 million less, if the acquisition moves forward, then, if Epic were installed by the hospital independently. Could you explain why this is the key?

MS. BORGSTROM: So a lot of that is the resources embedded in our implementation team, so we have a team already working. It's about 150-member team that is implementing Epic in the existing Yale-New Haven health system hospitals and the Yale School of Medicine.

That team is simply then able to incorporate the Hospital of Saint Raphael's into that existing project timeline.

If HSR needed to do that on their own, they would need to build their own team of individuals to conduct that build and implementation, so we simply take advantage of the existing resources.

MS. MARTONE: Okay, thank you. Okay. It's also mentioned, this is on page 117, that capital

improvements at the Hospital of Saint Raphael campus will be based on a party list, and that list will take into account regulatory requirements, updated faculties assessments, patient volumes and annual budget amounts, so what is the budgeted, what has been budgeted for capital improvements for the Hospital of Saint Raphael's for fiscal year 2013 at this point?

MS. BORGSTROM: So are you talking after the acquisition?

MS. MARTONE: Um-hum.

MS. BORGSTROM: Okay, so, I'm going to ask Vincent Tammaro, who is a Senior Finance Officer with the health system, who has helped us put this together. We've done some, while Vinnie is coming up, some inventory work of their campus.

We've had a list of some of their deferred capital investment items, and some of the infrastructure investments we will plan to make as quickly as we are able in mechanical systems and just basic building infrastructure, and some of the investments will, other than Epic, will follow the clinical integration discussions about what services we want to focus on that campus, because, as I said earlier, it's not just an overflow campus, and, so, those investments will relate to

that. We're assuming it's in budget already.

MR. VINCENT TAMMARO: Good morning.

HEARING OFFICER YANDOW: Good morning. You stood and took the oath earlier?

MR. TAMMARO: Yes, I did.

HEARING OFFICER YANDOW: Okay. If you could state your name, spell your last name, and give your title, also, please?

MR. TAMMARO: Vincent Tammaro, T-A-M-M-A-R-O, Vice President of Corporate Finance at Yale-New Haven Health System. Could you just please repeat the question?

MS. MARTONE: Sure. It's mentioned that capital improvements at the Hospital of Saint Raphael campus were based on a party list, so we're looking for the (coughing) been established and basically budgeted for fiscal year 2013.

MR. TAMMARO: All right, so, actually, as we looked at the entire cost of the project, as far as from a capital standpoint, assuming after the go-live date, we've identified approximately 129.5 million dollars of capital cost requirements over fiscal years 2013, '14 and '15.

That 129 is broken down into various components. Approximately 85 million dollars is for

infrastructure improvements. Another 25 million dollars is an incremental amount for routine capital. This is above and beyond the 50 million dollars that's already in the current capital budget at the Hospital of Saint Raph's, an additional 5.1 million dollars for IT integration between the two campuses, and the last amount, 14.4 million dollars, is the capital cost required for the Epic installation.

That 14.4 will be realized the entire amount in fiscal 2013 for Epic, because our intent is to go live with the Epic system on that campus in the summer of 2013.

As far as the 85 and 25 million dollars, we are currently, as part of the transition planning process and the overall 2013 budgeting process, are identifying the components that will be attributable to the 2013 year.

MS. MARTONE: Okay, so, they haven't been identified yet, in terms of which actual capital improvements --

MR. TAMMARO: So we're actually going through our whole capital budgeting process, not just for the main campus, but for the combined organizations.

MS. MARTONE: When would that be available?

MR. TAMMARO: Probably, over the next

couple of months.

MS. MARTONE: Okay. Okay. What is actually budgeted if the Hospital of Saint Raphael remains a standalone entity? Is there a differential?

MR. O'CONNOR: We've been, again, as you look at the separate financial statements of the two existing independent organizations as they currently stand, we've been spending about 10 million dollars a year over the past three years at the Hospital of Saint Raphael.

MS. MARTONE: Okay. What type of capital improvement?

MR. O'CONNOR: We've done a variety of items, including, you know, for fiscal year 2012, the purchase of a new linear accelerator, replacement of our da Vinci surgical system, and then the rest has been made up of, you know, routine capital spends, monitors, instruments and the like.

MS. MARTONE: And that was the first half of this year? What will be for fiscal year 2013, though?

MR. O'CONNOR: Again, we aren't contemplating this standalone fiscal 2013, because of the importance that I outlined in my testimony, that this transaction take place. There are bigger issues that we'd

be struggling with if we don't get approved.

MS. MARTONE: Okay, thank you. The applicants have also stated that there is no contractual commitment for Yale-New Haven to spend the 129.5 million on capital improvements at the Saint Raphael's campus during the first five years, so did the Hospital of Saint Raphael consider requiring a contractual obligation to make sure that certain capital improvements were on a fixed timetable?

MR. O'CONNOR: You know, when we went through the asset purchase agreement negotiation, we considered many factors, and, ultimately, coming to the purchase price that you see in front of you with the executed APA.

Clearly, the commitment on behalf of Yale-New Haven Hospital to invest in at that time, post-close, itself, we felt was not a requirement contractually, given that the benefit would be for the new organization.

MS. MARTONE: Okay. On page 144, the applicants mention that the value of the Hospital of Saint Raphael's charitable fund is expected to be 26 million at the time of closing, and that this will be made up of permanently and totally restricted funds, 13.5 and 12.5, respectively. What is the status of having these funds

transferred to Yale-New Haven?

MS. BORGSTROM: I just want to confer with counsel, because I'm not sure I'm looking at the right -- okay.

MR. O'CONNOR: I can begin. So there is a process that we're undertaking, similar as Rick described, the transition process for a number of assets from employees. Our transfer of the restricted funds is another work plan element that we are focused on.

Frankly, it's not -- you know we are in the process now of developing that plan. There are multiple steps to that plan, which will include conveying with our donors those that we can communicate with, the intention to move those restrictive funds over to Yale-New Haven, and if we are unable to communicate appropriately and follow the regulations, we will go to the Attorney General for a ruling.

MS. MARTONE: Okay, so, assuming that October 1 that all this will be identified and be available?

MR. O'CONNOR: I mean we're hoping, as we negotiated the asset purchase agreement, you know, we went through each one of these funds in extraordinary detail to identify those funds that we could actually pull down and

use for existing services or that have actually we've met those needs previously, to reduce the degree of restriction.

We're still in the process of working through many of those steps, and that we are hopeful that when we get to the integration period, that we'll have a fruitful process that our donors will be satisfied with, because the intention is is that, again, those services are going to continue to be provided going forward, so, you know, I believe that we'll be able to meet that donor intent.

MS. MARTONE: Okay.

MR. O'CONNOR: But we still have a process to complete.

MS. MARTONE: Okay. All right, so, has there been a specific amount of the charitable funds that have been used by Saint Raphael's for the benefit of the campus since the asset purchase agreement?

MR. O'CONNOR: I'd like to ask Jim Rude to come forward. He's our Controller and Treasurer. He knows this stuff in more detail.

MR. JAMES RUDE: Good morning.

HEARING OFFICER YANDOW: Did you stand earlier?

MR. RUDE: I did. My name is James Rude. The last name is spelled R-U-D-E. I'm the AVP of Finance at Saint Raphael's and acting interim Chief Financial Officer.

COURT REPORTER: One second, please.

MR. RUDE: Saint Raphael's continues to spend its restricted funds in accordance with the restrictions. Obviously, we can only spend restricted funds if the restrictions have been met, so we have over the course of the past year since signing first the letter of intent over the last six months since signing the asset purchase agreement, Saint Raphael's has continued to expend both the earnings on permanently restricted funds, as well as temporarily restricted funds that come into our organization, in accordance with the respective restrictions.

MS. MARTONE: Okay. Are there certain projects that you could identify?

MR. RUDE: As an example, we are the provider of WIC services to the New Haven community as a primary contractor, and Yale-New Haven is a subcontractor on that contract. As money comes in on grants, such as those, we provide the services and disperse the monies.

As it relates to the linear accelerator

acquisition that Chris O'Connor referred to before, some of those monies were raised through donated monies and were funded based upon the expenditure of some of those restricted monies.

So, again, all those expenditures are in the normal and recurring course of business. With the unmet restricted monies available as of the transaction date, again, intended to be sent over to Yale-New Haven as part of the transaction once we've completed the process of either contacting donors or going through the Cy pres protocols.

MS. MARTONE: Okay, so, were there any additional funds that were used outside let's say the Saint Raphael's campus in the Greater New Haven area, besides the WIC you've mentioned? Any others, in terms of charitable funds?

MR. RUDE: In terms of charitable funds? They're all used within the New Haven community.

MS. MARTONE: Okay.

MR. RUDE: I apologize. I'm hard pressed to think of --

MS. MARTONE: I'm testing you now. I'm sorry.

MR. RUDE: We also have grants related to

the psychiatric program.

MS. MARTONE: Okay.

MR. RUDE: That we use restricted monies for. Again, as it relates to many of the permanently restricted endowment funds that have normal uses at the hospital, we support cancer care, we support cardiac care, we support pediatric care, we support clinic functions, again, primarily through the day-to-day ongoing operations of the hospital, itself.

MS. MARTONE: Okay, thank you. Okay. I have some questions on trauma. I don't know if you have an expert on it.

MS. BORGSTROM: Why don't you give us the questions, and then we'll tell you.

MS. MARTONE: All right. On page 292, there's a discussion of the consolidated trauma service, so I just have some questions related to that, like when will the ED renovations at Yale be completed, even though I think I've heard that in other hearings, but, in particular, when will the four trauma bays be operational?

MS. BORGSTROM: Brad Bevers. Is Brad here? I think Brad, who leads Facilities at Yale-New Haven, can answer that best.

HEARING OFFICER YANDOW: You took the oath

earlier?

MR. BRAD BEVERS: Yes.

HEARING OFFICER YANDOW: Okay. State and spell your name, please, and your title.

MR. BEVERS: Brad Bevers. Last name is spelled B-E-V-E-R-S. I'm Director of Facility Design and Construction.

HEARING OFFICER YANDOW: Okay. Tynan, can you hear him?

COURT REPORTER: Could you just spell your name again?

MR. BEVERS: B-E-V-E-R-S.

COURT REPORTER: Thank you.

MR. BEVERS: Trauma bays in the ED?

MS. MARTONE: Um-hum.

MR. BEVERS: ED renovation continues. We're expecting construction to be complete by December 31st of this year. Move in will actually occur early January. One trauma bay has been completed, but not yet occupied. The other three will be completed by the end of the year.

MS. MARTONE: By the end of the year?

MR. BEVERS: Yes.

MS. MARTONE: Okay. How many adult and

then pediatric bays are currently operational at Yale?

MR. BEVERS: I don't know. We have I think 23 pediatric bays in the existing pediatric ED, and the adult bays is kind of a moving target, because, as we're doing the renovation, we open some and we close some. It's almost on a week-to-week basis.

MS. MARTONE: Okay. Do you feel that the current trauma facilities at Yale are sufficient to absorb the additional I guess it's 2.3 trauma cases per day that were estimated?

MS. BORGSTROM: Probably, that's not in Brad's purview.

MS. MARTONE: Okay.

MS. BORGSTROM: But I will ask Peter to comment on that, because, as he and Dr. Kliger have begun to look at demand, I think they've looked at resources, as well.

MS. MARTONE: Okay.

DR. HERBERT: Yeah. The total number of trauma activations at HSR last year were 400 and change. They led to something like 80 touches in the operating room, and, so, the demands on operating room time are relatively minimal, compared with our own trauma program.

In addition, we have in-house 24/7 trauma

surgeons, and we have the capacity now to I think manage all major trauma in the region and have no question about that.

MS. MARTONE: Okay. More on the financial side, can you provide an update or an updated status on the financing from Barclays Capital?

MS. BORGSTROM: Yes. I'm going to ask Mr. Tammaro to return. Did you hear the question?

MR. TAMMARO: What's the update on the debt financing?

MS. MARTONE: Yes.

MR. TAMMARO: So we've actually broken it down into two steps, because we weren't certain, as far as the date of the closing. We actually are in the process of securing short-term financing to make the payment of the 160 million dollars at time of closing, and we expect within two months post-closing to secure the permanent financing.

MS. MARTONE: And did Yale-New Haven, itself, conduct an analysis, you know, on the financing needs, or was this something --

MR. TAMMARO: That was part of our multi-year projection, so we came up with the purchase price initially of 160 million dollars, and then, over the next

couple of years, two years after, in 2014, we plan to issue another 100 million dollars of debt, and, in 2016, another 100 million dollars of debt.

MS. MARTONE: Okay. Could you elaborate on the 300 million in operational cost savings that's been described actually throughout the application?

MR. TAMMARO: Okay, so, the majority of that number, 270 million dollars, relates to elimination of duplicate infrastructure costs related to various business processes, including, but not limited to finance, information technology, human resources, legal and other administrative services.

MS. MARTONE: Okay. Will there be a report generated at some point after the proposed transaction takes place, which it will identify the cost savings, like the actual cost savings?

MR. TAMMARO: So we actually have put in place, not only as part of the dashboard that Rick had mentioned on the financial side, we had a model in place to keep track of all the savings related to the transaction.

MS. MARTONE: Okay.

HEARING OFFICER YANDOW: So that document is a -- there will be a finished document when that's all

assessed and evaluated?

MR. TAMMARO: When you say finished, it's an internal document that we will present to our senior management team, as well as our finance committees.

HEARING OFFICER YANDOW: Okay and when do you think that would be a completed document for your purposes? I mean is it already completed?

MS. BORGSTROM: Let me take a crack, because, you know, I think what you're looking for is how do you know if there are 270 million of the 300 million in these infrastructure savings, we actually get them and where, and we are in the process of refining where those specifically will come out over time, but they're also going to be dynamic, and we're going to track that over the next four to five years, but we're also embarking on many other efforts to save money.

That's not the only money that we expect to save. That's directly related to this integration, but given all of the pressures that we have in this environment, we are undertaking many initiatives concurrently to lower the cost per unit of service, and those additionally will extend to Saint Raphael's.

And I think that, you know, we'll be able to track most of that, but there may be new ways of

accomplishing cost savings as we do the integration that we're not even aware of, because, as Rick D'Aquila said so often, there's so much information that we aren't able to access about one another, you know, that we're doing the best job we can, but we are absolutely committed to getting that level of savings, but more savings across the Yale-New Haven health system, because it's just going to be a necessary part of doing business successfully.

MS. MARTONE: So you would be able to, you know, share with the Department on a six-month or annual basis some type of document that demonstrates the cost savings from this integration?

MS. BORGSTROM: Yes.

MS. MARTONE: Okay. That's all I had.

HEARING OFFICER YANDOW: I just have a couple, then I want to take a break, just to review our notes and the testimony that we've heard, but just a couple of questions, and this one is, just reviewing, and perhaps it's right in the beginning of the application, but the distance between the main campuses, how far is one main campus to the other? I don't know if we actually have that in.

MS. BORGSTROM: If we count them, I think it's five or six blocks. It's very close.

HEARING OFFICER YANDOW: Okay. I just wanted to, you know, for anyone, we certainly want to make sure we have enough evidence.

DR. KLIGER: We commonly walk back and forth between.

HEARING OFFICER YANDOW: Who has the better cafeteria? (Laughter)

DR. KLIGER: Am I under oath?

HEARING OFFICER YANDOW: The Hospital of Saint Raphael’s, is there anything, any physical plant or life safety issue, anything that needs to be remediated at this point? Are there any -- anything that’s been identified that’s going to have to be remedied?

MR. O'CONNOR: I think I would answer that, unequivocally, that providing safe patient care is and will continue to be our priority as we’re an independent institution, so there are no critical components that we believe pose any harm to our patients or our staff.

What I will say is that, as we’ve talked about over, you know, the course of this morning, there are a number of infrastructure improvements that are required that we have deferred that certainly would be, as Vinnie articulated, in the shorter term investment cycle for post-integration.

HEARING OFFICER YANDOW: And what's the fallback plan? If the acquisition doesn't take place, what's your fallback plan?

MR. O'CONNOR: Well, as I stated clearly in my testimony, I mean independence is not an option for Saint Raphael's, so, you know, frankly now, with the approval of the Catholic church, the approval from the Federal Trade Commission, or at least they're not objecting to the transaction, and the Attorney General, we believe and continue to believe that this is the absolute best alternative.

There are obviously others. You're seeing them in the State. There's an application for another type of alternative transaction. Far less desirable, and certainly does not have even close to the magnitude of impact in this community that we're talking about this morning.

HEARING OFFICER YANDOW: Okay. Before we take a quick break, do you have any questions of any of the applicants? Anything else right now? Okay. What I'd like to do is take a 15-minute break, and then come back, and perhaps go with further questions of the applicants. I just want to review basically what we've gone over this morning, okay? So we'll come back at five after 12:00.

(Off the record)

HEARING OFFICER YANDOW: Back on the record. I've reviewed the notes, and I don't have any further questions, but I do want to make the applicants aware that if the application is approved, it would most likely be approved with conditions, and what we would most likely be looking for, what the Department of Public Health would most likely be looking for would be summaries as time went on regarding quantifiable cost savings, summaries of the clinical integration, the primary care development, the transitional process.

We'd also be looking after close for unredacted copies of certain documents that have been filed with the application, including the purchase agreement, the asset purchase agreement after the closing.

And there will be no closing, unless this decision will come before, so I just wanted to make the applicant aware regarding past practices of the Department and other documents that we keep on file regarding mergers, the type of things that we would be looking for, okay?

And, then, just a couple of other follow-ups. Ms. Martone?

MS. MARTONE: Yes. I have one late file

I'd like to ask for. If we could have the month-end and year-to-date financial statements for both hospitals through May of this year?

MS. BORGSTROM: Those are not available.

MR. O'CONNOR: We could add April.

MS. MARTONE: Oh, up to April? That's fine. For Yale-New Haven, as well. Okay.

HEARING OFFICER YANDOW: Counsel, is there anything you have?

MS. MATTHEWS: I was just wondering if Marna could speak for a few minutes, just to clarify a few things about timing with respect to the transaction and notice periods and those sorts of things.

MS. BORGSTROM: Just because we have, if you can gather from the discussion that we've had today, this is an enormous opportunity, but there's also a lot of work that goes along with it and a lot of moving parts, and, just to be clear, in addition to the urgency that Mr. O'Connor described when he talked about Saint Raphael's financial condition, we are moving to close this as quickly as we can.

As a technical matter, we are looking to do a financial close late in the day on July 26th, and that is when monies will actually be wired consistent with the

asset purchase agreement, and then we will actually do an employee transition and formal close, so employees will wear a new badge on July 29th, and that is also the beginning of a pay period at Yale-New Haven, so with all the complexities of the transition, it allows us to do that.

In order to do that close and keep our cash flow going and bill and collect for patients, we have 30-day notice requirements with some of the payers that have to be posted at least 30 days prior to the close of the transaction.

I know that we've had discussions about the importance of helping you complete, as expeditiously as possible, your final review and decision-making of this, and that's the reason, is because with the 30-day notification requirement to Medicaid and other payers and a hard close date of the 26th of July, we are, you know, all eyes turned on getting everything done for this application.

So, you know, we will work with you, and I know that counsel can talk with you about how to best meet the needs that you've described. Obviously, it's in our interest to achieve all of the objectives that we've put in this, including cost savings, and we will continue to

do that, because we all see the same things coming in health care reform.

So, you know, we're very grateful for this opportunity to answer your questions. We're grateful for your willingness to consider this as expeditiously as possible, and just want to thank you for making yourselves available in New Haven today.

MS. MATTHEWS: I have just one other thing. Can I just clarify about timing of the late files? It sounds like those are available. We could likely submit those immediately.

HEARING OFFICER YANDOW: Great. So there's nothing else on behalf of the applicant, is that correct? What I'd like to do now is take a break, and, at 1:00, we will go into the public comment session of this hearing.

Okay, so, anything else before we break? Okay, we are on break now until 1:00.

MS. MATTHEWS: Thank you very much.

(Whereupon, the presentations and questioning concluded.)

RE: OFFICE OF HEALTH CARE ACCESS
JUNE 5, 2012

AGENDA

Convening of the Public Hearing	2
Applicant’s Presentation of the CON Proposal	8
OHCA’s Questions	43

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

RECEIVED
JUN 14 2012
OFFICE OF
HEALTH CARE ACCESS

OFFICE OF HEALTH CARE ACCESS

CERTIFICATE OF NEED APPLICATION
DOCKET NUMBER 12-31747

YALE-NEW HAVEN HOSPITAL, SAINT RAPHAEL HEALTHCARE SYSTEM, INC. AND THE HOSPITAL OF SAINT RAPHAEL

PROPOSAL FOR YALE-NEW HAVEN HOSPITAL'S ACQUISITION OF THE SAINT RAPHAEL HEALTHCARE SYSTEM, INC. AND THE HOSPITAL OF SAINT RAPHAEL

JUNE 5, 2012

GATEWAY COMMUNITY COLLEGE
60 SARGENT DRIVE
NEW HAVEN, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

RE: OFFICE OF HEALTH CARE ACCESS
JUNE 5, 2012

. . .Verbatim proceedings of a hearing before the Department of Public Health, Office of Health Care Access, held at Gateway Community College, Room 160, 60 Sargent Drive, New Haven, Connecticut, on June 5, 2012 at 10:09 a.m. . . .

HEARING OFFICER JOANNE YANDOW: Good morning. Before we begin, would everyone please turn off or silence your cell phones and beepers, please?

This is a public hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access. I am Joanne V. Yandow, the Hearing Officer in this matter, and I was designed by the DPH Commissioner, Dr. Jewel Brown. I'm sorry. Dr. Jewel Mullen.

Docket No. 12-31747-CON is being held today, June 5, 2012, to consider Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated and the Hospital of Saint Raphael's CON application for the proposal of Yale-New Haven Hospital's acquisition of the Saint Raphael Healthcare System, Incorporated and the Hospital of Saint Raphael.

This public hearing is being held pursuant to Connecticut General Statute, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes, Uniform Administrative Procedures Act.

Again, I'm Joanne V. Yandow, the Hearing Officer in this matter. Assisting me today with the public hearing is Kimberly Martone to my right, Director of Operations for the Office of Health Care Access. To my left is the Department of Public Health Legal Director, Marianne Horn.

The hearing is being recorded today by Post Reporting Services. Following the hearing, I will issue a proposed final decision, in accordance with General Statute 4-179.

I will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

In accordance with the General Statutes, Department of Public Health, Deputy Commissioner Lisa Davis, shall issue a final decision.

The applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated, and Hospital of Saint Raphael, have been designed as parties

to this proceeding.

Could I please have counsel for the applicants identify themselves for the record? And I'll start here.

MS. REBECCA MATTHEWS: Okay. Good morning. I'm Rebecca Matthews with Wiggin and Dana. I'm here on behalf of the applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System and the Hospital of Saint Raphael.

HEARING OFFICER YANDOW: For all three applicants?

MS. MATTHEWS: Yes.

HEARING OFFICER YANDOW: Any other counsel on the table? And, Attorney Matthews, who is it that will be offering testimony on behalf of the applicant today?

MS. MATTHEWS: I have with me today Marna Borgstrom, the CEO of Yale-New Haven Hospital, Chris O'Connor, the CEO of the Hospital of Saint Raphael, and Drs. Peter Herbert and Alan Kliger, who are the Chief Medical Officers of each of the hospitals.

HEARING OFFICER YANDOW: And are there -- is there anyone also here today, who wishes to offer testimony or make a statement in this case, other than

the individuals representing the applicant? The record can show that no one has come forward.

Okay. At this time, I would like all the individuals, who are going to testify on behalf of the applicants, to stand and raise your right hand to be sworn.

(Whereupon, the parties were sworn.)

HEARING OFFICER YANDOW: Okay and I will note for the record there are also people, who plan to testify on behalf of the applicant in the audience.

With counsel at the applicant's table we have -- you identified the people that have filed pre-filed testimonies?

MS. MATTHEWS: Yes, correct. There may be some questions that they would like to consult with some other folks here, so they have been sworn in, if that's okay. We'll have each of them introduce themselves and their titles when they come up.

HEARING OFFICER YANDOW: Okay. For those individuals, who just took the oath, please state your full name the first time you speak and adopt any written testimony you've submitted on the record.

We have Ms. Marna Borgstrom, Dr. Peter Herbert, Dr. Alan Kliger. Am I pronouncing that right?

DR. ALAN KLIGER: Yes.

HEARING OFFICER YANDOW: And Christopher O'Connor all present. Ms. Borgstrom, do you want to adopt the testimony that you have filed as pre-filed testimony?

MS. MARNA BORGSTROM: Yes, I do.

HEARING OFFICER YANDOW: Mr. Herbert, do you -- I'm sorry. Mr. Herbert, do you adopt the document that has been filed as pre-filed testimony with your signature?

DR. PETER HERBERT: I do.

HEARING OFFICER YANDOW: Dr. Kliger, do you adopt the testimony that has been filed as pre-filed testimony under your signature?

DR. KLIGER: Yes, I do.

HEARING OFFICER YANDOW: Mr. O'Connor, do you adopt the testimony that has been filed under your signature?

MR. CHRIS O'CONNOR: I do.

HEARING OFFICER YANDOW: Also, for everyone else that stood to be sworn, please make sure that you have printed your name and affiliation on the sign-up sheet that has been made available for the hearing.

At this time, I will ask Ms. Martone to read into the record those documents already appearing in OHCA's Table of Record in this case. All documents have been identified in the Table of Record for reference purposes.

MS. KIMBERLY MARTONE: Good morning. Kimberly Martone for this proposal, Docket Number 12-31747. We have Exhibits A through M, and we also have an additional exhibit, which we'll label Exhibit N, and those are the letters of support that were received by the office on June 1st.

HEARING OFFICER YANDOW: Okay. Have you seen the record of exhibits?

MS. MARTONE: Yes, I have.

HEARING OFFICER YANDOW: Any objection?

MS. MARTONE: We don't have any objection to any of the items listed. I would just like to note on the record a couple of matters with respect to Exhibit E, which is a letter from the physicians.

I'd just like to note that that letter was submitted anonymously. Obviously, OHCA can consider whatever evidence it thinks is relevant. I just wanted to have you consider that when determining how much weight to give to it.

The authors did not send a representative to participate in this proceeding, and since the time that it was submitted, there have been various discussions regarding medical staff integration that Drs. Herbert and Kliger will give you more detail on.

We're obviously happy to answer any questions you have about any of that.

HEARING OFFICER YANDOW: Okay. In Record Exhibit N, which came along with the pre-filed testimony, is a motion for pro hac vice.

MS. MARTONE: Yes.

HEARING OFFICER YANDOW: And --

MS. MARTONE: I think you can consider that application withdrawn at this point.

HEARING OFFICER YANDOW: You're going to withdraw that?

MS. MARTONE: Yes.

HEARING OFFICER YANDOW: So the motion pro hac vice is withdrawn at this point?

MS. MARTONE: Correct.

HEARING OFFICER YANDOW: And does not need a ruling. Okay. At this time, the applicants, Yale-New Haven Hospital, Saint Raphael Healthcare System, Incorporated, and Hospital of Saint Raphael may proceed

with their testimony.

MS. MARTONE: Okay, thank you. With your permission, I'll turn it over to Mrs. Borgstrom.

MS. BORGSTROM: Good morning, and thank you. My name is Marna Borgstrom, and I am the Chief Executive Officer of Yale-New Haven Hospital and the President and Chief Executive Officer of the Yale-New Haven Health System.

On behalf of all of our employees, our Boards and our affiliated physicians, I want to offer our appreciation to OHCA for your careful deliberation of this historic integration.

We recognize the challenges that are facing you in this evolving health care environment, and we're grateful for your time and consideration of this.

I have the distinct privilege of introducing and highlighting the importance of this proposed acquisition, and I'll provide you with an overview of a few of the reasons that we're seeking your regulatory approval for this transaction. And, as noted earlier, you're also going to be hearing from my colleagues at this table.

So let me take a few minutes, just to outline the reasons why this transaction is so vital to

our future and to the provision of high-quality health care to the people of Connecticut for years to come, we believe.

The concept of this acquisition was founded on three broad principles. One is to continue to advance quality and safe care that we already provide, two is to preserve and extend access to that care, and three is to provide that care in the most cost-effective manner possible.

Underlying these goals are two real imperatives. One are the financial challenges currently being faced by the Hospital of Saint Raphael, and you'll hear more about that from Mr. O'Connor, and the second are the extraordinary capacity restraints faced by Yale-New Haven, which have reached a point, where this acquisition is absolutely essential to increasing our ability to effectively take care of patients.

The acquisition will help us immediately relieve our crowded conditions. I will note that this morning our contact census was 956 patients at Yale-New Haven Hospital, and it will allow us to do that much more quickly than building a new bed tower, which comes at significant cost.

We were also pleased to find out, on June

1st, on Friday, that after reviewing thousands of documents, the Connecticut Attorney General and the Federal Trade Commission recognized these imperatives and announced that they would not be taking any action to oppose this acquisition.

This transaction represents a unique opportunity for us to better manage and coordinate care on behalf of the patients we serve. Supported by an integrated electronic medical records system, we can engage various health care providers to assist, track and influence the use of the very best evidence-based practices across the campuses.

Imagine a fully integrated patient care network, that empowers patients by providing them access to their medical records.

For anyone, who has left a caregiver and wondered if they heard the directions or instructions they were given clearly, or for anyone, who has had to rely on the memory of an older family member to proceed with the next steps of their care, having access to this will be a wonderful safety net.

Through this acquisition, we also believe that we can have a real impact on influencing downward the health care cost curve.

We can avoid duplicative investments in medical technology and talent, and we can spread our infrastructure costs over a wider base of operations, achieving the efficiencies that couldn't be attained under any other scenario, other than bringing these organizations together.

The transaction also gives Yale-New Haven Hospital the ability to avoid a 622-million-dollar capital investment and a new patient care tower, which we had already begun to plan. That includes the cost of the building, establishing a new chiller plant, because we've run out of chilled water capacity, putting in a new parking garage, because the City of New Haven has requirements for additional parking as new spaces bought, is built, adding or renovating space in buildings that patient care beds may be moved from in order to consolidate focused service line patient care in a new building, and, of course, the capitalized interest associated with a project like that.

So this allows us to increase our capacity in a much more cost-effective way, using the existing beds and the operating room time and space on the Saint Raphael campus.

As a result of growth and demand at Yale-

New Haven Hospital, our existing bed utilization is over 80 percent, and, most significantly, medical surgical occupancy is over 90 percent. Our volume projections forecast and occupancy rate of 93 percent by 2016, and that is simply unsustainable to operate a good organization with that kind of demand.

Yale-New Haven is unique in the state for the level of care we provide, from acutely ill patients, a level one trauma service, to high acuity referrals from other institutions.

In 2011, we instituted the Y Access line, which is a single-source phone referral system, where a physician can make one call, and all the arrangements for a patient, from transportation to the hospital, to admission, to insurance clearance, can be done.

As a result of that, the increased number of referrals has been growing substantially, and it affords an opportunity for better access for some of the most critically ill patients in Connecticut and from beyond.

So we're not just a state resource. We have become a regional resource, and having capacity is going to be critical to managing. Most of that is unexpected demand. People obviously don't book those in

advance, and we have to be able to handle the demand when the calls are made.

To manage our resources most effectively, we need to reach a maximum occupancy target of 80 percent, and, as I said earlier, the acquisition allows us to do that.

And we're convinced that the need for additional beds on the Yale-New Haven Hospital campus will remain clear, as well. Recognizing the extraordinary demands that you have, a great deal of work, we withdrew an application for additional capacity on the Yale-New Haven campus until after we've completed this acquisition, but that withdrawal is predicated on the assumption that you will approve all 511 beds in Saint Raphael's license to come into this integrated organization.

So what's this ultimately going to mean for Yale-New Haven and for the Hospital of Saint Raphael? First and foremost, this transaction will allow us to address the real and very pressing financial challenges that Saint Raphael's is facing, and, as I mentioned earlier, it provides a creative and cost-effective approach to addressing capacity challenges at Yale-New Haven.

It preserves existing commitments to charitable care and investments in our community. Last year alone, Yale-New Haven Hospital provided more than 160 million dollars in free and charitable and under-reimbursed care, and our charitable policies, which are among the most liberal we've heard of, including free care and sliding scale to those in need, will prevail after this acquisition.

As part of the acquisition, we've also agreed to honor the heritage of the hospital of Saint Raphael, including the recognition of the Catholic ethical and religious directives of the care provided on that campus, and this will essentially preserve health care as it is currently provided in New Haven.

The transaction provides an opportunity to invest in one of the really great hospitals in the State of Connecticut, and, as you've read under this proposal, Yale-New Haven has a commitment to strongly support the Hospital of Saint Raphael by investing in capital infrastructure and insuring that organization as a healthy, vibrant resource in the health care community for the Greater New Haven region.

The opportunity to integrate clinical services will support improvements in quality of care and

the creation of centers of excellence on the Saint Raphael's campus, so we're not looking to just use it for overflow. We're looking to make very focused patient care investments.

The transaction permits the two hospitals to integrate clinical services and support functions, and, as I mentioned earlier, achieve cost savings that are estimated to be up to 300 million dollars over five years.

While some positions will be eliminated, due to the transaction, already significant efforts have been made to minimize the impact on individual staff members.

For example, since the beginning of the year, vacancies have been held at the Yale-New Haven campus to increase the opportunity that we can transition Saint Raphael employees, whose positions are being lost, into other positions.

In the long run, as we continue to invest on both campuses, we expect that job opportunities will continue to grow, and that New Haven will continue to serve as an economic driver for the State of Connecticut.

But what is most important and most critical about our common vision is the ability to

advance access to high-quality care efficiently and effectively.

This is absolutely essential to our long-term ability to adapt to a changing health care environment.

In Connecticut, with an aging population, demand is going to be compounded in Connecticut as the baby boom generation is entering retirement with high levels of expectations for health care and support services.

In fact, Connecticut's population over 65 is already 14.2 percent, which exceeds the U.S. average of 13 percent.

And while the demand for services will continue to challenge our capacity, we also understand that reimbursements received by hospitals are going to continue to be contained, hence, the importance of operating as effectively and efficiently as we can.

In fact, the American Hospital Association committed, on behalf of its member hospitals in both Yale-New Haven and Saint Raphael, supported this to 155 billion dollars in cost reductions over the next 10 years, and we expect that number will continue to grow as the federal government's economic challenges intensify.

So we clearly understand that we have to do everything in our power to advance quality care, to advance access, and to do it in a cost-effective way.

OHCA, as you know, is tasked with a statutory mandate to evaluate proposals against certain guiding principles, including increasing access to high-quality care in the most cost-effective manner.

That is, obviously, the core of this proposal, and that is our promise. It allows us to creatively manage change in a way that's going to enhance access and quality, and it will have a lasting and positive impact on our state.

This opportunity to integrate the resources of these two institutional providers provides us the opportunity to meet the expectations of our patients, and it is clear that we are healthier, and only together can we overcome the pressure of the challenges facing both of our organizations and health care in general, so I obviously urge you to approve this Certificate of Need application.

It's now my pleasure to introduce Dr. Peter Herbert, who is the Chief Medical Officer at Yale-New Haven Hospital, to provide an overview of the clinical opportunities that this transaction provides to

the communities we serve.

DR. HERBERT: Thank you, Marna. As Marna mentioned, I'm the Chief Medical Officer for Yale-New Haven Hospital and Yale-New Haven Health System.

I've had the privilege over the last several months of working with my friend and colleague, Dr. Alan Kliger, on the implementation of clinical integration between our two campuses.

I think it's noteworthy that between 1990 and 1999 I spent virtually the decade as Chairman of the Department of Medicine at Hospital of Saint Raphael, and when I moved from Hospital of Saint Raphael to Yale-New Haven Hospital, Dr. Kliger took over in my position as Chief of Medicine at Hospital of Saint Raphael and since has become the Chief Medical Officer and the Chief Quality Officer.

Alan was also a full-time member of the Yale faculty for several years before he joined the community, and both of us are still clinical professors of medicine at Yale.

I want to expand a bit on Marna's testimony, as it relates to both what we have done to deal with the census challenge at Hospital of Saint Raphael and how we have prepared for the integration of

our two medical staffs.

Yale-New Haven Hospital right now is one of very few hospitals in the State of Connecticut that fundamentally operates all of its beds. Actually, probably one of the few in the country, and that relates to the fact that between 2005 and the present we yearly have increased discharges from the hospital by roughly three percent.

We work very hard on controlling our length of stay. In medicine, our biggest department, for instance, we've reduced length of stay from roughly 5.4 days to 5.0 days and change now.

Mr. Richard D'Aquila, our President, has led a very important safe patient flow initiative that has resulted in the average discharge time of patients being moved from roughly 3:00 to 1:00, the average number of patients being discharged by 11:00 in the morning, increasing from roughly seven percent to up to close to 25 percent, and it's only changes like this that have permitted us to function effectively with the number of licensed beds that we have at the current time.

Marna mentioned the Y Access patients that have come. The number of patients coming through Y Access the year before we implemented was in the range of

3,000. That number this year will grow by roughly 70 percent, so more than 4,500 patients will be transferred to us from other hospitals in the State of Connecticut.

That transfer is driven by a lot of special services that Yale-New Haven Hospital offers. Many of them were mentioned in my pre-filed testimony, and they include cardiac services, transplant services, trauma services and so forth.

The problem with the patients that come to us through the Y Access line is they are the sickest of the sick, and whereas our patients typically stay overall for the hospital around 5.24 days, these patients stay 11.8 days in the hospital.

If you look at the number of patients that we classify as emergent, who are admitted to Yale-New Haven Hospital, that number a year ago was roughly 73 percent. It's now about 76 percent.

So, as Marna mentioned, these patients come to us without a lot of advance information, and we're challenged with looking for places to place these patients when they come.

Marna mentioned a number of patients that were in the hospital this morning, and we've had days when the census in the hospital has exceeded 1,000.

That's contact census.

So on the Department of Medicine and Surgery, where we have had pretty much steady 90 percent occupancy, the number of patients, on average on that service, has increased from 511 to 577.

So when you work with such an extremely high census, we're forced often to put patients into what we consider to be overflow areas, and what are they?

They're one-bed patient rooms that have two patients in them. They're two patient rooms that end up with three patients in them. They are solariums.

And the consequence of this, you know, to the fragile and very ill patients that we admit is you have two or three people sharing the same bathroom, and patients tell us how they like that experience when we have patient census, and we get letters, and, you know, it's just not a great experience, when we're forced to use overflow beds.

We're fairly certain that our care is safe in these sites, but it's not, obviously, the kind of care that patients expect from us.

We have spent a lot of time, Alan and I, dealing with the issue of clinical integration. We've held meetings at both hospitals with clinical leadership,

with members of the general staff.

We have discussed what we think are good plans for the new institution, and we spent a lot of time looking at the rationale and the logistics of accomplishing this clinical integration.

A big question, of course, that arises is will we have problems with staffing from a physician point of view when the clinical integration begins, and I can assure you we're in a very good position right now.

Of the physicians, who are privileged at Hospital of Saint Raphael, roughly 80 percent of them already have privileges at Yale-New Haven Hospital.

That left approximately 400 physicians and mid-level physicians, mid-level practitioners, many of them employed by Hospital of Saint Raphael that we needed to privilege.

We worked extremely hard in the last three months to accomplish this, and I'm certain that virtually every vital caregiver at Hospital of Saint Raphael will be privileged at Yale-New Haven Hospital on day one.

We have dealt with the issue of the hospital-based services. We have agreed to accept the contracts that the hospital-based services, services like radiology, pathology, anesthesia and so forth, have at

Hospital of Saint Raphael, and those services will all be fully functioning on day one.

So we're very confident that we will be able to manage both campuses if OHCA grants this request for an asset purchase agreement.

Obviously, the other part of this is very important, is integrating the clinical services, themselves, and my colleague, Dr. Kliger, will address much of that in his testimony.

I'll be happy to answer questions later, and, at this point, Alan, I turn the microphone over to you.

DR. KLIGER: Thank you, Peter. I'm Alan Kliger, the Chief Medical Officer and the Chief Quality Officer for the Hospital of Saint Raphael.

You've heard about the capacity issues facing Yale-New Haven from Peter, and you've heard about the benefits of this transaction from Marna Borgstrom.

I really want to make three major points. First of all, this acquisition is going to further the mission of both hospitals to deliver care more effectively and efficiently and to integrate services to that end.

The second point I want to talk about is

the value of a single comprehensive information system that we intend to use, and, thirdly, the importance of this transaction to graduate medical education.

When we began to explore the possibility of these two hospitals coming together, we knew there would be challenges, but we also knew that there would be opportunity to plan and deliver services more effectively and more efficiently.

In particular, we knew that we'd have opportunities to avoid duplication of services and redundant investments in technology and infrastructure, and avoiding duplication of services is critical, not only to the business of hospitals, but to the experience of patients, for patients to be able to know that they can get the right care at the right time and not to have duplication of services or redundancy in their care.

Yale-New Haven Hospital and the Hospital of Saint Raphael share a vision of the future that will enhance the delivery of health care services in our region, recognizing and respecting the strengths of both of the institutions.

We see the value of coming together to form an integrated system that understands that great health care can be made even better.

When we integrate these services, the goal of integration is to offer the safest, highest quality of care to our patients and their families and our whole community.

To do this, we have to look carefully at what our current capabilities are, what investments we've made before, and then what opportunities for future investments we have.

But also importantly, we have to examine this from the patient's point of view, and, from a patient's point of view, we aim to deliver care that's easy to navigate, is patient-centered, without the inefficiencies of care and waste and duplication of tests and procedures that all too frequently characterize routine care.

Now this process of clinical integration that Peter and I have started to talk about will take some time to complete, because our goal is to organize care around patient needs and efficient use of resources, rather than around this sort of traditional departmental organization of care that we've had before.

Certain services we know will be focused on one campus or the other, while other services will be on both campuses or in several outpatient locations.

And Peter Herbert and I have been working with hospital administrators, medical leaders, nurses and doctors from both organizations to start soliciting input from them to facilitate that clinical planning.

At this time, we believe that the Yale-New Haven campus is best suited to deliver care in several clinical programs, trauma, in oncology care and its subspecialty areas, pediatrics, high-risk obstetrics.

These are all areas that the Yale-New Haven campus right now is very deep and rich in, and they've been selected, because of their highly specialized nature, the depth of physician expertise on the Yale-New Haven campus, and the very strong support services in technology that are present on the Yale-New Haven campus.

The Hospital of Saint Raphael's campus has been identified for the establishment of a musculoskeletal institute, which will include orthopedics, pain management, spine care, rehabilitation, podiatry.

The Saint Raphael's campus now has an established intensive rehabilitation service on campus and, also, sub-acute rehabilitation in our Grimes Center, allowing Saint Raphael's campus, therefore, to offer this

full continuum of care, from acute care, to rehabilitation, to sub-acute care.

The Hospital of Saint Raphael's campus might also be a focus for bariatric surgery and, also, for a primary family-oriented birthing center.

High-volume services we think will be offered at both campuses to meet community need, including general medicine, surgery, cardiology, vascular surgery, urology, psychiatry, low-risk obstetrics, dentistry and emergency services, as well as essential support services for the hospital locate services, such as anesthesia, pathology, laboratory medicine and radiology.

At the end of the day, we are confident that we can integrate these services under one license to provide access to exceptional care in a cost-efficient manner.

We can envision a future, where quality, safety and value for our patients are really at the center of everything that we do.

Let me move to my second point, the importance of a single electronic information system. A comprehensive electronic record and information system will transform, we believe, the way that we provide care

across our integrated network, reducing redundant tests and procedures and facilitating continuous quality improvement.

Hospitals across the country are struggling to meet the federal government's expectation for medical records and to reap some of the benefits for implementing those systems.

If the cost of these systems would be prohibited to the Hospital of Raphael's, were we to stand alone, given our current financial condition, this merging of our two hospitals will allow both campuses to deploy an integrated single electronic medical record.

Yale-New Haven Hospital has chosen a really wonderful comprehensive electronic information system, called Epic. Epic will connect inpatient to outpatient settings, connect physician offices, laboratories, diagnostic centers, and provide patients with direct access to their own medical records.

Access to a patient's clinical record by any Yale-New Haven provider will significantly enhance the coordination of patient care and reduce duplicative tests and procedures, but probably most importantly that single system improves the safety for our patients.

Epic provides a common list of current

medications that all of our patients are on, so that all caregivers have access to that same list of medications and any changes to those medications that are made, a list of allergies, a list of medical conditions and past history as a single unified record accessed by all caregivers.

It will be able to flash alerts to caregivers when there might be a reaction to a drug, or an allergy to a medicine, or a problem with a radiological contrast material.

Probably a good example of how a system like Epic can be so useful across both campuses is reflected even today in the fact that many patients seek care in the Emergency Department at both hospitals.

It's not at all unusual for a patient to be at the Yale-New Haven Emergency Room and get care there and be discharged, and five days later, or a week later come to the Saint Raphael's Emergency Room, either with a similar complaint, or continued problems.

Right now, those two hospitals don't have a uniform record. Understanding what tests were done, understanding what medicines were given is something that we currently do only with a difficulty of telephone calls, telephone calls at 3:00 a.m., trying to get

additional information.

Often, the same tests that have been done only a week earlier will be repeated in the other emergency room a week later, so that the doctors can be assured that all of those are normal.

A single integrative medical information system really helps save that type of evaluation and that type of duplication.

This system of integrated care and a single information system we think can deliver us to the future of accountable care, that concept that all of us are striving for, to deliver the best care at the lowest cost.

The last point I want to raise has to do with the training of future doctors, an important part of what both hospitals currently do.

A full integration of the graduate medical education program from Yale-New Haven Hospital and Saint Raphael provides us with the unique opportunity to broaden the medical education, by bringing together the best components of each institution to teach that next generation of doctors.

Under the terms of this acquisition, all residents and fellows currently enrolled in our Saint

Raphael's programs will have the opportunity to complete their training with a wider opportunity for education on both campuses.

Future enrollees will find stronger programs with wider opportunities for patient care and teaching. The teaching staff at Saint Raphael's will be working with the program directors at Yale-New Haven Hospital to insure uninterrupted training of our residents and fellows, and, as a result, the acquisition will permit the reduction of duplicative functions in the support areas for this graduate medical education.

Saint Raphael residency and fellowship programs in surgery, diagnostic radiology, geriatrics, nephrology, cardiology, oral and maxillofacial surgery all will be transferred to and integrated with the Yale-New Haven graduate education accredited programs.

Our internal medicine residency program will be integrated into Yale-New Haven primary care program.

We believe strongly that these changes will create a more patient-centered, safe and quality-driven care for our community than ever before.

While change can cause anxiety and uncertainty, it can also inspire and transform.

Together, we believe we can deliver high-quality care to more people in a more efficient manner.

So thanks, and let me, then, turn over the microphone to Chris O'Connor.

MR. O'CONNOR: Good morning. Thank you, Alan. My name is Christopher O'Connor. I'm the President and Chief Executive Officer of the Saint Raphael Health Care System and the Hospital of Saint Raphael.

I believe the testimony you've already heard from Marna, Peter and Alan articulates why this makes so much sense, given the extraordinary benefits it can provide to our patients, employees, physicians and our community.

This morning, I'd like to thank OHCA for your time and consideration of this exceptionally important question.

I'd also like to discuss the important reasons why the Hospital of Saint Raphael is pursuing acquisition by Yale-New Haven Hospital and why our timing is so critical in achieving our goals.

I can offer a unique perspective about the value of this transaction, especially with respect to the mounting challenges faced by Saint Raphael.

Our founders and sponsors, the Sisters of Charity of St. Elizabeth, our Board of Trustees, our leadership team firmly believe that this acquisition by and the full integration with Yale-New Haven Hospital represents the very best way to address the needs of the Saint Raphael's community.

I will try to provide you with a sense of our deliberations and how we concluded that this transaction is absolutely the right thing to do.

Today, Saint Raphael's is at a unique moment in time, when it must set a new course. As its current operation as an independent hospital is unsustainable for the future, here's where we are.

The hospital has suffered through five consecutive years of significant operating losses between fiscal years 2005 and 2009, including a staggering 17-million-dollar loss in fiscal year 2008.

These painful and deepening financial pressures required us to make extremely difficult choices to preserve the organization's solvency.

Saint Raphael's financial performance has put it out of compliance with a number of its bond covenants, specifically, those pertaining today's cash, long-term debt to capitalization and minimum fund

balance.

It's with this background that the Sisters, the Board and senior leadership determined back in 2008, prior to my arrival as CEO, that Saint Raphael's rapidly deteriorating financial position jeopardized its future as a standalone hospital.

A strategic partner had to be found. Simultaneously, the hospital also did what most would do facing similar circumstances. We turned to ourselves and worked hard to drive down costs and seek opportunities to expand revenue.

These actions, which continue to this day, fall within a magnitude of categories. In the expense reduction area, actions included, but certainly not limited to, cuts to existing employee benefits, most significantly ceasing contributions to the employee defined contribution plan, pension plan, defined contribution pension plan, as well as the employer matching funds to participants of 401K plans, use of value engineering to achieve efficiencies in the way that we operate, including right sizing our organization.

This involved labor and non-labor savings, initiatives in essentially all departments, including reducing the number of employees.

Deferred investments in our capital infrastructure as a result of financial pressures we have encountered, we have been spending well below depreciation levels, and, as a result, the average age of plant for the Hospital of Saint Raphael campus has increased from 16.5 years in 2008 to 26.2 years in 2011, making us the oldest in the State of Connecticut, a deferred investment in new technology, as well as information systems.

In addition, Saint Raphael's has taken deliberate steps to improve our revenue cycle. We have engaged third party payers to negotiate the most competitive rates possible, given our circumstances.

We have improved enrollment in Medicaid-eligible patients and are better capturing Medicaid usage, which results in higher DSH payments, and have pursued various appeals related to Medicare reimbursement, such as those relating to the area of wage indices.

We have improved medical record documentation to insure appropriate reimbursement for medically necessary services, improved charge capture oversight, streamline collections and diminished payment denials.

Unfortunately, all of these actions have not been enough. Despite all of our best efforts and despite all of the challenging decisions we have made, we remain very concerned about our ongoing viability.

It is clear that we can no longer exist as a standalone provider of medical services. The Hospital of Saint Raphael's still faces a significant amount of long-term debt, an enormous pension fund deficit, and deteriorating payer mix, as I've noted -- payer mix, as I've noted the fiscal plan is aging rapidly. It is now more than two and a half times older than the national average.

With our curtailment in 2010 of all post-retirement pension benefit contributions, the hospital can no longer compete effectively for the talent necessary to manage the organization, nor fulfill our commitments to those who have served with distinction.

Our day's cash on hand is perilously low at 23.5 days, as of our April 30, 2012 financials. At that level, we have a very limited ability to manage through business interruptions.

Even if we were to somehow triple the number of day's cash on hand, it would still be well below national averages.

COURT REPORTER: One second.

MR. O'CONNOR: From a capital perspective, a lack of available funds has placed us at a competitive disadvantage, vis-à-vis other hospitals in the state. Given the current state of our long-term debt, borrowing is simply not a possibility.

Compounding this are the volume declines experienced by the Hospital of Saint Raphael in the recent years. Our volume this year is down about eight percent, with that decline expected to continue if we remain as a standalone hospital.

Absent the ability to invest in our facilities, talent and equipment, we do not see this as a reversible trend.

About 70 percent of our patients, a number that is growing, are currently insured by either Medicare or Medicaid.

As Marna pointed out during her testimony, the economic pressures on government reimbursement will only intensify in the years ahead, and our ability to shift those losses to other payers, given our existing payer mix, is and will remain extremely limited.

So under the veil of that economic pressure, which has only intensified over the course of

the last five years, it has become critically important for us to seek a partner or a buyer that would enable the continued provision of high-quality care on the Saint Raphael campus, particularly to maintain our commitment to the most vulnerable populations.

The Sisters, Board and prior leadership began this process in 2008, initially reaching out to national Catholic health care organizations as a way to stabilize our financial footing while preserving our mission.

As those conversations progressed, however, it became clear that the combination of our organization's financial issues and the national economic conditions were serving as real and direct obstacles to our ability to consummate a working partnership that would address both our long-term capital and operating needs.

Following the leadership transition in 2009 and given our continuing fragility, we restarted the search for a strategic partner in 2010, with a very strong sense of urgency.

We chartered a path toward affiliation, which resulted in considering national, state, for-profit, Catholic and secular options.

Through that process, we established a series of criteria that would be essential to affiliation. These criteria included retaining our Catholic identity, a strong preference to remain not-for-profit, a commitment to providing high-quality accessible health care, an ongoing commitment to the local community, our physicians and employees, as well as access to capital that would allow us to address our longstanding financial needs.

Ultimately, our national evaluation led us right back home to New Haven. By the spring of 2011, we recognized that the acquisition by Yale-New Haven Hospital would allow us to meet all of our primary objectives and can serve as a unique and exciting opportunity to align and better coordinate care in our region.

The benefits of this acquisition cannot be matched by any other acquirer, including recognition of our Catholic heritage, retention of our not-for-profit status, retention of local decision making, an ability to improve the quality of care we deliver, the elimination of our long-term debt, a narrowing of our pension fund deficit, a capital investment in our infrastructure, and, as you heard from Alan, an implementation of Epic, an

electronic medical record system.

Saint Raphael's is at a crossroads. We must see this transaction closed by the end of July. The Vatican has provided its authorization to relinquish our official Catholic designation.

As you heard from Marna, the Connecticut Attorney General and Federal Trade Commission have stated that they will not oppose this transaction.

We need the support of OHCA, because the immediate liability of our hospital is at stake.

You've heard all the reasons today that motivated our decision to align with Yale-New Haven. This is about advancing high-quality care. It is about preserving access. It's about continuing to give patients in the community the option to receive care consistent with the Catholic tradition on the Saint Raphael's campus, and it is about doing so in a cost-efficient manner.

The promise of this transaction is unlimited, and the benefits to this community would be immediate.

As important, this acquisition is essential to the patients cared for on the Saint Raphael's campus, the physicians, who practice here, the

almost 4,000 employees, who come from all over Connecticut and even beyond, and the retirees, who are anxious about their pension benefit.

This acquisition is the only pathway to financial stability, long-term viability for the Saint Raphael campus, and it is imperative for the economic vitality of this entire region.

We need your support, and we need it as soon as you can provide it. Each month, as volume declines, as the staff and physicians seek alternative employment, our future gets cloudier.

Potential actions by our bond holders and solvency and bankruptcy are real and present threats. It is a very challenging, stressful time for our patients, our physicians, and our staff.

The Hospital of Saint Raphael was founded more than a century ago on the presumption of access and quality. That mission can continue and be furthered with the acquisition by Yale-New Haven Hospital.

On behalf of all the stakeholders, we urge your strong consideration and approval of this transaction. Time is of the essence. Thank you very much, and we'd be pleased to answer your questions.

HEARING OFFICER YANDOW: We can have some

questions. When answering the question, if there's any reference you have to the application that's been filed, or any of the completeness responses, it would certainly assist OHCA with your answers, so when we go back to review the record, we can also take a look at what you filed already.

MS. MATTHEWS: Okay.

MS. MARTONE: This is Kimberly Martone again. Okay. My first question is application page 35. The applicants state that this proposal is an opportunity to focus on key strategies, such as primary care development, to enhance access to services for patients in the region.

I was just wondering if you could, you know, expound on that statement and really provide us with more evidence, in terms of how this proposal will address access to services of primary care development.

MS. BORGSTROM: Let me start and ask some of our colleagues to provide additional information. Both organizations currently provide primary care in the form of clinics on campus, and we both operate ambulatory satellites.

We may not have covered the precise geographies from which our patients come as

comprehensively, and what this allows us to do is an inventory of the services provided, match that with the needs in the community as we know, working, also, collaboratively with other providers in the community, including the federally-qualified health centers, and try and make investments and decisions in the placement of ambulatory satellites and the recruitment of physicians that can enhance patient access to both ambulatory and related services.

And let me ask Alan or Peter Herbert to expand on that.

DR. HERBERT: So one of the major challenges in Connecticut is access to primary care physicians, and they include pediatricians, general practitioners and internal medicine specialties.

We have traditionally at both hospitals had categorical internal medicine training programs, but what we have seen in the last decade is the majority of graduates of these programs seek fellowships that leads them to specialization.

We intend, if this application is successful, to convert the categorical internal medicine program and Hospital of Saint Raphael's to a primary care internal medicine program, with the focus more on

ambulatory training than on inpatient medicine, and hope, through actual education and creating our own, we will develop the physicians that will populate the offices of the internists associated with our hospitals and actually continue and expand the availability of general internal medicine.

Right now, if you came to us and asked for a name of a vibrant internal medicine specialist that has openings in the practice, the only way we would succeed is personally calling them on your behalf and saying will you take this patient into your practice, because these practices right now are full?

Obviously, we are also at Yale-New Haven Hospital and system through the Northeast Medical Group, offering employment to physicians, who are primary care physicians, a stress on this in the New Haven environment, and this provides security against some of the vicissitudes of funding for physicians, which is another way to help stabilize the population of primary care physicians that we have.

DR. KLIGER: I just want to add a quick word to that. When I trained, and I did my training in the 1970s, everyone knew that the best doctors were the specialists. I mean I said everyone knew in quotation

marks, or the best doctors are the specialists, and, in fact, New Haven and Yale University grew as a place that became remarkably strong in specialty and sub-specialty medicine, and the result of that in the year 2012 is that we have a remarkably strong medical community in specialty and sub-specialty medicine and a relatively anemic primary care setting.

We have great primary care doctors here, but we don't have enough of them, and we don't have the kind of system planning to make primary care the center of a health care delivery system.

What this acquisition and new hospital will allow is for that kind of strategic thinking and planning for really establishing a strong primary care system to partner with our very strong specialty system here in our area.

MS. MARTONE: Okay. Thank you. Has the employee ED staff at Saint Raphael's reached terms yet with Northeast?

DR. HERBERT: We are in the process now of credentialing all, virtually all of the employed physicians with Northeast Medical Group.

We have met with them, we have explained the benefits to them, we have assured them that we will

accept, without knowledge, their current terms of employment, and we are in the process, both of credentialing them to Northeast Medical Group and credentialing them with payers, so, hopefully, shortly after the 1st of August, we will be able to bill and collect for them, as well.

And this group includes some 20 physicians, who are in emergency medicine at Hospital of Saint Raphael, so it has gone well, and it's accepted, because the hospitalist physicians, some 60 strong at Yale-New Haven Hospital and an equal number of mid-levels, made the transition a year ago from Yale-New Haven Hospital employment to Northeast Medical Group employment, so people feel very secure and like the benefits that are offered.

MS. MARTONE: Okay, thank you. Now, on page 36, sort of somewhat similar. If you have anything additional, please let me know.

It also states that the acquisition of Hospital of Saint Raphael's will position Yale for success as the health care environment focuses more on prevention and wellness. Any additional information you can provide on that, unless it's the same?

MS. BORGSTROM: I think that we're still

going to have people, who are going to require inpatient utilization, but I think more and more care is provided on an ambulatory basis, and I think the expansion of primary care that Peter and Alan had talked about is going to be the best way to help manage and integrate that care and cooperation with other providers in the Greater New Haven community.

MS. MARTONE: Okay.

DR. HERBERT: I would also add that we are now developing systems that are beginning with our employees to address preventative care for high-risk conditions, like chronic obstructive pulmonary disease, asthma and diabetes.

This year, we have begun employing care coordinators and have recruited patients to this program. This is something very new for us, something that we're going to be developing expertise to do.

And, certainly, as Alan mentioned, with the hopes some day that our care will be completely accountable, we'll have to address preventive care, as well as acute and episodic care.

DR. KLIGER: Just, again, if I can, a quick addition? When you talk about or when we talk about wellness, it's isolating the early care before

people develop disease.

The vision that we've had is a much more comprehensive one of engaging people in the community at a time of wellness through a time of disease, management of that disease appropriately, involvement of patients in the management of their own health, so, really, the idea of a much more comprehensive way of thinking about care than we've had before.

MS. MARTONE: Okay and that would be for both campuses I'll say at this point. There will be an overall strategic program addressing prevention and wellness, or continuing to, I should say. Okay.

Then, on page 36, again, it addresses the definitive asset purchase agreement that was executed in September 2011. When does that actually take effect, and if it did already, and have there been any amendments or modifications to that agreement?

MS. BORGSTROM: So the asset purchase agreement allowed us to begin the regulatory review processes with the federal government and the state and OHCA, and, as soon as we complete this process of review and get your approval, we will begin to move to close this transaction.

There have been, as we've learned more

about one another, we've gotten a more refined plan, but the overall terms of the asset purchase agreement remain in effect.

MS. MARTONE: Okay, so, the agreement, the signed agreement that was provided with the application, is that the complete agreement? There hasn't been any additions to that?

MS. BORGSTROM: We have not executed any legal changes to any agreements.

MS. MARTONE: Okay. On page 28 -- will there be any changes to Yale-New Haven's Board or governance structure that will take place as a result of the transaction?

MS. BORGSTROM: We have agreed, as part of this transaction, that the Yale-New Haven Hospital Board will not grow in its size. It can be up to 28 members.

We have held vacancies, and, as part of this transaction, we will bring over four nominees from the Hospital of Saint Raphael, and then they will go into our self-perpetuating governance process.

MS. MARTONE: Okay. Is it expected that charges for Yale-New Haven Hospital services will go up as a result of the transaction?

MS. BORGSTROM: We do not have any plans

to raise charges as a result of this transaction, and, in fact, have been working with the payers on this matter. And if you have additional questions, we'd be happy to introduce William Gedge, who is the Senior Vice President for Payer Relations, to discuss that, but the short answer is, no, the prices won't go up as a result of this transaction.

MS. MARTONE: Okay. If you would like him to, if he can discuss any steps that Yale-New Haven has taken to assure that there's no adverse financial impact on health care consumers?

HEARING OFFICER YANDOW: I know we did have -- I don't know if you stood before.

MR. WILLIAM GEDGE: I did.

HEARING OFFICER YANDOW: You did, okay. So could you state your name and spell your last name?

MR. GEDGE: Yes. I'm Bill Gedge, Senior Vice President, Yale-New Haven Health System, and responsible for the payer relationships.

With respect to the payer relationships, we've reached agreement with all the payers to move into the transaction on a budget-neutral basis.

We, obviously, do not have access to the Hospital of Saint Raphael's contracts or their rates, but

the anticipation is that when the transaction is completed, that we would then sit down with the payers and work out a new agreement, which would be budget-neutral and from a financial aspect, and we would merge together the provisions of the agreement, and that would probably take three to four months.

In the meantime, services provided on the Hospital of Saint Raphael's campus would be billed under their current billing system and paid under their current contracts, so there would be no adverse financial impact to the payers while that process of melding the two agreements occurs.

And then, once that's completed, then we'll move to a new agreement that we have negotiated with the payers on a budget-neutral basis forward from that point.

MS. MARTONE: Okay. Doesn't the application also say there's a letter of agreement that was worked out with Aetna? Is that true?

MR. GEDGE: Yes, that's correct.

MS. MARTONE: Okay. What does the agreement provide for? Is there any more specifics on that?

MR. GEDGE: No. It was essentially a

budget. It was as we presented in the CON. It was a budget neutrality, in terms of pulling together the both hospitals' agreements, so that there's no financial impact to the payer when those two agreements are put together.

MS. MARTONE: Okay. All right, thank you.

HEARING OFFICER YANDOW: I just want to make sure. Did you get the last name? Okay.

MR. GEDGE: Thank you.

MS. MARTONE: On page 39, the applicants have stated that the detailed transition plan to assure continuity of services and the integration of services was still in the process, with a target closing date very soon. Can you update OHCA on that plan?

MS. BORGSTROM: Yes. As you can imagine, this is taking a great deal of time, because it's important to us that we do this very well and as my colleague, Rick D'Aquila, the President at Yale-New Haven, would describe flawlessly, so I'm going to ask Rick to come forward and describe the process.

MS. MARTONE: Okay.

HEARING OFFICER YANDOW: And you took the oath earlier?

MR. RICHARD D'AQUILA: I did.

HEARING OFFICER YANDOW: Okay and could you say and spell your last name, please, and your title?

MR. D'AQUILA: Sure. It's Richard D'Aquila, D, apostrophe, capital A-Q-U-I-L-A, and I'm President and Chief Operating Officer, Yale-New Haven.

So let me start maybe with just a general framework, and then, if you have specifics that you want to hear more about, I can focus on them.

MS. MARTONE: Okay.

MR. D'AQUILA: But it is a kind of a massive effort to integrate services over time, but to really focus on four critical things as of August 1st. We're contemplating an August 1st transition date.

The real focus is, and it's going to sound kind of basic, but there are a huge number of steps, getting all the employee transitions made, getting the employees from the Hospital of Saint Raphael to the Yale-New Haven Hospital payroll, getting all that right, which is extraordinarily difficult, because there's a lot of information we don't have access to.

And if you think of all the things that need to happen, employee testing, employee training, employee orientation, it's a massive undertaking under normal circumstances, compounded in a short period of

time.

Getting the hospital to function, integration enough to function seamlessly for State of Connecticut, Joint Commission and CMS standards and requirements, so a seamless integration to operate as one provider, getting the bills out and getting contracts transitioned and payable.

So we have a -- we're using the support of an outside consulting firm. They are supporting about 20 executive teams that are made up of executives and managers responsible for key functional areas. They broke into this massive undertaking into 25 or 30 activity tracks, and, you know, the work is ongoing with a culmination date for the transition as of August 1st, so that's the basic framework of what we're doing and how we're doing it.

MS. MARTONE: Okay. Does that include the clinical integration?

MR. D'AQUILA: It does not. It really, and as Peter and Alan testified, the clinical integration really needs to play out over time. It needs to be done deliberately.

Physicians need to be engaged, services need to be thought through. On August 1st, the focus is

really on existing operations, absolute continuity, employee and licensure issues, and then, over time, we'll integrate clinical services and, particularly, those services that, you know, we've agreed upfront will be focused on the Yale-New Haven campuses, the trauma, the cancer, pediatrics and others.

MS. MARTONE: Okay and you're talking about the process, so is there an actual or will there be an actual written document, any type, about the integration?

MR. D'AQUILA: In terms of the process that we're following or the milestones?

MS. MARTONE: Process and then outcome.

MR. D'AQUILA: Yeah. Right now, there are good documents that memorialize the work of the transition teams.

MS. MARTONE: Okay.

MR. D'AQUILA: So we have, we can provide kind of high-level dashboards that track the basic activity tracks of employee transition, employee training, licensure, payer notifications, you know, the actual aggregate transactional components that get us through August 1st, and then there's kind of a longer term project schedule, which would have the clinical

integration.

MS. MARTONE: And will you be updating those dashboards as the integration evolves?

MR. D'AQUILA: The dashboard is our tracking tool as an executive team for staying on track for August 1st, and that dashboard is updated weekly.

MS. MARTONE: Oh, weekly.

MR. D'AQUILA: And it identifies areas of vulnerability, areas where, you know, where we need to put additional focus and effort to stay on track, but that's our real time monitoring of an effective transition as of August 1st.

MS. BORGSTROM: And let me add, and Rick I think will agree with this. There isn't a document that says the plan. This is something that's really a very dynamic document, and it's a way of tracking something that is evolving, and we want to know, as Rick said, where we need to put our shoulder in a little bit harder, but, you know, it's changing as frequently as it needs to.

HEARING OFFICER YANDOW: Okay, so, is there some point at the end that there will be a summary of what the whole transition plan was, and when do you expect that transition to be complete?

MS. BORGSTROM: I think the transition --

HEARING OFFICER YANDOW: Taking if all goes as you hope and August 1 is the date, is there some date out there you would see that to be complete?

MS. BORGSTROM: I think the end of July/August 1 is a transaction date. I think the transition and the integration is ongoing, and it will take a long time to ultimately get these integrated, because there's also the process of culturally integrating the employees and the physicians and the two organizations.

We have a lot of milestones along the way. We want to get as much of the clinical integration started, so that we have a defined way of approaching that in the first 100 days, but then that's going to happen sequentially, so we don't have an ending, say, as of four years from now, it's going to be 100 percent.

MR. D'AQUILA: And that's really by design, because we wanted to, we certainly want to focus on the transaction. The transaction is really a July 29th/August 1st transaction, and, you know, that's got very focused nuts and bolts.

What does it take to seamlessly operate the new organization and comply with all requirements and

minimize employee disruption? That's very detailed and very focused.

And then, at the second level, are the things we've agreed will be the focus, that we won't duplicate trauma, children's hospital, but then the rest really needs to play out, you know, like your question on ambulatory. It really needs to play out much more deliberately.

Ambulatory we're immediately looking at starting a planning process that's going to, back to your earlier question, look at all of the outpatient services in the community, identify where we have duplication, identify where we have gaps and opportunities to expand access, and then how do we reconfigure the system accordingly?

That's the right way to focus, you know, on ambulatory. It takes time and engagement to do that, and it's a bit premature, until we're through this whole process.

Plus, as you probably know, until we're one organization, we don't have access to a lot of information. We still have to function like competitors, so we'd be planning in a vacuum, and when the transaction is done, then, you know, then that stuff can really

proceed in a deliberate way, and the right people can be engaged.

MS. MARTONE: Okay and I appreciate that, and the questioning behind that is really related to, you know, a department will be publishing a statewide facility plan very shortly, and the hospital's long-range plan, strategic plan, is supposed to coincide with that plan, so it's important that we, you know, collect, and we have documents, or any type of summaries to make sure that they do coincide.

MR. D'AQUILA: Sure. We're happy, as we always have, we're happy to participate in that and share what we have.

MS. MARTONE: Okay. All right. In terms of Epic, it's not scheduled to be installed at the Hospital of Saint Raphael's until 11 months after closing, so could you explain how Yale-New Haven will provide for exchanges of medical record information between the campuses until that point?

MS. BORGSTROM: I'm going to ask Lisa Stump, who is here as a Senior Executive in the health system with Information Technology, and we've had, before we planned the acquisition of Saint Raphael's, we had a very detailed plan to role Epic out among physician

practices, Greenwich Hospital, Bridgeport and Yale-New Haven, and, as Greenwich has already gone live, there are already ways to integrate some of the information between campuses, and, Lisa, you can talk more about that and the schedule.

HEARING OFFICER YANDOW: Did you take the oath earlier?

MS. LISA STUMP: I did.

HEARING OFFICER YANDOW: Okay and if you could state your name for the record, spell your last name, and your title, also?

MS. STUMP: Lisa Stump. I'm the Vice President of the Epic project, and it's S-T-U-M-P.

So, as Marna said, we have, with the understanding that the acquisition of the Hospital of Saint Raphael's was a potential, closely looked at the timing for the potential to bring both campuses live on the same information system, being our Epic EMR.

In the interim, my colleagues in Information Technology have also done, where we can, gain as much information about the technology and use on the campus today, and we will integrate key pieces of the Information Technology systems through interfaces, so that operations, billing operations can flow, as well as

clinical information, where appropriate, until the time that we can bring the Hospital of Saint Raphael campus live on Epic, as well.

MS. MARTONE: Okay, thank you.

MS. STUMP: Thank you.

MS. MARTONE: On page 52, it's indicated that the installation of the Epic EMR system can be done at approximately 30 million less, if the acquisition moves forward, then, if Epic were installed by the hospital independently. Could you explain why this is the key?

MS. BORGSTROM: So a lot of that is the resources embedded in our implementation team, so we have a team already working. It's about 150-member team that is implementing Epic in the existing Yale-New Haven health system hospitals and the Yale School of Medicine.

That team is simply then able to incorporate the Hospital of Saint Raphael's into that existing project timeline.

If HSR needed to do that on their own, they would need to build their own team of individuals to conduct that build and implementation, so we simply take advantage of the existing resources.

MS. MARTONE: Okay, thank you. Okay.

It's also mentioned, this is on page 117, that capital improvements at the Hospital of Saint Raphael campus will be based on a party list, and that list will take into account regulatory requirements, updated faculties assessments, patient volumes and annual budget amounts, so what is the budgeted, what has been budgeted for capital improvements for the Hospital of Saint Raphael's for fiscal year 2013 at this point?

MS. BORGSTROM: So are you talking after the acquisition?

MS. MARTONE: Um-hum.

MS. BORGSTROM: Okay, so, I'm going to ask Vincent Tammaro, who is a Senior Finance Officer with the health system, who has helped us put this together. We've done some, while Vinnie is coming up, some inventory work of their campus.

We've had a list of some of their deferred capital investment items, and some of the infrastructure investments we will plan to make as quickly as we are able in mechanical systems and just basic building infrastructure, and some of the investments will, other than Epic, will follow the clinical integration discussions about what services we want to focus on that campus, because, as I said earlier, it's not just an

overflow campus, and, so, those investments will relate to that. We're assuming it's in budget already.

MR. VINCENT TAMMARO: Good morning.

HEARING OFFICER YANDOW: Good morning. You stood and took the oath earlier?

MR. TAMMARO: Yes, I did.

HEARING OFFICER YANDOW: Okay. If you could state your name, spell your last name, and give your title, also, please?

MR. TAMMARO: Vincent Tammaro, T-A-M-M-A-R-O, Vice President of Corporate Finance at Yale-New Haven Health System. Could you just please repeat the question?

MS. MARTONE: Sure. It's mentioned that capital improvements at the Hospital of Saint Raphael campus were based on a party list, so we're looking for the (coughing) been established and basically budgeted for fiscal year 2013.

MR. TAMMARO: All right, so, actually, as we looked at the entire cost of the project, as far as from a capital standpoint, assuming after the go-live date, we've identified approximately 129.5 million dollars of capital cost requirements over fiscal years 2013, '14 and '15.

That 129 is broken down into various components. Approximately 85 million dollars is for infrastructure improvements. Another 25 million dollars is an incremental amount for routine capital. This is above and beyond the 50 million dollars that's already in the current capital budget at the Hospital of Saint Raph's, an additional 5.1 million dollars for IT integration between the two campuses, and the last amount, 14.4 million dollars, is the capital cost required for the Epic installation.

That 14.4 will be realized the entire amount in fiscal 2013 for Epic, because our intent is to go live with the Epic system on that campus in the summer of 2013.

As far as the 85 and 25 million dollars, we are currently, as part of the transition planning process and the overall 2013 budgeting process, are identifying the components that will be attributable to the 2013 year.

MS. MARTONE: Okay, so, they haven't been identified yet, in terms of which actual capital improvements --

MR. TAMMARO: So we're actually going through our whole capital budgeting process, not just for

the main campus, but for the combined organizations.

MS. MARTONE: When would that be available?

MR. TAMMARO: Probably, over the next couple of months.

MS. MARTONE: Okay. Okay. What is actually budgeted if the Hospital of Saint Raphael remains a standalone entity? Is there a differential?

MR. O'CONNOR: We've been, again, as you look at the separate financial statements of the two existing independent organizations as they currently stand, we've been spending about 10 million dollars a year over the past three years at the Hospital of Saint Raphael.

MS. MARTONE: Okay. What type of capital improvement?

MR. O'CONNOR: We've done a variety of items, including, you know, for fiscal year 2012, the purchase of a new linear accelerator, replacement of our da Vinci surgical system, and then the rest has been made up of, you know, routine capital spends, monitors, instruments and the like.

MS. MARTONE: And that was the first half of this year? What will be for fiscal year 2013, though?

MR. O'CONNOR: Again, we aren't contemplating this standalone fiscal 2013, because of the importance that I outlined in my testimony, that this transaction take place. There are bigger issues that we'd be struggling with if we don't get approved.

MS. MARTONE: Okay, thank you. The applicants have also stated that there is no contractual commitment for Yale-New Haven to spend the 129.5 million on capital improvements at the Saint Raphael's campus during the first five years, so did the Hospital of Saint Raphael consider requiring a contractual obligation to make sure that certain capital improvements were on a fixed timetable?

MR. O'CONNOR: You know, when we went through the asset purchase agreement negotiation, we considered many factors, and, ultimately, coming to the purchase price that you see in front of you with the executed APA.

Clearly, the commitment on behalf of Yale-New Haven Hospital to invest in at that time, post-close, itself, we felt was not a requirement contractually, given that the benefit would be for the new organization.

MS. MARTONE: Okay. On page 144, the applicants mention that the value of the Hospital of

Saint Raphael's charitable fund is expected to be 26 million at the time of closing, and that this will be made up of permanently and totally restricted funds, 13.5 and 12.5, respectively. What is the status of having these funds transferred to Yale-New Haven?

MS. BORGSTROM: I just want to confer with counsel, because I'm not sure I'm looking at the right -- okay.

MR. O'CONNOR: I can begin. So there is a process that we're undertaking, similar as Rick described, the transition process for a number of assets from employees. Our transfer of the restricted funds is another work plan element that we are focused on.

Frankly, it's not -- you know we are in the process now of developing that plan. There are multiple steps to that plan, which will include conveying with our donors those that we can communicate with, the intention to move those restrictive funds over to Yale-New Haven, and if we are unable to communicate appropriately and follow the regulations, we will go to the Attorney General for a ruling.

MS. MARTONE: Okay, so, assuming that October 1 that all this will be identified and be available?

MR. O'CONNOR: I mean we're hoping, as we negotiated the asset purchase agreement, you know, we went through each one of these funds in extraordinary detail to identify those funds that we could actually pull down and use for existing services or that have actually we've met those needs previously, to reduce the degree of restriction.

We're still in the process of working through many of those steps, and that we are hopeful that when we get to the integration period, that we'll have a fruitful process that our donors will be satisfied with, because the intention is is that, again, those services are going to continue to be provided going forward, so, you know, I believe that we'll be able to meet that donor intent.

MS. MARTONE: Okay.

MR. O'CONNOR: But we still have a process to complete.

MS. MARTONE: Okay. All right, so, has there been a specific amount of the charitable funds that have been used by Saint Raphael's for the benefit of the campus since the asset purchase agreement?

MR. O'CONNOR: I'd like to ask Jim Rude to come forward. He's our Controller and Treasurer. He

knows this stuff in more detail.

MR. JAMES RUDE: Good morning.

HEARING OFFICER YANDOW: Did you stand earlier?

MR. RUDE: I did. My name is James Rude. The last name is spelled R-U-D-E. I'm the AVP of Finance at Saint Raphael's and acting interim Chief Financial Officer.

COURT REPORTER: One second, please.

MR. RUDE: Saint Raphael's continues to spend its restricted funds in accordance with the restrictions. Obviously, we can only spend restricted funds if the restrictions have been met, so we have over the course of the past year since signing first the letter of intent over the last six months since signing the asset purchase agreement, Saint Raphael's has continued to expend both the earnings on permanently restricted funds, as well as temporarily restricted funds that come into our organization, in accordance with the respective restrictions.

MS. MARTONE: Okay. Are there certain projects that you could identify?

MR. RUDE: As an example, we are the provider of WIC services to the New Haven community as a

primary contractor, and Yale-New Haven is a subcontractor on that contract. As money comes in on grants, such as those, we provide the services and disperse the monies.

As it relates to the linear accelerator acquisition that Chris O'Connor referred to before, some of those monies were raised through donated monies and were funded based upon the expenditure of some of those restricted monies.

So, again, all those expenditures are in the normal and recurring course of business. With the unmet restricted monies available as of the transaction date, again, intended to be sent over to Yale-New Haven as part of the transaction once we've completed the process of either contacting donors or going through the Cy pres protocols.

MS. MARTONE: Okay, so, were there any additional funds that were used outside let's say the Saint Raphael's campus in the Greater New Haven area, besides the WIC you've mentioned? Any others, in terms of charitable funds?

MR. RUDE: In terms of charitable funds? They're all used within the New Haven community.

MS. MARTONE: Okay.

MR. RUDE: I apologize. I'm hard pressed

to think of --

MS. MARTONE: I'm testing you now. I'm sorry.

MR. RUDE: We also have grants related to the psychiatric program.

MS. MARTONE: Okay.

MR. RUDE: That we use restricted monies for. Again, as it relates to many of the permanently restricted endowment funds that have normal uses at the hospital, we support cancer care, we support cardiac care, we support pediatric care, we support clinic functions, again, primarily through the day-to-day ongoing operations of the hospital, itself.

MS. MARTONE: Okay, thank you. Okay. I have some questions on trauma. I don't know if you have an expert on it.

MS. BORGSTROM: Why don't you give us the questions, and then we'll tell you.

MS. MARTONE: All right. On page 292, there's a discussion of the consolidated trauma service, so I just have some questions related to that, like when will the ED renovations at Yale be completed, even though I think I've heard that in other hearings, but, in particular, when will the four trauma bays be

operational?

MS. BORGSTROM: Brad Bevers. Is Brad here? I think Brad, who leads Facilities at Yale-New Haven, can answer that best.

HEARING OFFICER YANDOW: You took the oath earlier?

MR. BRAD BEVERS: Yes.

HEARING OFFICER YANDOW: Okay. State and spell your name, please, and your title.

MR. BEVERS: Brad Bevers. Last name is spelled B-E-V-E-R-S. I'm Director of Facility Design and Construction.

HEARING OFFICER YANDOW: Okay. Tynan, can you hear him?

COURT REPORTER: Could you just spell your name again?

MR. BEVERS: B-E-V-E-R-S.

COURT REPORTER: Thank you.

MR. BEVERS: Trauma bays in the ED?

MS. MARTONE: Um-hum.

MR. BEVERS: ED renovation continues. We're expecting construction to be complete by December 31st of this year. Move in will actually occur early January. One trauma bay has been completed, but not yet

occupied. The other three will be completed by the end of the year.

MS. MARTONE: By the end of the year?

MR. BEVERS: Yes.

MS. MARTONE: Okay. How many adult and then pediatric bays are currently operational at Yale?

MR. BEVERS: I don't know. We have I think 23 pediatric bays in the existing pediatric ED, and the adult bays is kind of a moving target, because, as we're doing the renovation, we open some and we close some. It's almost on a week-to-week basis.

MS. MARTONE: Okay. Do you feel that the current trauma facilities at Yale are sufficient to absorb the additional I guess it's 2.3 trauma cases per day that were estimated?

MS. BORGSTROM: Probably, that's not in Brad's purview.

MS. MARTONE: Okay.

MS. BORGSTROM: But I will ask Peter to comment on that, because, as he and Dr. Kliger have begun to look at demand, I think they've looked at resources, as well.

MS. MARTONE: Okay.

DR. HERBERT: Yeah. The total number of

trauma activations at HSR last year were 400 and change. They led to something like 80 touches in the operating room, and, so, the demands on operating room time are relatively minimal, compared with our own trauma program.

In addition, we have in-house 24/7 trauma surgeons, and we have the capacity now to I think manage all major trauma in the region and have no question about that.

MS. MARTONE: Okay. More on the financial side, can you provide an update or an updated status on the financing from Barclays Capital?

MS. BORGSTROM: Yes. I'm going to ask Mr. Tammaro to return. Did you hear the question?

MR. TAMMARO: What's the update on the debt financing?

MS. MARTONE: Yes.

MR. TAMMARO: So we've actually broken it down into two steps, because we weren't certain, as far as the date of the closing. We actually are in the process of securing short-term financing to make the payment of the 160 million dollars at time of closing, and we expect within two months post-closing to secure the permanent financing.

MS. MARTONE: And did Yale-New Haven,

itself, conduct an analysis, you know, on the financing needs, or was this something --

MR. TAMMARO: That was part of our multi-year projection, so we came up with the purchase price initially of 160 million dollars, and then, over the next couple of years, two years after, in 2014, we plan to issue another 100 million dollars of debt, and, in 2016, another 100 million dollars of debt.

MS. MARTONE: Okay. Could you elaborate on the 300 million in operational cost savings that's been described actually throughout the application?

MR. TAMMARO: Okay, so, the majority of that number, 270 million dollars, relates to elimination of duplicate infrastructure costs related to various business processes, including, but not limited to finance, information technology, human resources, legal and other administrative services.

MS. MARTONE: Okay. Will there be a report generated at some point after the proposed transaction takes place, which it will identify the cost savings, like the actual cost savings?

MR. TAMMARO: So we actually have put in place, not only as part of the dashboard that Rick had mentioned on the financial side, we had a model in place

to keep track of all the savings related to the transaction.

MS. MARTONE: Okay.

HEARING OFFICER YANDOW: So that document is a -- there will be a finished document when that's all assessed and evaluated?

MR. TAMMARO: When you say finished, it's an internal document that we will present to our senior management team, as well as our finance committees.

HEARING OFFICER YANDOW: Okay and when do you think that would be a completed document for your purposes? I mean is it already completed?

MS. BORGSTROM: Let me take a crack, because, you know, I think what you're looking for is how do you know if there are 270 million of the 300 million in these infrastructure savings, we actually get them and where, and we are in the process of refining where those specifically will come out over time, but they're also going to be dynamic, and we're going to track that over the next four to five years, but we're also embarking on many other efforts to save money.

That's not the only money that we expect to save. That's directly related to this integration, but given all of the pressures that we have in this

environment, we are undertaking many initiatives concurrently to lower the cost per unit of service, and those additionally will extend to Saint Raphael's.

And I think that, you know, we'll be able to track most of that, but there may be new ways of accomplishing cost savings as we do the integration that we're not even aware of, because, as Rick D'Aquila said so often, there's so much information that we aren't able to access about one another, you know, that we're doing the best job we can, but we are absolutely committed to getting that level of savings, but more savings across the Yale-New Haven health system, because it's just going to be a necessary part of doing business successfully.

MS. MARTONE: So you would be able to, you know, share with the Department on a six-month or annual basis some type of document that demonstrates the cost savings from this integration?

MS. BORGSTROM: Yes.

MS. MARTONE: Okay. That's all I had.

HEARING OFFICER YANDOW: I just have a couple, then I want to take a break, just to review our notes and the testimony that we've heard, but just a couple of questions, and this one is, just reviewing, and perhaps it's right in the beginning of the application,

but the distance between the main campuses, how far is one main campus to the other? I don't know if we actually have that in.

MS. BORGSTROM: If we count them, I think it's five or six blocks. It's very close.

HEARING OFFICER YANDOW: Okay. I just wanted to, you know, for anyone, we certainly want to make sure we have enough evidence.

DR. KLIGER: We commonly walk back and forth between.

HEARING OFFICER YANDOW: Who has the better cafeteria? (Laughter)

DR. KLIGER: Am I under oath?

HEARING OFFICER YANDOW: The Hospital of Saint Raphael's, is there anything, any physical plant or life safety issue, anything that needs to be remediated at this point? Are there any -- anything that's been identified that's going to have to be remedied?

MR. O'CONNOR: I think I would answer that, unequivocally, that providing safe patient care is and will continue to be our priority as we're an independent institution, so there are no critical components that we believe pose any harm to our patients or our staff.

What I will say is that, as we've talked about over, you know, the course of this morning, there are a number of infrastructure improvements that are required that we have deferred that certainly would be, as Vinnie articulated, in the shorter term investment cycle for post-integration.

HEARING OFFICER YANDOW: And what's the fallback plan? If the acquisition doesn't take place, what's your fallback plan?

MR. O'CONNOR: Well, as I stated clearly in my testimony, I mean independence is not an option for Saint Raphael's, so, you know, frankly now, with the approval of the Catholic church, the approval from the Federal Trade Commission, or at least they're not objecting to the transaction, and the Attorney General, we believe and continue to believe that this is the absolute best alternative.

There are obviously others. You're seeing them in the State. There's an application for another type of alternative transaction. Far less desirable, and certainly does not have even close to the magnitude of impact in this community that we're talking about this morning.

HEARING OFFICER YANDOW: Okay. Before we

take a quick break, do you have any questions of any of the applicants? Anything else right now? Okay. What I'd like to do is take a 15-minute break, and then come back, and perhaps go with further questions of the applicants. I just want to review basically what we've gone over this morning, okay? So we'll come back at five after 12:00.

(Off the record)

HEARING OFFICER YANDOW: Back on the record. I've reviewed the notes, and I don't have any further questions, but I do want to make the applicants aware that if the application is approved, it would most likely be approved with conditions, and what we would most likely be looking for, what the Department of Public Health would most likely be looking for would be summaries as time went on regarding quantifiable cost savings, summaries of the clinical integration, the primary care development, the transitional process.

We'd also be looking after close for unredacted copies of certain documents that have been filed with the application, including the purchase agreement, the asset purchase agreement after the closing.

And there will be no closing, unless this

decision will come before, so I just wanted to make the applicant aware regarding past practices of the Department and other documents that we keep on file regarding mergers, the type of things that we would be looking for, okay?

And, then, just a couple of other follow-ups. Ms. Martone?

MS. MARTONE: Yes. I have one late file I'd like to ask for. If we could have the month-end and year-to-date financial statements for both hospitals through May of this year?

MS. BORGSTROM: Those are not available.

MR. O'CONNOR: We could add April.

MS. MARTONE: Oh, up to April? That's fine. For Yale-New Haven, as well. Okay.

HEARING OFFICER YANDOW: Counsel, is there anything you have?

MS. MATTHEWS: I was just wondering if Marna could speak for a few minutes, just to clarify a few things about timing with respect to the transaction and notice periods and those sorts of things.

MS. BORGSTROM: Just because we have, if you can gather from the discussion that we've had today, this is an enormous opportunity, but there's also a lot

of work that goes along with it and a lot of moving parts, and, just to be clear, in addition to the urgency that Mr. O'Connor described when he talked about Saint Raphael's financial condition, we are moving to close this as quickly as we can.

As a technical matter, we are looking to do a financial close late in the day on July 26th, and that is when monies will actually be wired consistent with the asset purchase agreement, and then we will actually do an employee transition and formal close, so employees will wear a new badge on July 29th, and that is also the beginning of a pay period at Yale-New Haven, so with all the complexities of the transition, it allows us to do that.

In order to do that close and keep our cash flow going and bill and collect for patients, we have 30-day notice requirements with some of the payers that have to be posted at least 30 days prior to the close of the transaction.

I know that we've had discussions about the importance of helping you complete, as expeditiously as possible, your final review and decision-making of this, and that's the reason, is because with the 30-day notification requirement to Medicaid and other payers and

a hard close date of the 26th of July, we are, you know, all eyes turned on getting everything done for this application.

So, you know, we will work with you, and I know that counsel can talk with you about how to best meet the needs that you've described. Obviously, it's in our interest to achieve all of the objectives that we've put in this, including cost savings, and we will continue to do that, because we all see the same things coming in health care reform.

So, you know, we're very grateful for this opportunity to answer your questions. We're grateful for your willingness to consider this as expeditiously as possible, and just want to thank you for making yourselves available in New Haven today.

MS. MATTHEWS: I have just one other thing. Can I just clarify about timing of the late files? It sounds like those are available. We could likely submit those immediately.

HEARING OFFICER YANDOW: Great. So there's nothing else on behalf of the applicant, is that correct? What I'd like to do now is take a break, and, at 1:00, we will go into the public comment session of this hearing.

Okay, so, anything else before we break? Okay, we are on break now until 1:00.

MS. MATTHEWS: Thank you very much.

(Whereupon, the presentations and questioning concluded.)

RE: OFFICE OF HEALTH CARE ACCESS
JUNE 5, 2012

AGENDA

Convening of the Public Hearing	2
Applicant's Presentation of the CON Proposal	8
OHCA's Questions	43

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 12th day of June, 2012.

Paul Landman
President

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

June 27, 2012

IN THE MATTER OF:

An Application for a Certificate of Need filed Pursuant to Section 19a-638, C.G.S. by:	Notice of Agreed Settlement Office of Health Care Access Docket Number: 12-31747-CON
Yale-New Haven Hospital, Saint Raphael Healthcare System, Inc. & Hospital of Saint Rafael	**Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.**

To:

Jean Ahn
System Director
Planning & Business Development
Yale-New Haven Hospital
20 York Street (Howe 3)
New Haven, CT 065040

Terrie Estes
Director
Planning & Business Development
Saint Rafael Healthcare
1450 Chapel Street
New Haven, CT 06571

Dear Ms. Ahn & Ms.Estes:

This letter will serve as notice of the approved Certificate of Need Application in the above-referenced matter. On June 27, 2012, the Agreed Settlement, attached hereto, was adopted and issued as an Order by the Department of Health, Office of Health Care Access.

Kimberly R. Martone
Director of Operations

Enclosure
KRM:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Agreed Settlement

Applicants:	**Yale-New Haven Hospital** **Saint Raphael Healthcare System, Inc. &** **Hospital of Saint Raphael, Inc.**
Docket Number:	**12-31747-CON**
Project Title:	**Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.**

Project Description: Yale-New Haven Hospital ("YNHH") proposes to acquire certain assets of the Saint Raphael Healthcare System, Inc. ("SRHS"), including The Hospital of Saint Raphael ("HSR"). Following the acquisition, YNHH would be the sole acute care hospital in New Haven, Connecticut with two inpatient campuses and multiple ambulatory satellites.

Procedural History: On February 1, 2012, the Department of Public Health's Office of Health Care Access ("OHCA") received a Certificate of Need ("CON") application from YNHH, SRHS and HSR (collectively, the "Applicants") for the above-referenced project. A notice to the public concerning Applicants intent to file the CON application was published on January 9, 10 and 11, 2012 in the *New Haven Register*.

A public hearing regarding the CON application was held on June 5, 2012. On May 14, 2012, the Applicants were notified of the date, time and place of the hearing. On May 21, 2012, a notice to the public announcing the hearing was published in the *New Haven Register*.

Commissioner Jewel Mullen designated Joanne V. Yandow, Esq. as the hearing officer in this matter on May 22, 2012.

The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-639a of the Connecticut General Statutes. On June 6, 2012, OHCA received certain updated financial statements from Applicants that were requested as late filed submissions at the June 5, 2012 public hearing and, by letter dated June 7, 2012, Applicants were informed that the public hearing was closed.

OHCA's authority to review and approve, modify or deny this proposal is established by Sections 19a-638 and 19a-639a of the Connecticut General Statutes. These provisions, as well as the principles and guidelines set forth in Section 19a-639 of the Statutes, were fully considered by OHCA in its review.

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

FINDINGS OF FACT

1. YNHH is an acute care general hospital located at 20 York Street in New Haven, Connecticut that includes the Yale-New Haven Children's Hospital, the Yale-New Haven Psychiatric Hospital and the Smilow Cancer Hospital. YNHH's total licensed bed capacity of 1,008 licensed beds and bassinets includes 916 general hospital beds and 92 bassinets.[1] Ex. A, pp. 17, 22, 226-227.

2. YNHHS is a Connecticut non-stock 501(c)(3) corporation located at 20 York Street in New Haven, Connecticut and is the parent company of YNHH. Ex. A, pp. 76, 111, 223.

3. HSR is an acute care general hospital located at 1450 Chapel Street in New Haven, Connecticut. HSR's total licensed bed capacity of 533 licensed beds and bassinets includes 511 general hospital beds and 22 bassinets. Ex. A, pp. 20, 43, 111, 229.

4. SRHS is a Connecticut non-stock 501(c)(3) corporation located at 1450 Chapel Street in New Haven, Connecticut. SRHS is the parent company of HSR, Saint Raphael Healthcare System Affiliated Physicians, Inc., DePaul Health Services Corporation, Inc., Saint Raphael Foundation, Inc. and Saint Regis Health Center, Inc. d/b/a Sister Anne Virginie Grimes Health Center (the "Grimes Center"). Ex. A, pp. 78, 111.

5. On September 26, 2011, YNHH and YNHHS entered into an Asset Purchase Agreement with SRHS, HSR and the other above-listed SRHS subsidiaries for YNHH to acquire, among other assets, HSR, the Grimes Center, a 120-bed short-term rehabilitation and long-term care facility, and SRHS's ownership interest in three joint ventures: Saint Raphael Magnetic Resonance Center,[2] Connecticut CK Leasing, LLC, a business engaged in stereotactic radiosurgery in which HSR has a 49.1% interest, and Saint Raphael Dialysis Center Partnership, a business engaged in the provision of outpatient kidney dialysis services and managing HSR's inpatient kidney dialysis service in which DePaul Health Services holds a 49.1% interest.[3] Ex. A, pp. 20, 80-159; Ex. F, pp. 105-106.

6. The result of the proposed acquisition will be a single, acute care hospital in New Haven, Connecticut with two inpatient campuses and multiple ambulatory satellites. Ex. A, p. 20.

7. The Applicants based the need for the transaction on the following:

---

[1] Of these 1,008 total licensed beds, 874 general hospital beds and 92 bassinets are located in New Haven, and 42 dedicated pediatric beds are located on the campus of Bridgeport Hospital. See OHCA Docket No. 11-31714-CON (approving the addition of the 42 pediatric beds at Bridgeport Hospital to YNHH's license).

[2] Saint Raphael Magnetic Resonance Center ("SRMRC") operates two MRI scanners at 330 Orchard Street in New Haven, Connecticut and is a joint venture entity formed between DePaul Health Services Corporation, Inc. and Medical Imaging Associates, P.C., a subsidiary of New Haven Radiology Associates, P.C. YNHH's acquisition of DePaul's 50% interest in SRMRC is the subject of a separate CON Application under OHCA Docket No. 12-31759-CON.

[3] Certificates of need are not required for the acquisitions of Connecticut CK Leasing, LLC and Saint Raphael Dialysis Center Partnership. *See*, General Statutes § 19a-638.

a. HSR's significant financial losses in recent years, which have required reductions in operating expenses, including limiting employee benefits and delaying capital investments; and

b. Increased demand for inpatient bed capacity at YNHH.

Ex. A, pp. 26-27, 34-35.

8. HSR's service area includes the following 22 towns/cities: East Haven, New Haven, North Haven, West Haven, Hamden, Ansonia, Bethany, Branford, Cheshire, Clinton, Derby, Guilford, Madison, Meriden, Milford, North Branford, Orange, Oxford, Seymour, Shelton, Wallingford and Woodbridge. Ex. A, p. 38.

9. In fiscal year ("FY") 2011, HSR accounted for 5.43 % of Connecticut's acute care discharges. The cities and towns with the largest number of discharges that collectively made up 75% of HSR's total discharges were as follows:

Town	Discharges	Percent of Total	Cumulative Percent
New Haven	5,823	25.2	25.2
Hamden	3,381	14.6	39.8
West Haven	2,693	11.6	51.4
East Haven	1,888	8.2	59.6
North Haven	1,310	5.7	65.2
Branford	1,032	4.5	69.7
Wallingford	832	3.6	73.3
Milford	649	2.8	76.1

(Source: OHCA Hospital Inpatient Discharge Database)

10. In FY 2011, YNHH accounted for 13.55% of Connecticut's acute care discharges. The cities and towns with the largest number of discharges that collectively made up 75% of YNHH's total discharges were as follows:

Town	Discharge	Percent of Total	Cumulative Percent
New Haven	14,260	24.7	24.7
West Haven	4,318	7.5	32.2
Hamden	3,989	6.9	39.1
East Haven	2,932	5.1	44.2
Branford	2,694	4.7	48.8
Guilford	1,562	2.7	51.5
Milford	1,525	2.6	54.2
North Haven	1,465	2.5	56.7
Bridgeport	1,341	2.3	59
Wallingford	1,304	2.3	61.3
Madison	1,137	2	63.2
North Branford	1,055	1.8	65.1
Waterbury	874	1.5	66.6
Meriden	816	1.4	68
Cheshire	721	1.2	69.3
Clinton	665	1.2	70.4
New York	649	1.1	71.5
Other State/Cntry	643	1.1	72.6
Orange	612	1.1	73.7
Groton	571	1	74.7
Shelton	560	1	75.7

(Source: OHCA Hospital Inpatient Discharge Database)

11. In FY 2011, utilization of Connecticut hospitals by the residents of the locations identified in the tables in Findings of Fact ("FF") 9 and 10 was as follows:

FY 2011
Discharges

Town	Yale-New Haven Hospital	Hospital of Saint Raphael	Saint Vincent's Medical Center	Bridgeport Hospital	MidState Medical Center
Bridgeport	7%	0%	47%	41%	0%
Branford	70%	27%	1%	0%	0%
East Haven	59%	38%	1%	0%	0%
Guilford	71%	20%	0%	0%	0%
Hamden	51%	43%	1%	1%	1%
Madison	63%	17%	0%	0%	0%
Meriden	10%	4%	1%	0%	65%
Milford	25%	10%	10%	11%	0%
New Haven	69%	28%	0%	1%	0%
North Branford	61%	31%	0%	0%	2%
North Haven	48%	43%	0%	1%	4%
Orange	40%	34%	4%	3%	0%
Shelton	12%	3%	24%	24%	0%
Wallingford	25%	16%	0%	0%	47%
West Haven	54%	34%	1%	1%	0%
Clinton	48%	9%	0%	0%	0%
Groton	11%	0%	0%	0%	0%
Cheshire	28%	13%	1%	0%	28%
Waterbury	6%	1%	1%	0%	1%
New York	6%	0%	1%	1%	0%
Oth State or Ctry	21%	3%	4%	3%	2%
% of Total*	**31%**	**15%**	**9%**	**8%**	**6%**

* The remaining 31% of discharges for residents of the above locations were spread among the following hospitals: New Milford Hospital, Charlotte Hungerford Hospital, John Dempsey Hospital, Day Kimball Hospital, Windham Community Memorial Hospital, Griffin Hospital, William W. Backus Hospital, Milford Hospital, St. Mary's Hospital, St. Francis Hospital, Lawrence and Memorial Hospital, Bristol Hospital, Norwalk Hospital, Middlesex Memorial Hospital, Sharon Hospital, Waterbury Hospital, Greenwich Hospital, New Britain General Hospital, Rockville General Hospital, Johnson Memorial Hospital, Stamford Hospital, Manchester Memorial Hospital, Hartford Hospital, Danbury Hospital, Connecticut Children's Medical Center.

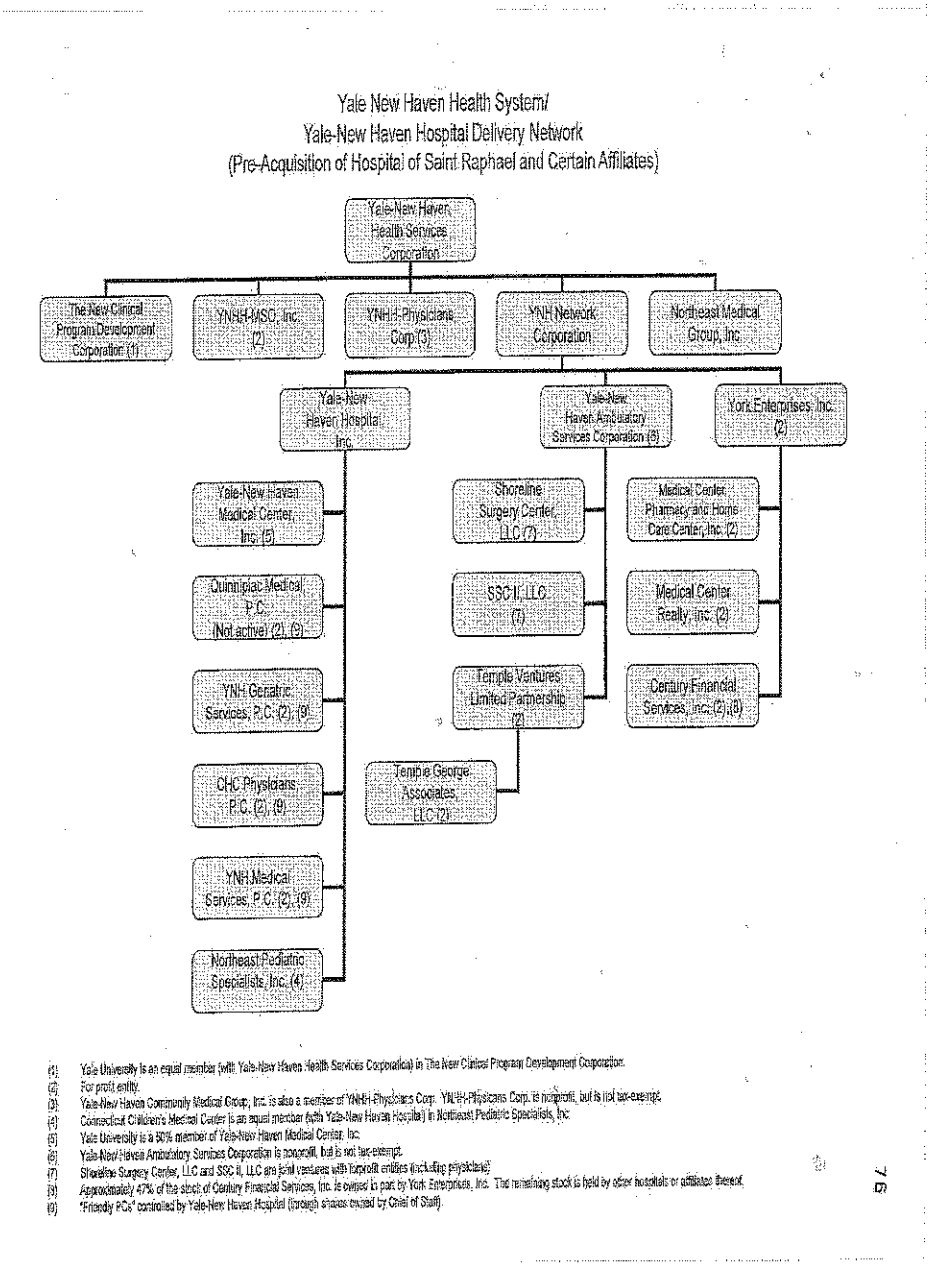
(Source: OHCA Hospital Inpatient Discharge Database)

12. With respect to the proposed transaction, Applicants provided the following general timeline:

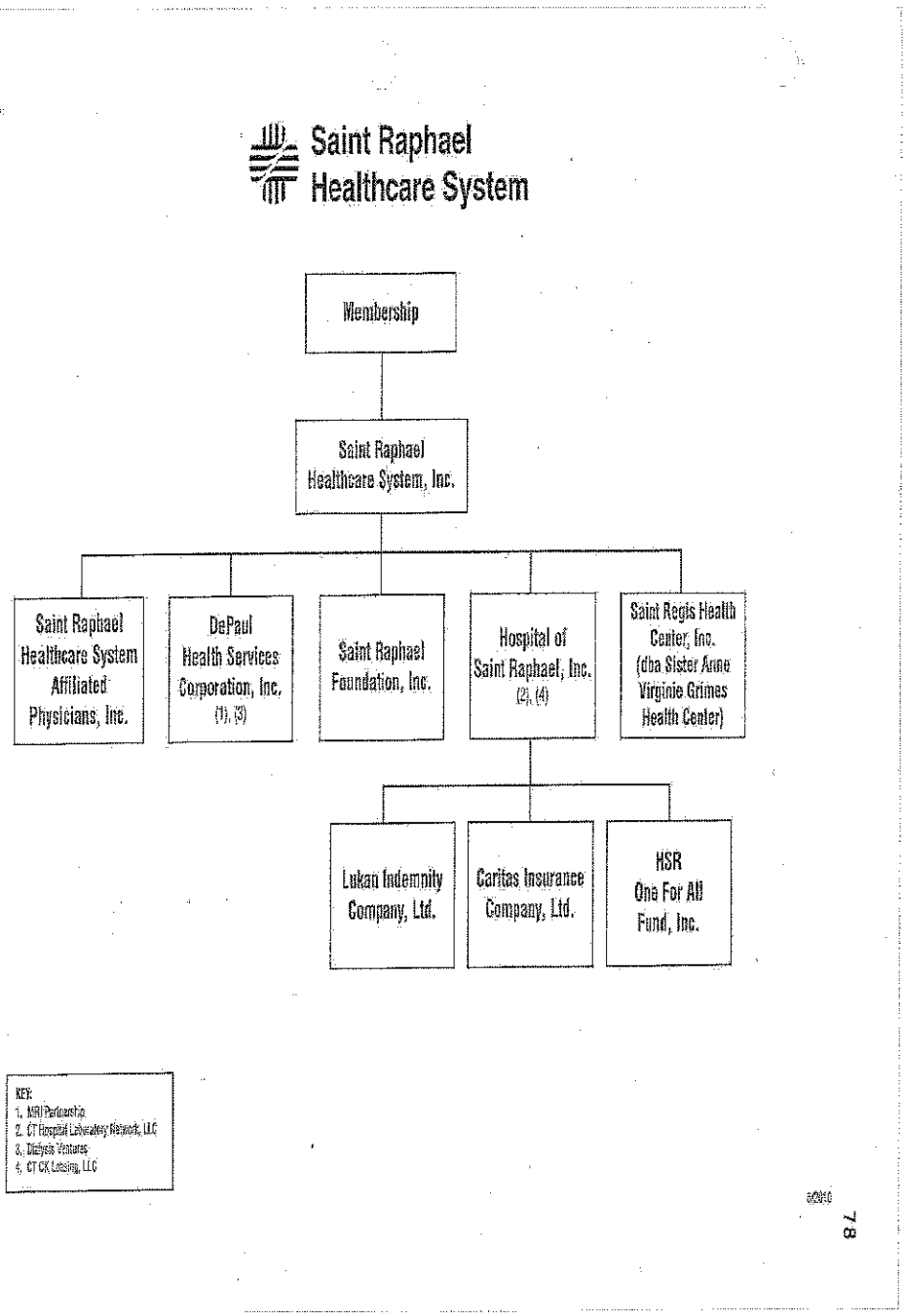
    a. Early 2010 – HSR approached YNHH to discuss how the organizations could work together;
    b. March 2011 - Applicants signed a letter of intent;
    c. In the months following March 2011 – Applicants engaged in the due diligence process; and
    d. September 2011 – Applicants executed Asset Purchase Agreement.

Ex. A, p. 36.

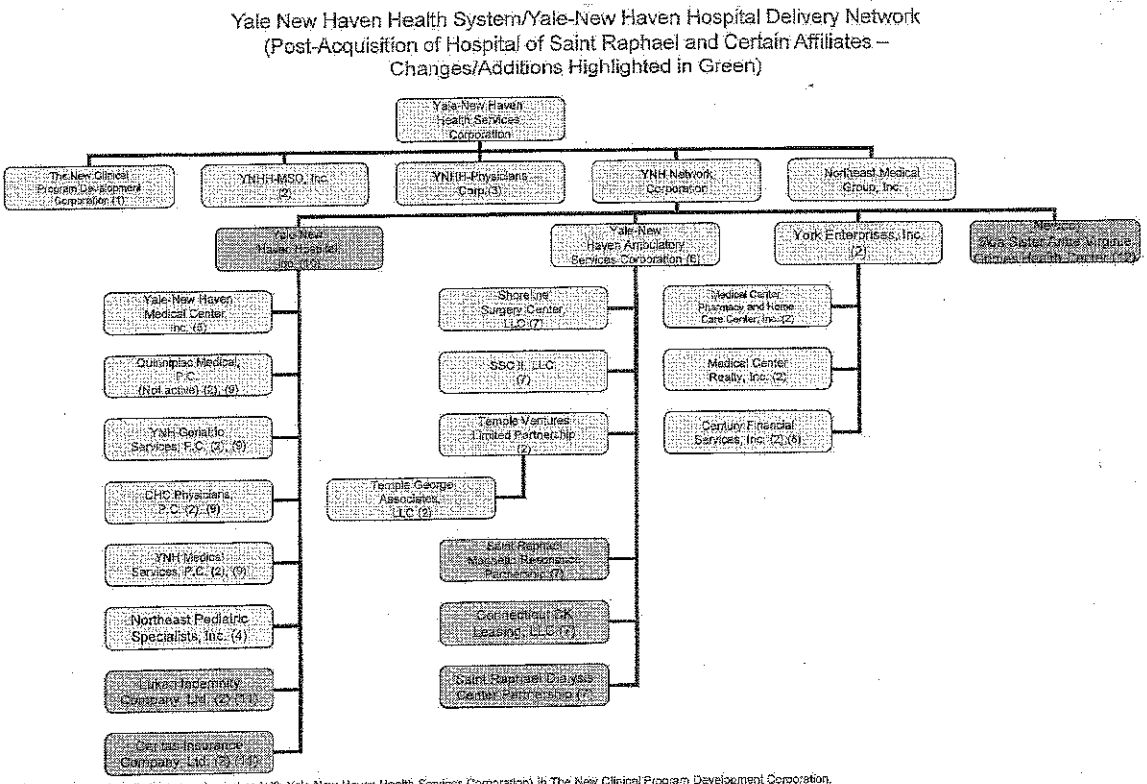
13. Applicants supplied an organizational chart of YNHHS prior to the proposed transaction that depicts the organization as follows: Ex. A, p. 76



14. Applicants supplied an organizational chart of SRHS prior to the proposed transaction that depicts the organization as follows: Ex. A, p. 78.



15. The Applicants provided an organizational chart of YNHHS following the proposed transaction that depicted the organization as follows:



Ex. A, pg. 77.

16. HSR had significant operating losses for FYs 2005 through 2009 and it cannot survive long-term as a standalone entity without outside assistance and investment. Ex. A, pp. 26-27; Transcript of June 5, 2012 Public Hearing ("Tr."), Testimony of Christopher O'Connor, President and Chief Executive Officer of HSR and SRHS, pp. 34-39.

17. Due to its financial situation, HSR has initiated cost-cutting measures, including negotiations with managed care organizations to improve reimbursement rates, productivity enhancements, supply chain cost reductions, fringe benefit eliminations, and cancellation and deferment of equipment, renovations, information technology ("IT") investments and other capital projects. Ex. A, p.26; Ex. F, pp. 110, 132-133.

18. Although it is licensed for 511 beds, HSR is currently operating 423 beds and has a current maximum physical plant capacity of 484 beds. Two units – Verdi 4N (30 beds)

and SLA (31 beds) – have been closed by HSR and an additional 27 beds have been removed as a result of renovations that occurred over the past few years. Ex. F, p. 118.

19. The following table depicts the inpatient hospital utilization for each of YNHH and HSR, as well as the two hospitals combined, for FYs 2009-2011:

	Discharges			Patient Days						
Yale-New Haven Hospital	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	4,644	4,494	4,596	26,189	26,401	24,465	-3%	2%	1%	-7%
Maternity	5,141	5,034	5,247	16,927	16,522	17,100	-2%	4%	-2%	3%
Psychiatric	3,189	3,300	3,077	30,470	30,453	32,083	3%	-7%	0%	5%
Rehabilitation	-	-	-	-	-	-				
Pediatric	5,492	5,643	5,599	21,249	20,833	19,822	3%	-1%	-2%	-5%
Medical or Surgical	35,956	38,291	39,232	184,531	190,458	206,503	6%	2%	3%	8%
Total	**54,422**	**56,762**	**57,751**	**279,366**	**284,667**	**299,973**	4%	2%	2%	5%
	Discharges			Patient Days						
Hospital of Saint Raphael	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	1,270	1,183	1,211	4,213	3,773	4,305	-7%	2%	-10%	14%
Maternity	1,403	1,286	1,292	4,026	3,661	3,888	-8%	0%	-9%	6%
Psychiatric	1,163	1,235	1,189	13,813	13,941	13,605	6%	-4%	1%	-2%
Rehabilitation	443	393	411	4,388	3,761	4,005	-11%	5%	-14%	6%
Pediatric	88	78	39	203	149	85	-11%	-50%	-27%	-43%
Medical or Surgical	20,601	20,335	18,998	105,242	99,828	96,742	-1%	-7%	-5%	-3%
Total	**24,968**	**24,510**	**23,140**	**131,885**	**125,113**	**122,630**	-2%	-6%	-5%	-2%
	Discharges			Patient Days						
YNHH/HOSR Combined	FY 2009	FY 2010	FY 2011	FY 2009	FY 2010	FY 2011	% chg 09-10	% chg 10 - 11	% chg 09-10	% chg 10 - 11
Newborn	5,914	5,677	5,807	30,402	30,174	28,770	-4%	2%	-1%	-5%
Maternity	6,544	6,320	6,539	20,953	20,183	20,988	-3%	3%	-4%	4%
Psychiatric	4,352	4,535	4,266	44,283	44,394	45,688	4%	-6%	0%	3%
Rehabilitation	443	393	411	4,388	3,761	4,005	-11%	5%	-14%	6%
Pediatric	5,580	5,721	5,638	21,452	20,982	19,907	3%	-1%	-2%	-5%
Medical or Surgical	56,557	58,626	58,230	289,773	290,286	303,245	4%	-1%	0%	4%
Total	**79,390**	**81,272**	**80,891**	**411,251**	**409,780**	**422,603**	2%	0%	0%	3%

(Source: OHCA Hospital Inpatient Discharge Database)

20. HSR's volume is down approximately 8% in the current year and cannot remain a viable standalone provider of hospital services due, in part, to the following:

    a. It has received a "going-concern" qualification in each auditor's report accompanying its audited financial statements since FY 2008. This qualification relates to its inadequate financial performance which has resulted in its inability to achieve financial covenant requirements of its long-term debt and insufficient current assets available to satisfy current liabilities if the credit-enhancers to its long term debt were to declare an event of default.

    b. Its employee and benefit matters have diminished the ability to attract and retain a robust workforce. It ceased all post-retirement pension benefit accruals for all employees effective during FY 2010 and its projections indicate that available resources will be inadequate to reinstitute these pension programs.

    c. Its unmet capital needs. Limitations on capital acquisitions over the last several years due to the lack of available funds continue to result in competitive disadvantages.

    d. It has experienced significant volume declines over the last several years.

    e. Payment rates from Medicare and Medicaid (approximately 70% of HSR net revenues) are expected to decline, and commercial payment rate increases will be more difficult to negotiate due to current economic conditions.

    f. As of April 30, 2012, HSR had only 23.5 days cash on hand. Existing loan agreement covenants require minimum days cash on hand of 40 days through 2013 and 45 days thereafter.

    g. As of February 29, 2012, HSR had a negative fund balance of $23.4 million, largely due to the underfunded position of the defined benefit pension plan. Existing loan agreement covenants include a minimum fund balance requirement of $54 million.

Ex. F, pp. 111-113; Ex. M, Pre-file Testimony of Christopher O'Connor, pg. 344-345; Tr., Testimony of Christopher O'Connor, p. 34-38.

21. HSR had the following liquidity, solvency and utilization measures as noted in the table below, for the last three FYs ending September 30, 2011:

Selected Liquidity and Solvency Measures for HSR

	FY 2009	FY 2010	FY 2011
Days Cash on Hand	16.5	11.2	21.0
Long Term Debt to Capital	(11.6)	(23.1)	(1.4)
Average Age of Plant	19.0	23.3	26.1

Source: OHCA Hospital Reporting System ("HRS") Twelve Months Filings Report 185 for Fiscal Year's 2009, 2010, and 2011

22. HSR's unmet capital needs have caused the age of its hospital physical plant to double in five years and become the oldest in the state at 26.2 years. HSR has deferred, postponed or cancelled capital needs as a result of the financial challenges it has faced in recent years that totals over $132 million. Ex. F, pp. 110-111, 139, 159, 232-243.

23. HSR's inability to fund capital expenditures has been especially noteworthy in two areas: medical equipment and IT. HSR's FY 2010 Capital Budget showed that although medical departments requested $34.8 million in medical equipment, HSR was able to commit only $3.8 million in that fiscal year, or just over 10% of requests. HSR was able to provide only $3.8 million in IT investment over the same period. A larger sum, estimated to be as high as $60 million, would be required to adopt the Epic electronic medical records ("EMR") system on a standalone basis.[4] Ex. F, p. 139.

24. In recognition of HSR's inability to achieve financial stability, the SRHS Board of Trustees and the sponsoring Sisters of Charity of Saint Elizabeth concluded that integrating with a stronger hospital or system was necessary to meet their mission of serving the poor, elderly and underserved. The SRHS Board's Ad Hoc Strategy Committee began a formal process in early 2010 to explore and evaluate its options. Ex. A, p. 26.

25. SRHS examined Catholic and secular, not-for-profit and for-profit, and national, Connecticut and local systems and determined that integrating with YNHH was in the best interest of SRHS, its staff, patients, physicians and community for the following reasons:

    a. The integration has the ability to transform and improve the way care is delivered in terms of quality, effectiveness, efficiency and access.

[4] Epic makes electronic medical record software for mid-size and large medical groups, hospitals and integrated healthcare organizations. An electronic medical record is a collection of electronic health information about individual patients or populations and is contained in a digital format that is capable of being shared across health care settings.

b. It will enable clinical service growth on the HSR campus.

c. It will provide financial stability for HSR, especially by eliminating long-term debt, significantly contributing to church pension plan obligations and providing much needed capital.

d. It will keep health care decisions local.

Ex. A, pp. 27-28; Ex. F, pp. 140-142.

26. Integrating with YNHH would provide the following benefits to HSR:

a. The organizations share a history of being part of the greater New Haven community.

b. YNHH would address HSR's financial challenges.

c. YNHH would employ the majority of HSR staffs.

d. YNHH would combine the medical staff of both hospitals.

e. YNHH would recognize the Teamsters as the bargaining unit for certain HSR employee groups.

f. YNHH would provide representation for HSR physicians on the YNHH Medical Board and its committees.

g. YNHH would enable HSR's campus to be the site of key centers of excellence.

h. YNHH would provide continuity and enhancement of patient care and stability through its investment in program development, infrastructure improvement and technology investments.

i. YNHH agrees to respect HSR's Catholic tradition by:

i. Continuing to provide care on the HSR campus according to the Ethical and Religious Directives (ERDs) for Catholic Health Care Services;

ii. Allowing the Sisters of Charity of Saint Elizabeth to have a role at YNHH through the selection of a senior leader to oversee matters pertaining to Catholic tradition, helping to select representatives for a committee to ensure clinical services are consistent with ERDs and serving on YNHH's Board of Trustees; and

iii. Honoring HSR's Catholic heritage on the HSR campus through signage, the continued presence of chapel, religious statuary and other symbols.

Ex. A, pp. 27-28.

27. HSR's long term-debt was $67.7 million as of February 29, 2012. All of this long-term debt will be extinguished as part of the acquisition transaction from a combination of HSR's cash on hand and a portion of the $160 million purchase price. Ex. F, p. 117.

28. HSR's Church plan pension shortfall was estimated to be approximately $86 million on a termination basis as of March 31, 2011 and included in the agreed upon purchase price of $160 million was the approximately $86 million shortfall. HSR's estimated Church plan pension shortfall on a termination basis as of December 31, 2011 was estimated to be approximately $135 million. The sources of funds to make up some of the shortfall in the pension obligation will be a combination of available HSR pension trust fund assets and a portion of the $160 million purchase price. Ex. F, p. 117.

29. YNHH developed the Y Access Line, a single-source phone center exclusively for physicians who are interested in transferring a patient to YNHH, which opened in August 2010. Inpatient cases transferred to YNHH totaled 2,996 the year before the Y Access Line was initiated and increased to 3,990 during the first year of its operation. This represents a 33% increase in volume, and it is projected that more than 4,500 patients will be transferred via the Y Access Line this year. Ex. A, pp. 30-31; Ex. M, Pre-file Testimony of Marna Borgstrom, Chief Executive Officer, YNHH, p. 325; Tr., Testimony of Peter Herbert, M.D., Chief of Staff and Senior Vice President for Medical Affairs of YNHH, pp. 20-21.

30. Patients referred through the Y Access Line are high acuity and in FY 2011 had an average length of stay of 10.81 days, more than double that of the average length of stay of 5.24 days for all YNHH inpatients. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 331.

31. In FY 2011, 73% of YNHH's admissions were categorized as emergent, and the figure increases to 76% if one excludes maternity, pediatrics and psychiatry. YNHH estimates that approximately three quarters of its admissions arrive with little or no advance notice. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 332.

32. YNHH has considered constructing a 5th bed tower to meet growing demand for bed capacity. Ex. A, p. 24.

33. As a result of its bed capacity constraints, YNHH periodically places patients on units not typically intended for their primary diagnosis, overflow areas have been developed to hold patients until they can be admitted to a bed, double rooms have been converted to triples and emergency department patients may wait in the ED for an extended period of time until an acute care or ICU bed becomes available. Ex. A, p. 31; Tr., Testimony of Peter Herbert, M.D., pp. 20-22.

34. YNHH has managed patient length of stay in the hospital through numerous initiatives and although length of stay reductions are projected (YNHH has projected average length of stay for FY 2012 at 5.10 days, reducing to 4.89 days by 2016), continued length of stay reduction will be challenging given the treatment of higher acuity patients via the Y Access Line and the aging of the population. Ex. A, pp. 33-34; Tr., Testimony of Peter Herbert, M.D., pp. 20-22.

35. If YNHH were to construct a 5th bed tower in order to meet projected inpatient demand, it estimates cost at approximately $537 million (and up to $622 million when the full cost of parking facilities and a new chiller plant are factored in). The only available site on the YNHH campus prohibits the new bed tower from being tied to YNHH's existing central medical complex and therefore would require construction of duplicate facilities to service the new tower. The bed tower would not be available until late 2016. The average occupancy rate for YNHH is projected to climb to 93% by 2016 without the ability to expand bed capacity. Ex. A, pp. 34-35; Ex. F, pp. 113, 149; Tr., Testimony of Marna Borgstrom, pp. 12-13.

36. As the cost and time required to build a 5th bed tower is a less than ideal solution, YNHH determined that the acquisition of HSR presents a much more cost effective and timely option for increasing its acute care bed capacity. Ex. A, p. 35.

37. After the closing of YNHH's acquisition of HSR, the two closed units on the HSR campus would be reopened, providing 484 operational beds in FY 2012. Renovation and staffing plans are also being made to bring 15 more beds into operation in FY 2013 for a total of 499 operational beds at HSR. The following table summarizes HSR's bed capacity between FY 2012 and FY 2015:

HSR Planned Bed Capacity				
	FY 2012	FY 2013	FY 2014	FY 2015
Beds	484	499	499	499
Bassinets	22	22	22	22
TOTAL	**506**	**521**	**521**	**521**

Ex. F, p. 120.

38. If the acquisition is approved, YNHH's projected total bed utilization would be 79%, 79%, 80%, 81% and 83% in FYs 2012 through 2016, respectively. Ex. H, pp. 294-298.

39. YNHH plans to spend a total of $129.5 million in capital expenditures on the HSR campus during the first five years after closing. A total of $85 million of this amount is earmarked for infrastructure (mechanical, electrical and plumbing) and architecturally related facility and appearance improvements (including operationalizing, by FY 2013, 15 of the 27 beds that have been removed from HSR in recent years). Another $25 million will be spent for routine capital needs, and $5.1 million will be spent for IT integration, including upgrades to the local area network, wireless network and computing equipment on the HSR campus. Lastly, $14.4 million will be spent to implement the Epic EMR system on the HSR campus. The Epic system is scheduled to be installed at YNHH on February 1, 2013. If the acquisition is approved, it is estimated that the installation of Epic on the HSR campus will be implemented in the summer of 2013. Ex. F, pp. 114-117, 144; Tr., Testimony of Vincent Tammaro, Vice President of Finance of YNHHS, pp. 64-65.

40. Prioritization of the capital improvements projects on the HSR campus will be determined by YNHH's senior leadership and based on a variety of factors, including regulatory requirements, updated facility assessments, patient volumes and annual budget amounts. YNHH is currently undertaking a budgeting process to identify planned capital expenditures for the HSR campus in FY 2013. Ex. F, p. 117; Tr., Testimony of Vincent Tammaro, pp. 65-66.

41. The following tables represent the patient population mixes for YNHH if the CON proposal is approved and for HSR currently. The projected payer mix for YNHH is based on the combination of YNHH volume and HSR volume by payer category, and projected volumes for FY 2013-2015 include holding current HSR volume flat and increasing YNHH volume 3% per year for inpatient admissions and 5% per year for outpatient encounters.

Patient Population Mix- YNHH – Inpatient (2013 – 2015 assumes HSR acquisition)

	Current FY 2012**	**Year 1 FY 2013**	**Year 2 FY 2014**	**Year 3 FY 2015**
Medicare*	31%	38%	38%	38%
Medicaid*	29%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**60%**	**63%**	**63%**	**64%**
Commercial Insurers*	38%	35%	35%	34%
Uninsured (Self Pay)	2%	2%	2%	2%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**40%**	**37%**	**37%**	**36%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Current includes only YNHH.

Patient Population Mix- YNHH – Outpatient (2013 – 2015 assumes HSR acquisition)

	Current FY 2012**	**Year 1 FY 2013**	**Year 2 FY 2014**	**Year 3 FY 2015**
Medicare*	21%	25%	25%	24%
Medicaid*	27%	25%	25%	26%
CHAMPUS & TriCare				
Total Government	**48%**	**50%**	**50%**	**50%**
Commercial Insurers*	45%	44%	44%	44%
Uninsured (Self Pay)	7%	6%	6%	6%
Workers Compensation	Incl . in commercial	Incl . in commercial	Incl . in commercial	Incl . in commercial
Total Non-Government	**52%**	**50%**	**50%**	**50%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

* Includes managed care activity.
** Current includes only YNHH.

Patient Population Mix- HSR Inpatient

	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	55%	N/A	N/A	N/A
Medicaid*	14%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**69%**	N/A	N/A	N/A
Commercial Insurers*	29%	N/A	N/A	N/A
Uninsured	2%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**31%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

Patient Population Mix- HSR Outpatient (Discharge Equivalent)

	Current FY 2012	Year 1 FY 2013	Year 2 FY 2014	Year 3 FY 2015
Medicare*	36%	N/A	N/A	N/A
Medicaid*	20%	N/A	N/A	N/A
CHAMPUS & TriCare		N/A	N/A	N/A
Total Government	**56%**	N/A	N/A	N/A
Commercial Insurers*	40%	N/A	N/A	N/A
Uninsured	4%	N/A	N/A	N/A
Workers Compensation	Incl . in commercial	N/A	N/A	N/A
Total Non-Government	**44%**	N/A	N/A	N/A
Total Payer Mix	**100%**	N/A	N/A	N/A

* Includes managed care activity.

Ex. A, pp. 47-49.

42. Applicants are preparing a transition plan and, during the next six months, will develop an operating plan which will identify the timing and process to integrate clinical services, clinical support, non-clinical support and infrastructure services over a three year period following the closing of the transaction. The plan is to ensure a smooth transition from two hospitals to one hospital with two campuses and an integrated ambulatory network. All services currently provided will remain and new services will be offered over time. Ex. A, p. 39.

43. As part of the transition plan, Applicants will integrate the medical staffs of the two hospitals to ensure coverage at both campuses at closing. They have almost completed the process of credentialing the HSR physicians who did not already have privileges at YNHH. More than 400 doctors, physician assistants and APRNs/midwives are being added to the YNHH medical staff and virtually every vital caregiver at HSR will be privileged by the closing date. Ex. H, p. 292; Tr., Testimony of Peter Herbert, M.D., pp. 46-47.

44. YNHH states that virtually all employed physicians at HSR have agreed to employment with the YNHHS, including emergency medicine physicians, intensivists, traumatologists and hospitalists. YNHH has agreed to accept assignment of the contracts of physicians and physician groups providing service in the primary care and specialty clinics at HSR. Site medical directors have been identified for all clinical services, and the hospital-based service providers (radiology, pathology, therapeutic radiology and anesthesiology) have agreed to assign their contracts to YNHH. Ex. M, Pre-File Testimony of Peter Herbert, M.D., p. 334.

45. As part of the transition plan, YNHH will integrate HSR's teaching and residency programs into its own teaching and residency programs, and existing residents and fellows will be able to continue their training under YNHH. Substantially all of the teaching staff at HSR will continue their teaching duties. Ex. F, p. 130.

46. As part of the transition plan, YNHH will expand the research and clinical trials conducted as a result of the transaction, and, after the closing, patients at both hospitals will have access to trials conducted at YNHH and YNHH will continue all of the trials that were ongoing at HSR prior to the closing of the transaction. Ex. F, p. 131.

47. Applicants have financial assistance policies to support patients with limited financial means, and, after the transaction, the financial policies of YNHH will be used for services provided on both campuses. YNHH financial assistance policies are broader and offer financial assistance to a wider range of patients at or around the poverty level than existing HSR financial assistance policies. With the exception of differences where YNHH policies provide additional assistance, all other financial assistance processes and collection practices of the hospitals are the same. Ex. F, p. 131; Ex. H, 299-321.

48. YNHH will bill for the proposed services. It indicates that new provider contracts will be negotiated based on the relative mix and volume of services in the combined institution and that the intent will be to establish melded, budget neutral agreements that will not result in an adverse impact to managed care payers or the self-funded employers. YNHH does not have any plans to raise charges as a result of the HSR acquisition. Ex. A, pp. 50-51; Tr., Testimony of William Gedge, Senior Vice President of Payer Relations for YNHHS, pp. 51-52.

49. The transaction-related investigations conducted by the state Attorney General and the Federal Trade Commission have been completed, and on June 1, 2012, these authorities indicated to Applicants that they will not oppose the transaction. The parties plan to formally close the transaction effective July 29, 2012, and they indicate that this date is important for many reasons, including the following: further delay is likely to cause HSR to lose additional key personnel and financial deterioration of HSR might force HSR to lay off more employees. Ex. F, p. 150; Tr., Testimony of Marna Borgstrom, p. 11.

50. The expected value of HSR's donor restricted funds at closing will be approximately $26 million. Applicants state that any charitable funds that cannot be transferred to YNHH or a YNHH affiliate will be used by HSR at or for the benefit of the HSR campus and consistent with donor intent. In the event that some charitable funds cannot be used for the benefit of HSR or consistent with donor intent, donors will be asked by HSR to consent to a transfer to YNHH or a revised charitable purpose, or the parties will seek court intervention to modify the donation in a manner that such funds may be used by YNHH or used to fund activities that benefit the delivery of health care services in the greater New Haven area consistent with the ERD Services. Ex. F, p. 144; Tr., James Rude, Assistant Vice President of Finance and acting interim Chief Financial Officer of HSR, pp. 69-72.

51. HSR currently provides the following community-based programs and each is expected to continue following the closing of the transaction: Father Michael J. McGivney Cancer Center in Hamden, Occupational Health Program, Blood Draw Centers in Amity/New Haven and Hamden, Midwifery Services in Shelton, Geriatric Assessment Centers in Branford and Hamden; ElderCare Geriatric Clinics; Project Mothercare; Smiles to Go! Dental Van, School-based health clinics, CareCard, Lifeline, Parish Nurse, WIC, Nurturing Families Network, New Haven Healthy Start, Project Brotherhood, Sister to Sister Program, Off Campus Classroom, H.O.P.E., AIDS/HIV Services, Bereavement Support Programs and the Family-Based Recovery Program. Ex. F, pp. 106-109.

52. It is expected that both campuses will continue to provide general medical/surgical, cardiology, vascular surgery, urology, psychiatric, low-risk obstetrical, gynecological, dentistry and non-trauma emergency services. Certain subspecialties will be consolidated on one campus. Ex. F, pp. 151-152.

53. The establishment of a musculoskeletal institute, including orthopedics, pain management, spine, rehabilitation, podiatry, and possibly a bariatric surgery program, is being planned for the HSR campus. Ex. F, p. 152.

54. Cardiac surgery, pediatrics, high risk obstetrics, trauma and medical, thoracic, gynecologic, surgical and breast oncology will likely be located on the YNHH campus. With regard to cardiac surgery, YNHH has made significant investments in its cardiac surgery program and can accommodate volume for both campuses. With regard to trauma, YNHH offers a Level I adult and pediatric trauma center, while HSR has a Level II trauma center. Following the acquisition, a single location for trauma will be established at YNHH. This is expected to simplify transport from the field. With regard to pediatrics, inpatient pediatric care is highly specialized, and HSR currently transfers almost all pediatric patients to YNHH. With regard to high risk obstetrics, HSR currently refers most of its high risk obstetrical cases to YNHH. In addition, Applicants state that high-risk obstetrics should be located in the same building as a Level III nursery, which YNHH currently has. Finally, with regard to oncology services, the Smilow Cancer Hospital's infrastructure along with Yale University Medical School's designation as a NCI-Comprehensive Cancer Center, make the YNHH campus the preferred campus for cancer treatment. Ex. F, pp. 151-152.

55. YNHH currently has two designated adult trauma bays and will have four following its current emergency department renovation which is scheduled to be completed in December, 2013. Based on FY 2011 trauma cases, HSR's trauma volume represents an additional 2.3 trauma cases per day to YNHH, and Applicants indicate that HSR's volume can be accommodated on the YNHH main campus. Ex. H, pg. 292; Tr., Testimony of Peter Herbert, M.D., pp. 74-75.

56. The acquisition will result in expanded facilities for ambulatory services such as outpatient clinics, community based practices and programs, radiation therapy and imaging services and will also improve access to healthcare services for YNHH patients. The acquisition will also create greater economies of scale and efficiencies and will eliminate duplication of investments and maximize capacity while also allowing it to focus on primary care development. As part of its clinical integration activities, YNHH will convert the internal medicine training programs for both YNHH and HSR into a primary care medicine program to expand the availability of such physicians in the community. Ex. A, p. 35; Tr., Testimony of Peter Herbert, M.D., pp. 44-45.

57. A major benefit of the proposed acquisition is the opportunity to expand the use of Epic to the YNHH and HSR campuses, outpatient services areas and physicians. The benefit of such a system is the ability to access consistent, clinical information across the health care continuum, reducing the need for duplicate tests and procedures and providing patients access to their clinical records. Such a system improves patient safety by providing a list of the patient's current medications, allergies, medical conditions and medical/surgical history and inserting such data directly into the patient's medical record without the time and potential errors of having a clinician write, then type, the information. Applicants estimate that the installation of the Epic system at HSR will cost approximately $30 million less if done as part the overall YNHH installation as opposed to being done by HSR on a standalone basis. Ex. A, p. 52; Ex. M, Pre-file Testimony of Alan Kliger, M.D., Senior Vice President, Chief Medical & Quality Officer of SRHS, pp. 340-341.

58. YNHH expects that it will initially secure short-term financing to raise the $160 million being paid for purchase of the assets and will secure long-term financing for this amount approximately two months after closing. YNHH's lead underwriter on the transaction (Barclays Capital) has done debt capacity evaluations and projections of special interest to rating agencies and, from this work, YNHH has concluded that the hospital has the ability to obtain necessary funding for the transaction. Ex. A, p. 46; Ex. F, p. 154; Tr., Testimony of Vincent Tammaro, p. 65.

59. HSR projects that, without approval of the CON proposal, it will incur a deficit of approximately $4.1 million in FY 2012 followed by deficits of approximately $8 million, $15 million and $17 million in FYs 2013 through 2015, respectively. Ex. A, p. 234.

60. SRHS projects that, without approval of the CON proposal, it will incur a deficit of approximately $6.1 million in FY 2012 followed by deficits of approximately $10.5 million, $18 million and $21 million in FYs 2013 through 2015, respectively. For the seven months ending April 30, 2012, SRHS provided financial statements reporting a net operating loss of $3.5 million. Ex. A, p. 233; Ex. P, p. 362.

61. YNHH projects that, if the CON proposal is approved, it will incur a deficit incremental to the CON of approximately $11.9 million in FY 2012 due to one-time acquisition costs associated with the transaction, thereby reducing its total projected surplus of $82.9 million to $71 million for the fiscal year. Thereafter, YNHH projects a total surplus incremental to the CON of $12.3 million, $16.5 million and $24.4 million in fiscal years 2013 through 2015, respectively. For the seven month ending April 2012, YNHH provided financial statements reporting a net gain of $45.7 million. Ex. A, p. 231; Ex. P, p. 355.

62. Applicants engaged a consultant (Deloitte) to help identify cost savings that could be achieved through the acquisition. The combined hospital will be able to achieve a cost savings of approximately $700 million, derived from capital cost avoidance savings of almost $400 million and operational cost savings of approximately $300 million, over the first five years. The capital cost avoidance savings is largely the result of avoiding the need to construct a fifth bed tower and not replacing certain capital equipment (DaVinci robot, PET, CT), and the operational cost savings is largely the result of labor cost savings and savings in contractual obligations resulting from the integration of various business functions and medical specialties. The operational costs savings were separated into two parts: infrastructure (non-clinical) cost savings and clinical cost savings. The infrastructure cost savings are expected to result from the integration of various business functions (including, but not limited to, finance, human resources, information technology, marketing, strategic planning and legal) across the two campuses. On the clinical side, Applicants indicate that the cost savings over the first five years after closing are expected to be almost $26 million. In addition, because estimates for the cost of the 5th bed tower have increased over time, the Applicants expect that total cost savings from the acquisition appear likely to exceed the amount calculated during the Deloitte engagement. Ex. F, pp. 127-128.

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 and the Applicant bears the burden of proof in this matter by a preponderance of the evidence. Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790 (2008); Steadman v. SEC, 450 U.S. 91, 101 S.Ct. 999, reh'g den., 451 U.S. 933 (1981); Bender v. Clark, 744 F.2d 1424 (10th Cir. 1984); Sea Island Broadcasting Corp. v. FCC, 627 F.2d 240, 243 (D.C. Cir. 1980).

SRHS is the parent company of HSR and YNHHS is the parent company of YNHH. FF 2, 4. HSR and YNHH are both acute care general hospitals located in New Haven, Connecticut. FF 1, 3. The two hospitals are integral parts of the health delivery system in the region. FF 19. Pursuant to Applicants' proposal, YNHH would acquire certain assets of SRHS, including HSR, with the result being YNHH operating a single, acute care hospital with two inpatient campuses and multiple outpatient satellites. FF 5, 6. Applicants base the need for their proposal on HSR's significant financial losses in recent years, which have required reductions in operating expenses, including limiting employee benefits and delaying capital investments, and increased demand for inpatient bed capacity at YNHH. FF 7.

HSR has experienced a decrease in its annual patient days in all service areas, including medical/surgical, since FY 2009. FF 19. In addition, HSR has received a "going concern" qualification in each auditor's report accompanying its audited financial statements since FY 2008, ceased all post-retirement pension benefit accruals for all employees effective during FY 2010 without being able to reinstitute them, and reported low liquidity and solvency measures in terms of long term debt to capital and days cash on hand since FY 2008. FF 20. HSR also reported that the average age of its physical plant rose to 26.1 years in FY 2011 and provided a list of capital needs totaling over $132 million that have been deferred, postponed or cancelled due to its deteriorating financial condition. FF 22, 23. SRHS' financial statements for the month ending April 2012 also show a year-to-date operating loss of over $3.5 million and the Chief Executive Officer of HSR testified that HSR's current operation as an independent hospital is unsustainable. FF 16, 60.

YNHH has experienced increased demand for inpatient beds in recent years that it attributes to growth of its specialty care services and increased referrals of high acuity patients from health care providers both inside and outside Connecticut. FF 29-31. YNHH described its efforts to manage length of stay, but nonetheless indicated that continued length of stay reduction will be challenging due to the high acuity of its Y Access Line patients. FF 35. To create more inpatient capacity, YNHH has contemplated the construction of a 5th bed tower on its main campus at an estimated capital cost of $622 million. FF 35. YNHH claims it has pursued the acquisition of HSR because it presents a more cost effective and timely option for increasing acute care bed capacity than constructing the new bed tower. FF 36. Applicants have projected the bed utilization for YNHH after the acquisition of HSR to be 79%, 79%, 80%, 81% and 83% in FYs 2012 through 2016, respectively. FF 38.

Portions of the $160 million purchase price for SRHS' assets will be used to extinguish HSR's long-term debt and to fund the shortfall in its pension plan. FF 27, 28. In addition, during the first

five years after closing, YNHH plans to spend $129.5 million on capital expenditures at the HSR campus to address infrastructure improvements and routine capital needs as well as provide technology integration and implementation of the Epic electronic medical record system. FF 39. Given the challenges faced by HSR, this acquisition will help ensure continued access for Connecticut residents to hospital services on its campus while also allowing for enhancements in patient care through infrastructure improvement and technology investments at that location. FF 26. The acquisition of HSR will also provide YNHH with additional bed capacity without the capital expenditure and delay associated with new construction. FF 36.

OHCA expects that a single hospital provider with two campuses will create greater economies of scale and efficiencies and will eliminate duplication of investments and maximize capacity at both locations. FF 56. However, OHCA will monitor this process further due to Applicants' inability to submit a transition/operating plan identifying the timing and process to integrate clinical, support and infrastructure services for the combined hospital.

It is anticipated that both campuses will continue to provide general medical/surgical, cardiology, vascular surgery, urology, psychiatric, low-risk obstetrical, gynecological, dentistry and emergency services. FF 52. With respect to hospital services that may be consolidated in one location, it is expected that the HSR campus will house a new musculoskeletal institute, including orthopedics, pain management, spine, rehabilitation, podiatry, and possibly a bariatric surgery program. FF 53. On the other hand, cardiac surgery, pediatrics, high-risk obstetrics and trauma services as well as medical, thoracic, gynecologic, surgical and breast oncology services are expected to be consolidated on the existing YNHH campus. FF 54. YNHH affirmed its ability to handle the trauma cases shifted from HSR in its Emergency Department, which is presently being renovated, and it is further expected that the acquisition will result in expanded facilities for outpatient clinics, community based practices and programs, as well as radiation therapy and imaging services. FF 55, 56. In addition, YNHH plans to adopt financial assistance policies that are broader than HSR's on its new campus, and each of the numerous community-based programs currently operated by HSR is expected to continue following the closing of the transaction. FF 47, 51. Accordingly, OHCA finds that access to quality health care in the region will be maintained and improved by this proposal.

OHCA also finds that the Applicants' projected cost savings of approximately $700 million over the first five years following the closing appear reasonable and achievable. However, OHCA will monitor this process further to determine if such savings are actually realized. The projected cost savings are broken down into capital cost avoidance savings of almost $400 million and operational cost savings of approximately $300 million. The capital cost avoidance savings are expected to result from avoiding new construction for bed capacity and not replacing certain capital equipment (DaVinci robot, PET, CT), and the operational cost savings are expected to result from labor cost savings and savings in contractual obligations resulting from the integration of various business functions and medical specialties. FF 62. YNHH also plans to enter into budget neutral payer agreements that will not cause managed care companies or self-funded employers to be adversely affected by the HSR acquisition and stated that it has no plans to raise charges as a result of this transaction. FF 48. Accordingly, this proposal should achieve savings that will improve the cost effectiveness and efficiency of the health care delivery system in the region and make it more efficient.

In summary, OHCA finds that the Applicants have demonstrated a clear public need for the proposed transaction and, by avoiding further financial losses and possible insolvency for HSR, the acquisition of SRHS's assets by YNHH will positively impact the financial strength of the state's health care system. As Applicants have represented that specific service integration and cost savings will occur as a result of the acquisition, OHCA, as set forth in the Order, herein, establishes conditions to monitor the transition.

ORDER

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access, and Yale-New Haven Hospital ("YNHH"), the Saint Raphael Healthcare System ("SRHS") and Hospital of Saint Raphael, Inc. ("HSR") hereby stipulate and agree to the terms of settlement with respect to the acquisition of certain assets of SRHS, including HSR, as follows:

1. Within five (5) calendar days of the closing of YNHH's acquisition of certain assets of SRHS, including HSR, YNHH agrees to report to the Office of Health Care Access ("OHCA") the date of such and, upon surrender of HSR's acute care hospital license to the Department of Public Health, YNHH shall be authorized to increase its licensed bed capacity from the present 916 licensed hospital beds and 92 bassinets to 1,427 licensed hospital beds and 114 bassinets.

2. The Applicants agree that within sixty (60) calendar days of the closing date, YNHH shall provide OHCA with an unredacted copy of the Asset Purchase Agreement that was provided as Attachment III to the CON Application (Ex. A). The unredacted copy will be entered as part of the permanent record in this proceeding.

3. YNHH agrees to submit to OHCA, no later than January 31, 2013, a detailed and comprehensive document showing the three-year plan ("the plan") to integrate the operations of both hospitals and attain the cost savings stated within the CON Application. At a minimum, the submission shall address the planned location of services and beds, anticipated cost savings, staffing and quality improvements, and merger-related revenue enhancements. Subsequent to the submission of the plan, YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the 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. Due dates are May 31, 2013, November 30, 2013, May 31, 2014, November 30, 2014, May 31, 2015, and November 30, 2015. YNHH shall submit the following on a semi-annual basis:

    a. YNHH agrees to file narrative updates on the progress of the implementation of the plan. This would include integration of all affected clinical services including primary care initiatives in the community.

    b. YNHH agrees to report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, 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,F,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. YNHH will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. YNHH agrees to file a completed Balance Sheet and Statement of Operations for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. YNHH agrees to file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

4. Applicants agree to comply with all state and federal statutes and regulations applicable to all licenses and certificates issued by the Department of Public Health.

5. DPH and YNHH, SRHS, and HSR agree that this Agreed Settlement represents a final agreement between OHCA and YNHH, SRHS, and HSR with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes, which may have been raised by the Applicants with regard to Docket Number 12-31747-CON.

6. This Agreed Settlement is an order of the Department of Public Health Office of Health Care Access with all the rights and obligations attendant thereto, and the Department of Public Health may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Signed by Marna P. Borgstrom Chief Exec. Officer
(Print name) (Title)

6/27/12
Date

Marna P. Bo
Duly Authorized Agent for
The Yale-New Haven Hospital

Signed by JAMES R. RUDE, AVP-FINANCE
(Print name) (Title)

6/27/12
Date

James R. Rude
Duly Authorized Agent for
The Hospital of Saint Raphael

Signed by JAMES F RUDL, AVP-FINANCE
(Print name) (Title)

6/27/12
Date

James F. Rudl
Duly Authorized Agent for
Saint Raphael Health Services

As the designated Hearing Officer in this matter, I respectfully recommend to Deputy Commissioner Lisa A. Davis that she accept and approve the terms of this Agreed Settlement.

6/27/12
Date

Joanne V. Yandow, Esq.
Hearing Officer

The above Agreed Settlement is hereby accepted and so ordered by the Department of Public Health Office of Health Care Access on June 27, 2012.

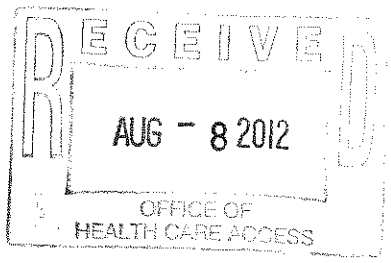
6/27/2012
Date

Lisa A. Davis
Lisa A. Davis MBA, BSN, RN
Deputy Commissioner

YALE-NEW HAVEN HOSPITAL

August 6, 2012

VIA OVERNIGHT MAIL



Lisa Davis, Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

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

Re: Agreed Settlement Docket Number 12-31747-CON
Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System Inc.

Dear Deputy Commissioner Davis and Ms. Martone:

As your office is aware, Yale-New Haven Hospital and the Saint Raphael Healthcare System, Inc. are proceeding as expeditiously as possible towards closing. Our target closing date is now September 12, 2012.

At the time that the parties entered into the above-referenced Agreed Settlement, it was anticipated that the closing would occur earlier this summer. As such, the parties agreed to submit an integration plan (the "Plan") in accordance with Order Number 3 of the Agreed Settlement by January 31, 2013. The parties further agreed to provide the Office of Health Care Access with various other documents in connection with the transaction on deadlines that are triggered by the closing date.

In light of the new target date for closing, Yale-New Haven Hospital respectfully requests that the Agreed Settlement be modified to require that the Plan be submitted within six (6) months of the closing date. Please let us know if that timeframe for submission is acceptable.

Thank you in advance for your assistance.

Sincerely,

Gayle Capozzalo

cc: William J. Aseltyne, Esq., General Counsel, Yale-New Haven Hospital
Marna Borgstrom, CEO, Yale-New Haven Hospital
Christopher O'Connor, President & CEO, Hospital of Saint Raphael
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael

RECEIVED
SEP 12 2012
Department of Public Health
Office of the Commissioner

VIA HAND DELIVERY

September 12, 2012

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 34038
Hartford, Connecticut 06134-0308

Re: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. (Docket Number 12-31747-CON)

Dear Deputy Commissioner Davis,

In accordance the Agreed Settlement entered into in connection with the above referenced Certificate of Need, we are pleased to report to the Office of Health Care Access that Yale-New Haven Hospital has acquired certain assets of the Saint Raphael Health System, including the Hospital of Saint Raphael, effective as of **12:01am, September 12, 2012**.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Marna P. Borgstrom
Title: Chief Executive Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: William J. Aseltyne, General Counsel, Yale-New Haven Hospital, Inc.
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael

YALE-NEW HAVEN HOSPITAL

Hospital of Saint Raphael

VIA HAND DELIVERY

September 12, 2012

Lisa A. Davis, M.B.A., B.S.N., R.N.
Deputy Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 34038
Hartford, Connecticut 06134-0308

Re: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. (Docket Number 12-31747-CON)

Dear Deputy Commissioner Davis,

In accordance the Agreed Settlement entered into in connection with the above referenced Certificate of Need, we are pleased to report to the Office of Health Care Access that Yale-New Haven Hospital has acquired certain assets of the Saint Raphael Health System, including the Hospital of Saint Raphael, effective as of **12:01am, September 12, 2012**.

Sincerely,

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: Marna P. Borgstrom
Title: Chief Executive Officer

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: Christopher M. O'Connor
Title: President and Chief Executive Officer

cc: William J. Aseltyne, General Counsel, Yale-New Haven Hospital, Inc.
Janeanne Lubin-Szafranski, General Counsel, Hospital of Saint Raphael

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

October 9, 2012

Gayle Capozzalo
Chief Exectuvie Officer
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510-3220

Re: Docket Number 12-31747-MDF: A Request to Modify Docket Number 12-31747-CON
Yale-New Haven Hospital
Requet to Modify Condition 3 of the Order under Docket No.: 12-31747-CON

Dear Ms. Capozzalo:

On August 8, 2012, the Office of Health Care Access ("OHCA") received a request from Yale-New Haven Hospital ("Applicant") to modify the Certificate of Need ("CON") issued under Docket No.: 12-31747-CON, which authorized the Applicant to acquire the Saint Raphael Healthcare System, Inc. The Applicant requested a modification of Condition 3 of the Order under the Agreed Settlement due to the postponement of the final Closing Date in this matter.

In accordance with Connecticut General Statutes § 4-181a(b), OHCA hereby modifies Conditon 3 of the Order under Docket No.: 12-31747-CON as follows:

3. YNHH agrees to submit to OHCA, no later than March 31, 2013, a detailed and comprehensive document showing the three-year plan ("the plan") to integrate the operations of both hospitals and attain the cost savings stated within the CON Application. At a minimum, the submission shall address the planned location of services and beds, anticipated cost savings, staffing and quality improvements, and merger-related revenue enhancements. Subsequent to the submission of the plan, YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the 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. Due dates are November 30, 2013, May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, and May 31, 2016. YNHH shall submit the following on a semi-annual basis:

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

a. YNHH agrees to file narrative updates on the progress of the implementation of the plan. This would include integration of all affected clinical services including primary care initiatives in the community.

b. YNHH agrees to report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, 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,F,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. YNHH will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. YNHH agrees to file a completed Balance Sheet and Statement of Operations for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. YNHH agrees to file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

If you have any questions regarding this action, please contact Steven W. Lazarus, Associate Health Care Analyst at (860) 418-7012.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3088
RECIPIENT ADDRESS	912036883472
DESTINATION ID	
ST. TIME	10/12 11:41
TIME USE	00'32
PAGES SENT	3
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: Gayle Capozzalo

FAX: (203) 688-3472

AGENCY:

FROM: Steven Lazarus

DATE: 10/12/12 TIME: 10:30 a

NUMBER OF PAGES:
(including transmittal sheet

Comments:
CON Modification # 12-31747-MDF.

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, November 07, 2012 10:32 PM
To: Lazarus, Steven; Olejarz, Barbara
Cc: Greer, Leslie; Roberts, Karen
Subject: Fw: Docket #12-31747-CON
Attachments: Davis APA Unredacted Cover Ltr 110712.pdf; APA - EXECUTED YNHH-HSR Unredacted FINAL SIGNED 092612.pdf

---

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Wednesday, November 07, 2012 02:03 PM
To: Martone, Kim
Cc: Aseltyne, Bill <Bill.Aseltyne@ynhh.org>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>
Subject: Docket #12-31747-CON

Attached please find the letter and Asset Purchase Agreement per the settlement of Docket Number 12-31747-CON. The material is being mailed today.

Thank you.
Gayle

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

YALE NEW HAVEN HEALTH

November 7, 2012

Lisa Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capital Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06137

Re: Docket Number 12-31747-CON
"Yale-New Haven Hospital's Acquisition of the Hospital of Saint Raphael Healthcare System, Inc."

Dear Deputy Commissioner Davis:

In accordance with the agreed upon settlement to the above referenced Certificate of Need, please find attached a signed unredacted copy of the Asset Purchase Agreement, which was provided as Attachment 3 to the CON application. It is our understanding that this unredacted copy will be entered as part of the permanent record in this proceeding.

Thank you very much for your attention to this matter.

Gayle Capozzalo
Executive Vice President
Strategy & System Development

GC/lm/eg

ASSET PURCHASE AGREEMENT

BY AND AMONG

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

HOSPITAL OF SAINT RAPHAEL

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC.

DEPAUL HEALTH SERVICES CORPORATION, INC.

SAINT RAPHAEL FOUNDATION, INC.

SAINT REGIS HEALTH CENTER, INC.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

YALE-NEW HAVEN HOSPITAL, INC.

Dated as of September 26, 2011

TABLE OF CONTENTS

Page

ARTICLE 1. DEFINITIONS 2
ARTICLE 2. PURCHASE AND SALE OF ASSETS 13
2.1 Purchase and Sale of Assets 13
2.2 Assumption of Liabilities 15
2.3 Purchase Price 15
2.4 Title Company Escrow 15
ARTICLE 3. REPRESENTATIONS AND WARRANTIES OF SELLERS 16
3.1 Organization; Authority 16
3.2 Powers; Consents; Absence of Conflicts 16
3.3 Absence of Certain Changes 16
3.4 Compliance with Laws 17
3.5 Licenses 18
3.6 Accreditation; Government Reimbursement Programs 18
3.7 Medical Staff Matters 19
3.8 Contracts and Leases 19
3.9 Real Property; Condition of Facilities 20
3.10 Personal Property 22
3.11 Labor and Employee Matters 22
3.12 Litigation or Proceedings 24
3.13 Special Funds 24
3.14 Tax Matters 25
3.15 Environmental Matters 25
3.16 Insurance 26
3.17 Brokers 27
3.18 Solvency 27
3.19 Financial Statements 27
3.20 Assets; Sufficiency of Assets 27
3.21 Equipment 28
3.22 Intellectual Property 28
3.23 Software 28

TABLE OF CONTENTS
(continued)

Page

3.24 Absence of Default 28
3.25 Charitable Funds 28
3.26 Bank Accounts 29
3.27 No Undisclosed Liability 29
3.28 No Untrue or Inaccurate Representations or Warranties 29
ARTICLE 4. REPRESENTATIONS AND WARRANTIES OF BUYER 29
4.1 Organization; Authority 29
4.2 Powers; Consents; Absence of Conflicts 29
4.3 Brokers 30
ARTICLE 5. CERTAIN COVENANTS OF SELLERS 30
5.1 Information 30
5.2 Operations 31
5.3 Negative Covenants 32
5.4 Governmental Approvals 33
5.5 Charitable Funds 34
5.6 Church Approvals 34
5.7 Closing Conditions 34
5.8 Payment of Obligations 34
5.9 No-Shop Clause 35
5.10 Transfer of Assets 35
5.11 Real Property 35
5.12 Insurance Coverage 35
5.13 Bankruptcy 35
5.14 Pharmacy License 36
5.15 Disclosure Supplements 36
5.16 Continuation of Group Health Plan Coverage and COBRA Continuation Coverage 37
5.17 Notice of Breach 37
ARTICLE 6. CERTAIN COVENANTS OF BUYER 37
6.1 Governmental Approvals 37

TABLE OF CONTENTS
(continued)

Page

6.2 Church Approvals 38
6.3 Closing Conditions 38
6.4 Notice of Breach 38
6.5 Real Property Reports 38
ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER 38
7.1 Representations/Warranties 38
7.2 Covenants 39
7.3 Officers' Certificate 39
7.4 Litigation or Proceedings 39
7.5 Governmental Approvals 39
7.6 Church Approvals 39
7.7 Closing Deliveries 39
7.8 Third Party Consents 39
7.9 Satisfaction of Retained Liabilities 39
7.10 Charitable Funds 40
7.11 Grimes Center Medical Rate 40
7.12 Solvency Upon Closing 40
ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS 41
8.1 Representations/Warranties 41
8.2 Covenants 41
8.3 Officers' Certificate 41
8.4 Litigation or Proceedings 41
8.5 Governmental Approvals 41
8.6 Closing Deliveries 41
8.7 Church Approvals 41
ARTICLE 9. CLOSING 42
9.1 Closing 42
9.2 Actions of Sellers at Closing 42
9.3 Actions of Buyer at Closing 44
9.4 Close of Title Company Escrow 44

TABLE OF CONTENTS
(continued)

Page

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS 47
10.1 Operations Transition 47
10.2 Preservation of Catholic Heritage 50
10.3 Preservation and Access to Records After Closing 52
10.4 Employee Matters 52
10.5 Tax Matters 54
10.6 Sellers' Cost Reports 55
10.7 Allocation of Purchase Price 55
10.8 Patient Receivables 55
10.9 Return of Payments 56
10.10 Title and Survey Contingency 56
10.11 Due Diligence Contingency 57
10.12 Confidentiality 58
10.13 Tail Insurance 59
10.14 Press Releases 59
10.15 Compliance with the Transfer Act 59
10.16 Post Effective Time Operations 60
10.17 Post Effective Time Negative Covenants 60
10.18 Restrictive Covenants 61
ARTICLE 11. TERMINATION 62
11.1 Termination 62
11.2 Effect of Termination 63
11.3 Break-Up Fee and Expense Reimbursement 63
11.4 Conditions for and Payment of Break-Up Fee and Expense Reimbursement 63
11.5 Joint and Several Liability of Sellers for Break-Up Fee and Expense Reimbursement 64
ARTICLE 12. INDEMNIFICATION 64
12.1 Indemnification by Sellers 64
12.2 Indemnification by Buyer 65
12.3 Time and Amount Limitations 65

TABLE OF CONTENTS
(continued)

Page

12.4 Notice and Control of Litigation 66
ARTICLE 13. GENERAL 67
13.1 Choice of Law 67
13.2 Assignment 67
13.3 Cost of Transaction 67
13.4 Notice 68
13.5 Severability 69
13.6 Gender, Number and Inferences 69
13.7 Divisions and Headings 69
13.8 No Third-Party Beneficiaries 69
13.9 Entire Agreement 69
13.10 Counterparts 70
13.11 Amendment 70
13.12 Waiver of Breach 70
13.13 Other Interpretative Matters 70
13.14 Reproduction of Documents 70
13.15 Waiver of Jury Trial 70
13.16 Time of the Essence 71

EXHIBITS

Exhibit A	Facilities
Exhibit B	Assignment and Assumption of Leases Agreement
Exhibit C	Bill of Sale, Assignment and Assumption Agreement
Exhibit D	Caritas SPA
Exhibit E	Deeds
Exhibit F	Lukan SPA
Exhibit G	Foundation Liquidation Plan
Exhibit H	[Not Utilized]
Exhibit I	A – Wind Down Services Agreement
	B – Transition Services Agreement
Exhibit J	Title Insurance
Exhibit K	Jointly Retained Consultant Fees
Exhibit L	Purchase Price Payment Schedule
Exhibit M	Form of Estoppel Certificates
Exhibit N	Wind Down Plan
Exhibit O	Captives' Net Assets Certificate

ASSET PURCHASE AGREEMENT

THIS ASSET PURCHASE AGREEMENT (this "**Agreement**") is made and entered into as of September 26, 2011 (the "**Effective Date**"), by and among: (a) Saint Raphael Healthcare System, Inc., a Connecticut nonstock corporation ("**SRHS**"), (b) Hospital of Saint Raphael, a Connecticut nonstock corporation ("**HSR**"), (c) Saint Raphael Healthcare System Affiliated Physicians, Inc. d/b/a Affiliated Physicians of Saint Raphael, a Connecticut nonstock corporation ("**SRHSAP**"), (d) DePaul Health Services Corporation, Inc., a Connecticut nonstock corporation ("**DHSC**"), (e) Saint Raphael Foundation, Inc., a Connecticut nonstock corporation (the "**Foundation**"), (f) Saint Regis Health Center, Inc. d/b/a Sister Anne Virginie Grimes Health Center, a Connecticut nonstock corporation ("**Grimes Center**" and each of SRHS, HSR, SRHSAP, DHSC, Foundation and Grimes Center, a "**Seller**" and, collectively, the "**Sellers**"), Yale-New Haven Health Services Corporation d/b/a Yale New Haven Health System, a Connecticut nonstock corporation ("**YNHHS**") and Yale-New Haven Hospital, Inc., a Connecticut nonstock corporation or its designee in accordance with Section 13.2 ("**Buyer**").

RECITALS

A. SRHS is the tax-exempt parent company of the Sellers;

B. Sellers, through the operation of the Hospital (as defined below) and the other health care facilities and businesses identified on Exhibit A hereto and all of their health care related businesses operating in the State of Connecticut (together with the Hospital, the "**Facilities**"), are in the business of, and are dedicated to, assuring the promotion of health and the provision of the continuum of health care services, ranging from wellness programs to acute care and long-term care (the "**Business**");

C. HSR, under the control of SRHS, owns and is engaged in the business of operating, a 511-bed general acute care community and teaching hospital facility in New Haven, Connecticut (the "**Hospital**");

D. YNHHS, through its several delivery networks, including Buyer, provides comprehensive, cost-effective, advanced patient care, educates health professionals and advances clinical care in affiliation with the Yale University School of Medicine;

E. Buyer owns and is in the business of operating a 966-bed tertiary medical center in New Haven, Connecticut that provides comprehensive, multidisciplinary, family-focused care and is the primary teaching hospital for the Yale University School of Medicine;

F. HSR desires to sell to Buyer, and Buyer desires to purchase from HSR, certain of the assets used by HSR in the operation of the Hospital on the terms and subject to the conditions set forth in this Agreement.

G. Sellers desire to sell to Buyer, and Buyer desires to purchase from Sellers, certain of the assets used by Sellers in the operation of the Business on the terms and subject to the conditions set forth in this Agreement; and

H. Sellers desire to assign to Buyer, and Buyer desires to assume from Sellers, certain liabilities of Sellers incurred in the operation of the Business on the terms and subject to the conditions set forth in this Agreement.

AGREEMENT

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1. DEFINITIONS

The following terms used in this Agreement shall have the respective meanings ascribed to them in this Article 1:

"**Additional Continuing Employees**" has the meaning set forth in Section 10.4(c).

"**Additional Employees**" has the meaning set forth in Section 10.4(c).

"**Affiliate**" means, as to the entity in question, any Person that directly or indirectly controls, is controlled by, or is under common control with, the entity in question; and the term "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, membership interests, by contract, the power to appoint directors or trustees or otherwise.

"**Agreement**" has the meaning set forth in the introductory paragraph.

"**Alternative Transaction**" means any of the following transactions with a Person other than Buyer, or an Affiliate thereof, involving any of the Sellers or any Affiliates of the Sellers: (a) sale, transfer or other disposition of the ownership or direct or indirect control of any of the Sellers or any of their Affiliates; (b) merger, reorganization, consolidation, affiliation or other business combination or similar transaction involving any of the Sellers or their Affiliates; (c) sale, lease, exchange, transfer or other disposition of a substantial portion of the assets or the Purchased Assets of any of the Sellers or their Affiliates; or (d) agreement with any Person or organization (other than Buyer and its Affiliates) with respect to any ownership or control interest in any Seller or the management or operation of the Purchased Assets or any material portion thereof (other than any employment contract entered into with any management employee in the ordinary course of business). For the avoidance of doubt, an Alternative Transaction shall include any transactions arising under a sale authorized pursuant to title 11 of the United States Code, a plan of reorganization, plan of liquidation or other plan of arrangement under applicable law, in each case, that provides for the sale or restructuring of all, substantially all or any substantial portion of the assets of the Business.

"**Applicable Law**" means any constitution, law, ordinance, principle of common law, code, statute, act, treaty or order of general applicability of any Governmental Authority, including the rules and regulations promulgated thereunder.

"**Assignment and Assumption of Leases**" means an assignment and assumption of leases agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit B.

"**Assumed Contracts**" means the Contracts listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Leases**" means the Leases listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Liabilities**" has the meaning set forth in Section 2.2(a).

"**Balance Sheet Date**" means March 31, 2011.

"**Bankruptcy Code**" has the meaning set forth in Section 5.13.

"**Bargaining Unit Employees**" means the employees of HSR and Grimes Center currently represented by the Teamsters.

"**Basket Amount**" has the meaning set forth in Section 12.3(c).

"**Benefit Liabilities**" means the liabilities with respect to the frozen accrued pension benefits under the Church Plan and the liabilities incurred by HSR under its post-retirement medical benefits plan.

"**Benefit Plans**" has the meaning set forth in Section 3.11(a).

"**Bid Protection Motion**" has the meaning set forth in Section 5.13.

"**Bid Protection Order**" has the meaning set forth in Section 5.13.

"**Bill of Sale, Assignment and Assumption Agreement**" means a bill of sale, assignment and assumption agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit C.

"**Break-Up Fee**" has the meaning set forth in Section 11.3(a).

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

"**Buyer**" has the meaning set forth in the introductory paragraph.

"**Buyer Effect**" means a material adverse effect on the ability of Buyer to perform its obligations under this Agreement or to consummate the transactions contemplated hereby.

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.1.

"**Caritas**" has the meaning set forth in Section 5.12.

"**Caritas SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit D.

"**Charitable Funds**" has the meaning set forth in Section 5.5.

"**Church**" has the meaning set forth in Section 5.6.

"**Church Approvals**" has the meaning set forth in Section 5.6.

"**Church Plan**" means The Retirement Plan for Employees of The Hospital of Saint Raphael, a frozen defined benefit pension plan that qualifies as a church plan described in Section 414(e) of the Code.

"**Claims**" has the meaning set forth in Section 10.11(d).

"**Claims Notice**" has the meaning set forth in Section 12.4(a).

"**Close of Escrow**" has the meaning set forth in Section 9.4(a).

"**Closing**" has the meaning set forth in Section 9.1.

"**Closing Date**" has the meaning set forth in Section 9.1.

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

"**Combined Medical Staff**" has the meaning set forth in Section 10.1(b).

"**Combined Medical Staff Bylaws**" has the meaning set forth in Section 10.1(b).

"**Commitment Period**" means the period of time beginning at the Effective Time and continuing until the five-year anniversary of the Effective Time.

"**CON Filing**" means the filings, application and process by and pursuant to which Certificate of Need authorization is requested from the State of Connecticut Office of Health Care Access and any other Governmental Authority with respect to this Agreement and the transactions contemplated hereunder.

"**Confidential Information**" has the meaning set forth in Section 10.12.

"**Continuing Employees**" means, collectively, the Additional Continuing Employees, the Continuing Bargaining Unit Employees and the Continuing Non-Bargaining Unit Employees.

"**Continuing Bargaining Unit Employees**" has the meaning set forth in Section 10.4(b).

"**Continuing Non-Bargaining Unit Employees**" has the meaning set forth in Section 10.4(a).

"**Contracts**" means all rights, benefits and interests of any Seller in, to and under all contracts relating to the conduct of the Business, including, without limitation, physician agreements, agreements with third party payors, joint venture or partnership agreements, supply purchase agreements, employment agreements, tenant leases, equipment leases, equipment maintenance agreements, agreements with municipalities and labor organizations, settlement

agreements, loan agreements, bonds, mortgages, liens or other security agreements, but excluding the Leases.

"**Cost Reports**" means all cost and other reports related to the Sellers filed pursuant to the requirements of the Government Reimbursement Programs for cost-based payments or reimbursement due to or claimed by the Sellers from the Government Reimbursement Programs or their fiscal intermediaries or payor agents, including all Cost Report receivables or payables and all related appeals and appeal rights and other forms or claims filed or submitted by the Sellers to the Government Reimbursement Programs or their fiscal intermediaries or payor agents for payment or reimbursement due to or claimed by the Sellers on a fee-for-service, prospective payment, fee schedule or other similar basis.

"**Deeds**" means the special warranty deeds for each parcel of the Owned Real Property, dated as of the Closing Date, executed by each Seller, as applicable, substantially in the form of Exhibit E.

"**DHSC**" has the meaning set forth in the introductory paragraph.

"**De Minimis Threshold**" has the meaning set forth in Section 12.3(c).

"**Directives**" means Catholic ethical tradition as referenced in the Ethical and Religious Directives for Catholic Health Care Services (Fifth Edition).

"**Disclosure Schedule**" means the disclosure schedule, dated as of the date hereof, that is attached hereto and incorporated in and made a part of this Agreement.

"**Effective Date**" has the meaning set forth in the introductory paragraph.

"**Effective Time**" has the meaning set forth in Section 9.1.

"**Environmental Laws**" means all statutes, laws, rules, regulations, codes, ordinances, standards, guidelines, authorizations and orders of any federal, state or local public agency or authority having jurisdiction over the Purchased Assets that deal with Solid Waste, toxic or hazardous waste, wastewater discharges, water quality, drinking water, air emissions, air quality, Hazardous Substances (including Medical Hazards), lead-based paint or employee health, safety or community right-to-know.

"**Environmental Permits**" has the meaning set forth in Section 3.15(a).

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

"**Expense Reimbursement**" has the meaning set forth in Section 11.3(b).

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

"**Final Order**" means an order or judgment of the bankruptcy court, or other court of competent jurisdiction, as entered on the docket in a Seller's chapter 11 case or the docket of any other court of competent jurisdiction, that has not been reversed, stayed, modified or amended,

and as to which the time to appeal or petition for certiorari or move for a new trial, reargument or rehearing has expired, and as to which no appeal or petition for certiorari or other proceeding for a new trial, reargument or rehearing that has been timely taken is pending, or as to which any appeal that has been taken or any petition for certiorari that has been timely filed has been withdrawn or resolved by the highest court to which the order or judgment was appealed or from which certiorari was sought or the new trial, reargument or rehearing shall have been denied or resulted in no modification of such order.

"**Final Order Exception**" shall mean any of the following: (a) Buyer and Sellers shall have consummated the transactions contemplated in this Agreement; (b) Buyer shall have, in its sole and absolute discretion, waived in writing the requirement that the Sale Order shall have become a Final Order; or (c) any appeal from the Sale Order that does not (i) involve an appeal by any party or parties in interest as to which the matter in dispute in the appeal with respect to that party, or in the aggregate by all parties taking an appeal, is in excess of $3,000,000, (ii) involve an appeal by the United States Trustee or any regulatory or governmental agency involving a matter in dispute in the appeal that could prevent consummation of or result in the unwinding of the transactions contemplated by this Agreement or (iii) in any way threaten or challenge Buyer's protection under Section 363(m) of the Bankruptcy Code.

"**Financial Advisor**" has the meaning set forth in Section 7.12(b).

"**Financial Certificate**" has the meaning set forth in Section 9.2(j).

"**Financial Statements**" has the meaning set forth in Section 3.19.

"**Foundation**" has the meaning set forth in the introductory paragraph.

"**GAAP**" means generally accepted accounting principles in the United States.

"**Good Standing**" with respect to individuals employed by Sellers shall mean that such individual is legally eligible to work in the State of Connecticut and, within the 12 months immediately preceding the Effective Time, the individual has (a) not received a written warning or higher-level of discipline pursuant to Sellers' progressive disciplinary process, (b) not been placed on a performance improvement plan or similar process, and (c) received at least a satisfactory performance evaluation on the last such evaluation. In offering employment to Sellers' employees, Buyer shall reasonably determine their good standing based on their official personnel file where the foregoing information is retained by Sellers.

"**Government Reimbursement Programs**" means the Medicare program, the Connecticut Medicaid program, the federal TRICARE program, and any other, similar or successor federal, state or local health care payment programs with or sponsored by Governmental Authorities, including without limitation, current federal and Connecticut disproportionate share "DSH" reimbursement or adjustments applicable to Sellers, and federal reimbursement or adjustments for or related to the Sellers' graduate medical education programs.

"**Governmental Authority**" means any federal, state, local or any foreign governmental unit, agency, commission or authority.

"**Guarantee**" by any Person means any obligation, contingent or otherwise, of such Person directly or indirectly guaranteeing or otherwise supporting in whole or in part the payment of any Indebtedness or other obligation of any other Person and, without limiting the generality of the foregoing, any obligation, direct or indirect, contingent or otherwise, of such Person (a) to purchase or pay (or advance or supply funds for the purchase or payment of) such Indebtedness or other obligation of such other Person (whether arising by virtue of partnership arrangements, by agreements to keep well, to purchase assets, goods, securities or services, to take or pay, or to maintain financial statement conditions or otherwise) or (b) entered into for the purpose of assuring in any other manner the obligee of such Indebtedness or other obligations of the payment of such Indebtedness or to protect such obligee against loss in respect of such Indebtedness (in whole or in part). The term "Guarantee" used as a verb has a correlative meaning.

"**Hart-Scott-Rodino Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations promulgated thereunder.

"**Hazardous Substances**" means asbestos, radioactive substances, radon, PCBs, petroleum, Medical Hazards and any chemical, substance or material that is listed or regulated under Environmental Laws as a hazardous or toxic substance, material, chemical substance, pollutant, waste, pesticide or fungicide or that under applicable Environmental Laws requires special handling or notification of any federal, state or local governmental agency or authority in its collection, storage, treatment, recycling or disposal.

"**Healthcare Laws**" means, collectively, any and all federal, state or local statutes, rules, regulations and administrative manuals, orders, guidelines and requirements of law of any Governmental Authority governing the licensure of or regulating healthcare providers, professionals, facilities or payors or otherwise governing or regulating the provision of, or payment for, healthcare services, the sale of controlled substances or other pharmaceuticals, medical devices or supplies and the like. Without limiting the generality of the foregoing, Healthcare Laws include, without limitation, state corporate practice of medicine laws, statutes and regulations, Section 1128B(b) of the Social Security Act, as amended, 42 U.S.C. Section 1320a 7(b) (Criminal Penalties Involving Medicare or State Health Care Programs), commonly referred to as the "Federal Anti-Kickback Statute," Section 1877 of the Social Security Act, as amended, 42 U.S.C. Section 1395nn and related regulations (Prohibition Against Certain Referrals), commonly referred to as "Stark Law", the federal False Claims Act, 31 U.S.C. Section 3729 et seq., corresponding state laws and other state and federal fraud and abuse laws.

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

"**HSR**" has the meaning set forth in the introductory paragraph.

"**HSR Financing Agreements**" means the agreements associated with the CHEFA Hospital of Saint Raphael Series H, L and M bond financing and the Master Financing Agreement, dated January 1, 2006, by and among Chase Equipment Leasing Inc., State of Connecticut Health and Education Facilities Authority and HSR.

"**Improvements**" means means all buildings, structures, parking areas, sidewalks, landscaping and other improvements located on the Owned Real Property.

"**Indebtedness**" of any Person means either (a) any liability of such Person (i) for borrowed money (including the current portion thereof), (ii) under any reimbursement obligation relating to a letter of credit, bankers' acceptance or note purchase facility, (iii) evidenced by a bond, note, debenture or similar instrument (including a purchase money obligation), (iv) for the payment of money relating to any lease that is required to be classified as a capitalized lease obligation in accordance with GAAP, (v) for all or any part of the deferred purchase price of property or services (other than trade or accounts payables), including any "earnout" or similar payments or any noncompete payments, (vi) under interest rate swap, hedging or similar agreements or (vii) for any credit card payables with respect to charges having a transaction date of 30 days or more prior to the Closing Date or related to non-business related activities; or (b) any liability of others described in the preceding clause (a) that such Person has Guaranteed, that is recourse to such Person or any of its assets or that is otherwise its legal liability or that is secured in whole or in part by the assets of such Person. For purposes of this Agreement, "Indebtedness" includes (A) any and all accrued interest, success fees, prepayment premiums, make whole premiums or penalties and fees or expenses actually incurred (including attorneys' fees) associated with the prepayment of any Indebtedness, (B) all "cut" but uncashed checks issued by any Seller that are outstanding as of the Closing Date, (C) cash, book or bank account overdrafts and (D) any and all amounts owed by any Seller to any of its Affiliates. The Financial Certificate sets forth the entire amount of Sellers' Indebtedness (indicating the amount of each individual component of Indebtedness and the Person to whom such Indebtedness is owed).

"**Indemnified Party**" has the meaning set forth in Section 12.4(a).

"**Indemnifying Party**" has the meaning set forth in Section 12.4(a).

"**Intellectual Property Rights**" has the meaning set forth in Section 3.22.

"**IRCA**" has the meaning set forth in Section 3.11(e).

"**Key Employee**" means, with respect to each Seller, the president and/or chief executive officer and his direct reports and the chief financial officer and his assistant vice presidents.

"**Knowledge**" shall, with respect to the particular provision it qualifies, mean (a) all matters with respect to which any such Person or its Affiliates have received written notice, or (b) with respect to any Seller, (i) the actual knowledge of such Seller's president and/or chief executive officer and chief financial officer, including, with respect to each, the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer or chief financial officer, as the case may be, or (ii) the actual knowledge of any member of the congregation of SOC appointed to the governing board or any office of such Seller.

"**Leased Real Property**" has the meaning set forth in Section 3.9(a).

"**Leases**" means all rights, benefits and interests of any Seller, as the case may be, as the lessor, lessee or sublessee, as the case may be, in, to or under any lease or sublease relating to real property or the conduct of the Business.

"**Liability Claim**" has the meaning set forth in Section 12.4(a).

"**Lien**" **or** "**Encumbrance**" means any lien, pledge, claim, liability, interest, restriction or other encumbrance.

"**Litigation or Proceedings**" has the meaning set forth in Section 3.12.

"**Litigation Conditions**" has the meaning set forth in Section 12.4(b).

"**Loss**" or "**Losses**" means any debt, loss, damage, diminution in value, adverse claim, fines, penalties, liability or obligation (whether direct or indirect, known or unknown, asserted or unasserted, absolute or contingent, accrued or unaccrued, matured or unmatured, determined or determinable, disputed or undisputed, liquidated or unliquidated, or due or to become due, and whether in contract, tort, strict liability or otherwise), and including all costs and expenses relating thereto (including all fees, disbursements and expenses of legal counsel, experts, engineers and consultants and costs of investigation) to the extent not covered by insurance proceeds actually received.

"**Lukan**" has the meaning set forth in Section 5.12.

"**Lukan SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit F.

"**March 31, 2011 Balance Sheet**" means the balance sheet included in the March 31, 2011 Financial Statements.

"**March 31, 2011 Financial Statements**" has the meaning set forth in Section 3.19.

"**Material Adverse Effect**" means any occurrence, condition, change, development, circumstance, effect, event or fact, occurring after the Effective Date (a "**Matter**"), that individually or in the aggregate, has resulted in, would result in or could reasonably be expected to result in (a) the inability of Sellers to timely and fully perform their obligations under this Agreement or to timely and fully consummate the transactions contemplated hereby; or (b) the inability of Sellers, after giving effect to the transactions contemplated hereby, to satisfy the Retained Liabilities. Any Matter specifically disclosed on the Disclosure Schedules at the Effective Time shall not be deemed to constitute a Material Adverse Effect and shall not be considered in determining whether a Material Adverse Effect has occurred.

"**Material Contracts and Leases**" has the meaning set forth in Section 3.8.

"**Maximum Liability Amount**" has the meaning set forth in Section 12.3(b).

"**Medical Hazards**" means all biological and chemical materials that under applicable Environmental Laws or industry standards are required to be handled in accordance with certain

procedures, and all other materials that may contain or be contaminated with such biological or chemical materials, and all devices or materials that could puncture or cut the skin (including, without limitation, those commonly known as "sharps").

"**Net Assets**" means Total Assets less Total Liabilities.

"**Nonassignable Contract**" has the meaning set forth in Section 2.1(b).

"**Non-Bargaining Unit Employees**" means such employees of HSR and Grimes Center who are not represented by any union or bargaining unit, including the Teamsters.

"**Noncompete Period**" has the meaning set forth in Section 10.18(a).

"**Notice to Tenants**" has the meaning set forth in Section 9.2(q).

"**Owned Real Property**" has the meaning set forth in Section 3.9(a).

"**Patient Receivables**" means accounts receivable of HSR arising from the provision of services, drugs, items and supplies to patients at the Facilities through Closing and relating to Government Reimbursement Programs or other third party payors.

"**Permitted Encumbrances**" means (a) Liens or Encumbrances created by Buyer or securing any indebtedness specifically assumed by Buyer as an Assumed Liability; (b) Liens or Encumbrances for Taxes, assessments or other similar governmental charges which are not due and payable as of the Closing Date; (c) Liens or Encumbrances set forth on Schedule 3.9(a) Part A, and (d) rights of counterparties under Assumed Contracts and Assumed Leases.

"**Person**" means any individual, sole proprietorship, partnership, corporation, limited liability company, limited partnership, joint venture, unincorporated society or association, trust, estate or other entity or organization, or any division of such Person.

"**Personal Property**" means tangible personal property (including, without limitation, equipment, fixtures, vehicles, furniture, tools, furnishings, machinery, instruments, spare parts, supplies, pharmacueticals and inventory).

"**Pharmacy License**" means HSR's license to operate a retail pharmacy issued by the Connecticut Department of Consumer Protection's Commission of Pharmacy.

"**Physician**" means any licensed doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry or chiropractor, or any group, partnership, corporation, of whatever form, made up of one more such persons.

"**Physician Contract**" means any Contract, direct or indirect, including unwritten or unexecuted financial arrangements and agreements, regardless of amount or payment, entered between or among parties, one of which is a Seller or an Affiliate thereof, and the other of which is one or more Physician(s), Physician group(s) and/or other entities owned in whole or in part, by one or more Physicians (or any member of the Immediate Family of a Physician) and/or Physician groups, where one or more Physicians makes Referrals, including, without limitation,

physician employment agreements, medical director agreements, administrative services agreements, professional services agreements, teaching services agreements, preceptorship agreements, call coverage agreements, moonlighting agreements, per-diem services agreements, research agreements, any lease agreement, (including leases of space or equipment), recruitment agreements, income guarantee arrangements, loan agreements, loan guarantee arrangements, billing services agreements, practice support agreements, management services agreements, agreements for the provision of personnel, agreements for the sale or purchase of assets, joint venture arrangements of any structure and risk-sharing or shared-savings agreements. For purposes of this definition "Referral" means a request or order for any item or services, including the request for a consultation with another Physician (and any test or procedure ordered by or performed by or under the supervision of the other Physician), provided to patients. For purposes of this definition, "Immediate Family" means husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister- in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

"**PMA Agreement**" has the meaning set forth in Section 10.4(g).

"**Pre-Closing Tax Period**" means a taxable period or portion thereof that ends on or prior to the Closing Date; if a taxable period begins on or prior to the Closing Date and ends after the Closing Date, then the portion of the taxable period that ends on and includes the Closing Date shall constitute a Pre-Closing Tax Period.

"**Purchase Price**" has the meaning set forth in Section 2.3.

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

"**Real Property**" has the meaning set forth in Section 3.9(a).

"**Real Property Lease**" has the meaning set forth in Section 3.9(a).

"**Rejection Notice**" has the meaning set forth in Section 5.15.

"**Restricted Entities**" has the meaning set forth in Section 10.18(a).

"**Retained Assets**" has the meaning set forth in Section 2.1(c).

"**Retained Liabilities**" has the meaning set forth in Section 2.2(b).

"**Sale Motion**" has the meaning set forth in Section 5.13.

"**Sale Order**" has the meaning set forth in Section 5.13.

"**Section 1060 Allocation**" has the meaning set forth in Section 10.7.

"**Security Agreement**" has the meaning set forth in Section 10.4(g).

"**Seller**" and "**Sellers**" have the meanings set forth in the introductory paragraph.

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.2.

"**Seller Tax Returns**" has the meaning set forth in Section 3.14(b).

"**SOC**" means the Sisters of Charity of Saint Elizabeth, a New Jersey nonprofit corporation.

"**Software**" has the meaning set forth in Section 3.23.

"**Solid Waste**" means any substance deemed under any applicable federal or state law or regulations as waste.

"**Solvent**" or "**Solvency**" means, with respect to the Sellers and each of them: (a) the fair value of the Seller's assets exceeds the fair value of the Seller's liabilities, including contingent liabilities; (b) the Sellers, and each of them, do not have, and are not incurring debts or liabilities beyond the applicable Seller's ability to pay as such debts and liabilities mature; (c) the Sellers are generally able to pay their debts as they become due and payable and are, in fact, paying such debts as they become due and payable; and (d) the Sellers, and each of them, are not engaged in a business or transaction, and are not about to engage in a business or transaction, for which the Sellers' property would constitute unreasonably small capital to carry on each of their businesses as it is then conducted. The amount of contingent liabilities at any time shall be computed as the amount that, in light of all the facts and circumstances existing at the time, represents the amount that can reasonably be expected to become an actual or matured liability.

"**Sponsoring Organization**" means (a) SRHS as the sponsor of the Church Plan or (b) an organization designated and maintained by SRHS that shall be controlled by, or associated with, the Church.

"**SRHS**" has the meaning set forth in the introductory paragraph.

"**SRHSAP**" has the meaning set forth in the introductory paragraph.

"**Tail Insurance Policies**" has the meaning set forth in Section 10.13.

"**Tax**" or "**Taxes**" means all taxes, fees, levies or other assessments imposed by the United States or any state, country, local or foreign government or subdivision or agency thereof, including, without limitation, income, gross receipts, excise, real and personal property, premiums, municipal, capital, value-added, goods and services, consumption, sales, transfer, license, payroll and franchise taxes, and such term shall include any interest, penalties or additions to tax attributable to such taxes, fees, levies or other assessments.

"**Tax Returns**" means any report, return or other information required to be supplied to any federal, state or local taxing authority in connection with Taxes.

"**Teamsters**" means the Teamsters Local 443, affiliated with the International Brotherhood of Teamsters.

"**Teamsters Plan**" means the multiemployer pension plan to which SRHS or HSR is obligated to make contributions to or for the benefit of Bargaining Unit Employees.

"**Title Company**" means First American Title Insurance Company.

"**Title Company Escrow Agent**" means First American Title Insurance Company in its capacity as closing escrow agent.

"**Title Company Escrow Funds**" means an amount equal to the amount required to be paid by Buyer to Sellers at Closing in accordance with Section 2.3 and as adjusted by Section 9.4 and Section 13.3.

"**Title Policies**" means ALTA Form Owner's Policy (6/17/06) owner policies of title insurance covering each of the Owned Real Property in the amounts set forth on Exhibit J, naming Buyer as the insured, and containing as exceptions to title only the Permitted Encumbrances.

"**Total Assets**" means, in the case of Caritas and Lukan, total assets per financial statements less premiums receivable, and in the case of HSR, restricted assets set aside for malpractice, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

"**Total Liabilities**" means, in the case of Caritas and Lukan, total liabilities less unearned premiums on premiums receivable, and in the case of HSR, its tail liability, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

"**TPC Agreement**" has the meaning set forth in Section 10.4(g).

"**Transfer Act**" means the Connecticut Transfer Act, Connecticut General Statutes Sections 22a-134 et seq.

"**Transition Services Agreements**" means the Transition Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and Buyer, substantially in the form attached hereto as Exhibit I-B.

"**Wind Down Plan**" has the meaning set forth in Section 7.9.

"**Wind Down Services Agreement**" means the Wind Down Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and YNHH, substantially in the form attached hereto as Exhibit I-A.

"**YNHHS**" has the meaning set forth in the introductory paragraph.

ARTICLE 2. PURCHASE AND SALE OF ASSETS

2.1 Purchase and Sale of Assets.

(a) On the terms and subject to the conditions set forth in this Agreement, at Closing, Buyer shall purchase from each Seller, and each Seller shall sell, assign, transfer, convey and deliver to Buyer or Buyer's Affiliate, all of each Seller's right, title and interest in, to and under all of the rights, properties and assets of every kind, character or description, wherever located and whether real, personal or mixed, or fixed, contingent or otherwise, that are owned, used or held for use by such Seller in the conduct of the Business, including, but not limited to, those assets identified in Section 2.1(a) of the Disclosure Schedule, but excluding the Retained Assets (collectively, the "**Purchased Assets**"), free and clear of any Liens or Encumbrances, other than the Permitted Encumbrances. Without limiting the generality or effect of the foregoing, at Closing, HSR shall transfer, convey and deliver to Buyer (i) good and marketable title to the Owned Real Property, together with all fixtures and Improvements thereon, (ii) all of each Seller's leasehold interests in the Leased Real Property (subject to the terms of the applicable leases and related instruments governing such interests, and (iii) all right, title and interest of each Seller to the other Purchased Assets (subject to the terms of any applicable Assumed Contract or Assumed Lease), in each case free and clear of any Liens or Encumbrances, other than Permitted Encumbrances.

(b) To the extent that any Assumed Contract or Assumed Lease to be assigned pursuant to the terms of Section 2.1(a) is not capable of being assigned without the consent of a third party or if such assignment or attempted assignment would constitute a breach thereof or a violation of any law (any such Assumed Contract or Assumed Lease being referred to herein as a "**Nonassignable Contract**"), nothing in this Agreement shall constitute an assignment or an attempted assignment thereof prior to the time at which all consents necessary for such assignment shall have been obtained. Each Seller shall use commercially reasonable efforts to obtain the consent to the assignment of any Nonassignable Contracts and Buyer shall reasonably cooperate with each Seller's efforts to obtain such consent. To the extent that such consents are not obtained, if and to the extent requested by Buyer, such Seller shall, during the term of the affected Nonassignable Contract, use reasonable best efforts to (i) provide to Buyer the benefits under any such Nonassignable Contract, (ii) cooperate in any reasonable and lawful arrangement designed to provide such benefits to Buyer, and (iii) enforce, at the written request of Buyer, for the account of Buyer, any rights of such Seller under the affected Nonassignable Contract (including the right to elect to terminate such Nonassignable Contract in accordance with the terms thereof upon the direction of Buyer). Buyer shall reasonably cooperate with such Seller in order to enable such Seller to provide the benefits contemplated by the immediately preceding sentence to Buyer. Buyer shall perform the obligations of each Seller arising under the affected Nonassignable Contracts, but only if and to the extent that such Seller provides to Buyer the benefits thereof pursuant to this Section 2.1(b).

(c) For purposes of this Agreement, the term "**Retained Assets**" means all of each Seller's right, title and interest in, to and under the following:

(i) the corporate record books of each Seller (other than medical records, all of which shall be Purchased Assets);

(ii) the Benefit Plans;

(iii) the Medicare, Medicaid and any other payor agreements and provider numbers of each Seller except for the Medicare, Medicaid and other payor agreements and provider numbers of Grimes Center identified as Purchased Assets in Section 2.1(a) of the Disclosure Schedule;

(iv) cash, cash equivalents, certificates of deposit, treasury bills, securities, accounts and accounts receivable (except for the amount held by HSR for the satisfaction of malpractice tail liabilities and except as otherwise set forth in Section 10.8 with respect to Patient Receivables);

(v) the Pharmacy License;

(vi) HSR's general acute care hospital license issued by the Connecticut Department of Public Health;

(vii) any surety bonds issued to cover workers' compensation claims with respect to any Seller;

(viii) any other assets identified in Section 2.1(c) of the Disclosure Schedule; and

(ix) all contracts and leases of any Seller that are not Assumed Contracts or Assumed Leases.

2.2 Assumption of Liabilities.

(a) At and after the Effective Time, Buyer agrees to assume, satisfy, discharge and perform as and when due, and to hold each Seller harmless against, the future payment and performance of only the following obligations and liabilities of each Seller related to the Purchased Assets (collectively, the "**Assumed Liabilities**"):

(i) all obligations and liabilities arising from and after the Effective Time under the Assumed Contracts and Assumed Leases;

(ii) all obligations and liabilities with respect to the ownership and operation of the Purchased Assets that arise from and after the Effective Time;

(iii) all workers' compensation liabilities;

(iv) the HSR malpractice tail liability; and

(v) all obligations and liabilities set forth on Section 2.2(a) of the Disclosure Schedule.

(b) Each Seller shall retain and be responsible and liable for, and Buyer shall not assume or be responsible or liable for, all of its obligations and liabilities that are not Assumed Liabilities (the "**Retained Liabilities**"), including, without limitation, (i) the obligations and liabilities described in Section 2.2(b) of the Disclosure Schedule; (ii) all contracts

and leases of any Seller that are not Assumed Contracts or Assumed Leases; and (iii) the Benefit Liabilities.

2.3 Purchase Price. In consideration of the purchase and sale of the Purchased Assets and consummation of the transactions contemplated by this Agreement, Buyer hereby agrees to pay (or cause to be paid) to Sellers an amount equal to $160,000,000 (the "**Purchase Price**"). The Purchase Price shall be paid in accordance with the payment schedule set forth on Exhibit L.

2.4 Title Company Escrow. At or before Closing, Buyer shall deliver to the Title Company Escrow Agent, by wire transfer of immediately available funds to the account designated for such purpose by the Title Company Escrow Agent, the Title Company Escrow Funds, and such Title Company Escrow Funds shall be paid to each appropriate Seller upon satisfaction of all conditions precedent to the Closing as described herein.

ARTICLE 3. REPRESENTATIONS AND WARRANTIES OF SELLERS

In order to induce Buyer to purchase the Purchased Assets it is purchasing hereunder, each Seller, jointly and severally, represents and warrants to Buyer that the statements contained in this Article 3 are correct and complete in all material respects as of the Effective Date and, subject to Section 5.15, will be correct and complete in all material respects through and including the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 3); provided, however, that the statements contained in Section 3.18 will be made only as of the Closing Date and not as of the Effective Date.

3.1 Organization; Authority. Each Seller is a corporation duly formed, validly existing and in good standing under the laws of its state of incorporation and has the requisite power and authority to conduct its Business as now being conducted. Each Seller is duly qualified or licensed to do business and is in good standing in each jurisdiction in which the nature of its business or the ownership or leasing of its properties makes such qualification or licensing necessary.

3.2 Powers; Consents; Absence of Conflicts. Except as set forth in Section 3.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement, the Caritas SPA, the Lukan SPA and the Transition Services Agreements by each Seller, as applicable, and the consummation of the transactions contemplated hereunder and thereunder by such Sellers: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of each Seller and have been duly authorized by all appropriate corporate action (including by any Affiliate, as applicable); (b) do not and will not require any approval or consent of, or filing with, any Governmental Authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any Contract or Lease to which any Seller is a party or by which any Seller or any Purchased Asset is bound or subject; and (e) do not and will not

violate any judgment, order or decree of any court or other Governmental Authority to which any Seller or any Purchased Asset may be subject. This Agreement has been duly executed and delivered by each Seller and, as to each Seller, is valid and binding on each such Seller with respect to its obligations hereunder, enforceable against it in accordance with its terms, except to the extent enforceability may be limited by bankruptcy, insolvency, moratorium or similar laws affecting creditors rights and remedies.

3.3 Absence of Certain Changes. Except as otherwise set forth in Section 3.3 of the Disclosure Schedule, since September 30, 2010, each Seller has operated the Business in the ordinary course of business and there has not been any:

(a) damage to, destruction or loss of, any portion of the Purchased Assets having an aggregate value of $250,000 or more, whether or not covered by insurance;

(b) sale, lease or other disposition of any portion of the Purchased Assets having an aggregate value of $250,000 or more (except in the ordinary course of business and the disposition of obsolete and worn out equipment or materials), or imposition of any material Lien or Encumbrance on any of the Purchased Assets other than Permitted Encumbrances;

(c) grant by any Seller to any of its non-management employees or independent contractors of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits or establishment of any new compensation or benefit plans or arrangements or amendment to any existing plans, except in the ordinary course of business or as may be contemplated under any existing agreements or required by Applicable Law;

(d) grant by any Seller to any of its management employees (i.e., assistant vice president or above), directors or officers of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, except in the ordinary course of business or as may be contemplated by existing agreements or required by Applicable Law;

(e) entry into, termination of or receipt of written notice of termination of (i) any material license, joint venture, credit or similar agreement, or (ii) any Material Contract or Lease or Real Property Lease except such terminations as are non-discretionary and contemplated by the terms of the Material Contract, Lease or Real Property Lease;

(f) any merger or consolidation with, any material capital investment in, any material loan to, any material advance to or material acquisition of the securities, assets or Indebtedness of, any other Person;

(g) any distribution of cash or other property by a Seller to its members, or any payment or transfer of cash or other property to any of its Affiliates;

(h) change in any method of accounting or accounting practice or policy;

(i) receipt of a notice of deficiency from any Governmental Authority or other regulator, including any consent orders or corrective action requests from the Connecticut Department of Public Health; or

(j) agreement, whether oral or written, by any Seller to do any of the foregoing.

3.4 Compliance with Laws. Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers are in compliance with all Applicable Laws that do not constitute Healthcare Laws. Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers have at all times during the past seven years operated the Business in accordance with all Healthcare Laws. Each Seller has timely filed all reports, data and other information required to be filed with Governmental Authorities with respect to the conduct of the Business or to the ownership and use of any of the Purchased Assets. Except as set forth in Section 3.4 of the Disclosure Schedule, Seller nor any Affiliate of any Seller has, with respect to the operation of the Business, received written notice from a Governmental Authority with respect to the operation of the Business, that it is under investigation with respect to any violation or alleged violation of, or that it has any obligation to take remedial action under: (a) any Applicable Law or Healthcare Laws, (b) any license, certificate or certificate of need issued or (c) any order, judgment or decree entered by any Governmental Authority relating to the Business.

3.5 Licenses. Section 3.5 of the Disclosure Schedule sets forth a list, as of the Effective Date, of all material licenses and permits held by each Seller in connection with the operation of the Business. Sellers have held and hold all licenses, permits, certifications, consents, approvals, authorizations, qualifications and orders of any Governmental Authority as are necessary for Sellers' conduct of the Business and ownership and use of the Purchased Assets. Except as set forth in Section 3.5 of the Disclosure Schedule, each such license, permit, certification, consent, approval, authorization, qualification and order is valid and in full force and effect, and each Seller is in compliance in all material respects with each such license, permit, certification, consent, approval, authorization, qualification and order. Except as set forth in Section 3.5 of the Disclosure Schedule, as of the Effective Date, no Seller has received any written notice from any Governmental Authority regarding (a) any non-compliance or alleged non-compliance under any such license, permit, certification, approval, authorization, qualification or order or any investigation or potential investigation of any Seller in connection with any such non-compliance or alleged non-compliance or (b) any obligation or alleged obligation of any Seller to take remedial action under any such license, permit, certification, approval, authorization, qualification or order.

3.6 Accreditation; Government Reimbursement Programs.

(a) Except as set forth in Section 3.6(a) of the Disclosure Schedule, each Seller, as applicable, is duly accredited by the Joint Commission for the period indicated in Section 3.6(a) of the Disclosure Schedule. No Seller has been excluded, debarred or otherwise deemed ineligible to participate in Medicare, Medicaid or any other federal or state health care programs or in any federal or state procurement or non-procurement programs, nor has any Seller been convicted of a criminal offense related to the provision of federal health care items or

services, nor, to Sellers' Knowledge, is an investigation or proceeding regarding the foregoing pending or threatened.

(b) Except as set forth in Section 3.6(b) of the Disclosure Schedule, each of the Sellers that provides services to beneficiaries of Government Reimbursement Programs is (i) qualified for participation in, and has current and valid provider contracts with, the Government Reimbursement Programs and/or their fiscal intermediaries or paying agents and is in material compliance with the conditions of participation or requirements applicable with respect to such participation and (ii) eligible for payment under the Government Reimbursement Programs for services rendered to qualified beneficiaries.

(c) The Cost Reports for each of the Sellers that provide services to beneficiaries of Government Reimbursement Programs were filed when due, and have been audited (with Notices of Program Reimbursement issued), for the Cost Report periods described in Section 3.6(c) of the Disclosure Schedule.

(d) Except as set forth in Section 3.6(d) of the Disclosure Schedule, all amounts shown as due from any of the Sellers in the Cost Reports either were remitted with such Cost Reports or will be remitted when required by Applicable Law, and all amounts shown in the Notices of Program Reimbursement as due have been or prior to Closing will be paid when required by Applicable Law. Except to the extent liabilities and contractual adjustments with respect to the Sellers under the Government Reimbursement Programs have been properly reflected and adequately reserved in the Financial Statements, or as set forth in Section 3.6(d) of the Disclosure Schedule, the Sellers have not received or submitted any claim for payment to the Government Reimbursement Programs (or their fiscal intermediaries or paying agents) in excess of the amount provided by Applicable Law or applicable provider contracts, and the Sellers have not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding any of the Sellers and the Government Reimbursement Programs or the participation by any of the Sellers in such programs.

(e) The Sellers have no, and are not subject to or the beneficiary of any, outstanding loan, grant or loan guarantee pursuant to the Hill Burton Act (42 U.S.C. Section 291a, et seq.).

3.7 Medical Staff Matters.

(a) Each Seller, as applicable, has previously delivered or made available to Buyer, with respect to the Business, (i) the forms generally used as of the Effective Date with respect to medical staff privilege and membership application, and (ii) all medical staff bylaws, policies, rules and regulations, as in effect on the Effective Date.

(b) Section 3.7(b) of the Disclosure Schedule sets forth a true and correct list as of the Effective Date of the name and specialty of each member of the medical staff of the Facilities. Except as set forth in Section 3.7(b) of the Disclosure Schedule and actions and appeals as to which disclosure is prohibited by federal or state law, there are no, and there have not been at any time during the five years prior to the Effective Date, (i) any pending or threatened disciplinary or corrective actions or appeals by any Seller with respect to its medical

staff members, other professional staff members or applicants to the medical staff of the Facilities or, to Sellers' Knowledge, with respect to such medical staff members, professional staff members or applicants at any other facility at which such member or applicant has or has applied for privileges; or (ii) any pending or threatened challenges to any decisions of the medical staff relating to delineation of privileges at the Facilities.

3.8 Contracts and Leases. Section 3.8 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of (a) all Leases, excluding Real Property Leases, involving annual payments of $250,000 or more and (b) all Contracts to which any Seller is a party or to which any of their assets are bound (i) governing the borrowing of money or the Guarantee or the repayment of Indebtedness of any Seller or granting of Liens on any property or asset of any Seller (including any such contract under which any Seller has incurred any Indebtedness); (ii) providing for the employment of any Person and, to the extent not subject to confidentiality restrictions, any settlements relating thereto; (iii) containing covenants limiting the freedom of any Seller to compete in any line of business or with any Person or in any geographic area or market; (iv) concerning the use of or restricting the use of any Intellectual Property Rights or other intellectual property; (v) with any members, trustees, directors, officers, employees of any Seller or their respective Affiliates or Affiliates of any Seller; (vi) providing for the purchase, maintenance or acquisition or the sale or furnishing, of materials, supplies, merchandise, equipment or services (including computer hardware, software, online hosting arrangements or other property or services) involving payments in excess of $250,000; (vii) granting to any Person a first refusal, first offer or similar preferential right to purchase or acquire any right, asset or property of any Seller; (viii) pertaining to the lease of equipment or other Personal Property and involving annual payments of $250,000 or more; (ix) providing for any offset, countertrade or barter arrangement; (x) involving a distributor, sales representative, broker, franchise or advertising arrangement; (xi) involving a joint venture, partnership or similar arrangement; (xii) involving non-employee management services, consulting services, independent contractor services, support services or any other similar services involving annual payments of $250,000 or more, including service agreements under which any Seller is required to provide services to insurers, self-insured employees or any governmental or private health plan, managed care plan or other similar Person; (xiii) involving the acquisition of any business enterprise whether via stock or asset purchase or otherwise; (xiv) as to which the breach, nonperformance, cancellation or failure to renew by any party thereto would have a Material Adverse Effect; (xv) concerning any Physician, Physician group or medical practice entity; and (xvi) with respect to Grimes Center, resident admission agreements and any other written agreements with residents (collectively, the "**Material Contracts and Leases**"). Each Seller has delivered or made available to Buyer true and correct copies of the Material Contracts and Leases. Except as set forth in Section 3.8 of the Disclosure Schedule, no Seller is in breach of, or has any Knowledge of any material breach or default under, any of the Material Contracts and Leases that are Assumed Contracts or Assumed Leases or has received any written notice from any party of the same, and, to Sellers' Knowledge, no other party to any such Assumed Contract or Assumed Lease is in breach thereof. Each Assumed Lease listed in Section 3.8 of the Disclosure Schedule (w) was negotiated on an arms-length basis, (x) is valid and existing in full force and effect, and (y) is not in default nor has any tenant thereunder received a written notice of default.

3.9 Real Property; Condition of Facilities.

(a) Part A of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property owned by Sellers in fee simple as more particularly described in the legal descriptions for such real property attached to such Disclosure Schedule as Schedule A (the "**Owned Real Property**"). Part B of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property with respect to which a Seller holds a leasehold interest as to all or a portion of such real property, as applicable (the "**Leased Real Property**") (subject to the terms of the applicable leases and related instruments governing such interest, collectively the "**Real Property Leases**"). The Owned Real Property and the Leased Real Property are referred to herein collectively as the "**Real Property**".

(b) Except as set forth in Section 3.9(b) of the Disclosure Schedule, there are no outstanding violations of any Applicable Law, order, or any condemnations, liens, pledges, claims or similar recorded liabilities or assessments, relating to any material portion of the Owned Real Property and Seller has not received any written notice of the same and to Sellers' Knowledge, there are no outstanding violations of any Applicable Law, order or any condemnations, Liens or assessments, relating to any material portion of the Leased Real Property and Seller has not received any written notice of the same.

(c) Except as set forth in Section 3.9(c) of the Disclosure Schedule, the Owned Real Property, and to Sellers' Knowledge, the Leased Real Property is in compliance with all Applicable Laws relating to zoning and land use, regulations and ordinances, including, but without limitation, all Applicable Laws relating to parking and Connecticut State Traffic Certificates.

(d) All water, sewer, gas, electricity, telephone and other utilities required for the use, occupancy, operation and maintenance of the Owned Real Property are connected thereto and are adequate to service the normal operations of the Owned Real Property, are supplied directly to the Owned Real Property by facilities of public utilities and the cost of installation and connection of such utilities has been fully paid.

(e) Seller has not received any written notice from any insurance company or inspection or rating bureau setting forth any requirements as a condition to the continuation of any insurance coverage on or with respect to the Real Property or the continuation thereof at premium rates existing at present which have not been remedied or satisfied.

(f) Except as set forth in Section 3.9(f) of the Disclosure Schedule, no services, material or work have been supplied to or have been performed in connection with, as applicable, the Owned Real Property, or in the case of the Leased Real Property, to Sellers with respect to the relevant leased premises, for which payment has not been made in full in a timely manner.

(g) Except as set forth in Section 3.9(g) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.9(g) of the Disclosure Schedule, (i) each of (A) the heating, ventilation and air conditioning system

(HVAC), (B) the mechanical, electrical and plumbing system (MEP) and (C) the roof of each Owned Real Property, and to Sellers' Knowledge the roof of each Leased Real Property, is in good working condition, was constructed in a good and workmanlike manner and is free from defects which would render it unfit for continued use in the manner in which it is presently used, subject, however, to ordinary wear and tear and (ii) the foundation, walls and all structural components of the buildings and other improvements of the Owned Real Property, and to Sellers' Knowledge of the Leased Real Property, are structurally sound and no Seller has Knowledge of any material defects or material damage to any of the foregoing.

(h) Each of the Real Property Leases and each of the leases relating to an Owned Real Property (i) was negotiated on an arms-length basis, (ii) is valid and existing in full force and effect and (iii) to Sellers' Knowledge, is not in default nor has any Seller received a written notice of default from the applicable landlord of such Leased Real Property.

3.10 Personal Property.

(a) Except as set forth in Section 3.10(a) of the Disclosure Schedule, all Personal Property used by Sellers in the operation of the Business is either owned by a Seller or leased by a Seller under a Lease.

(b) Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, there are no pending claims in an amount in excess of $250,000 by any Seller against a manufacturer, distributor or lessor of any Personal Property for warranty, repair, return or defective condition. All inventory and supplies, including pharmaceuticals, (i) are, and have been throughout their possession by Sellers, properly stored, inventoried and labeled, and are usable in accordance with their intended use, (ii) have been maintained in the ordinary course of business and (iii) at the Effective Time, shall be at levels consistent with operation of the Business in accordance with past practices of Sellers. Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, the improvements on the Real Property and the Personal Property have been reasonably maintained in the ordinary course of business, are in good operating condition (ordinary wear and tear excepted), and are reasonably suitable for the uses for which they are intended.

3.11 Labor and Employee Matters.

(a) Section 3.11(a) of the Disclosure Schedule sets forth each pension, profit sharing, deferred compensation or other employee pension or health or welfare benefit plan or arrangement, as defined in Section 3(3) of ERISA (or each such plan that is a church plan as defined in Section 414(e) of the Code), relating to the Business that is currently in effect or that has been in effect at any time during the past three years (the "**Benefit Plans**"). Except as set forth in Section 3.11(a) of the Disclosure Schedule: (i) no Benefit Plan is subject to Title IV of ERISA and no Benefit Plan is a Multiemployer Pension Plan within the meaning of Section 3(37) of ERISA; (ii) no prohibited transaction as defined in Section 4975 of the Code,

has occurred with respect to any Benefit Plan and there are no pending or, to any Seller's Knowledge, threatened claims by, on behalf of or against the Benefit Plans or by any employee of any Seller alleging a breach or breaches of fiduciary duties or violations of other applicable state or federal law that could result in liability on the part of any Seller or the Benefit Plans under ERISA or any state law applicable to any church plan listed in Section 3.11(a) of the Disclosure Schedule, nor to Sellers' Knowledge is there any basis upon which such a claim can reasonably be anticipated; and (iii) all returns, reports, disclosure statements and premium payments required to be made under ERISA and the Code with respect to the Benefit Plans have been timely filed or delivered.

(b) Except as specified in Section 3.11(b) of the Disclosure Schedule, (i) no Seller is a party to or bound by any union contract, collective bargaining agreement, employment contract, independent contractor agreement, consultation agreement or other similar type of contract; (ii) no Seller has agreed to recognize any union or other collective bargaining representative; (iii) no union or collective bargaining representative has been certified as representing the employees of any Seller; and (iv) to Sellers' Knowledge, no labor union or collective bargaining representative has made any attempt or threatened to organize any employees of any Seller. No Seller has experienced any labor strike, dispute, slowdown or stoppage or any other material labor difficulty during the past five years, and to Sellers' Knowledge, there are no facts or circumstances that might reasonably be expected to lead to any such labor dispute. Sellers have provided Buyer true and complete copies of all agreements listed on Section 3.11(b) of the Disclosure Schedule.

(c) Sellers have provided Buyer with a complete list of all employees and independent contractors of each Seller, their respective positions, locations, exempt or non-exempt status, applicable independent contractor agreements, information on the bases for concluding that any such Person qualifies as an independent contractor rather than an employee of the Seller(s), and the rates of all regular and additional compensation and commissions payable to each such Person in any and all capacities and any regular or special compensation or commissions that will be payable to each such Person in any and all capacities as of the Closing Date other than the then-current accrual of regular payroll compensation. Except as set forth in Section 3.11(c) of the Disclosure Schedule, the employees of each Seller are "at will," and no Seller employs or engages any employee or independent contractor who, subject to compliance with Applicable Law, cannot be dismissed immediately, whether currently or immediately after the Effective Time, without notice and without further liability to such Seller.

(d) With respect to the employees of Sellers, during the last 12 months, there has been no mass layoff, plant closing or shutdown that triggers application of the Worker Adjustment & Retraining Notification Act of 1988, as amended, or any similar law.

(e) Each Seller has completed and retained to the extent required by the Immigration Reform and Control Act of 1986 ("**IRCA**") the employment verification paperwork for all current and former employees. Further, at all times prior to the Effective Date, each Seller was in material compliance with both the employment verification provisions (including the paperwork and documentation requirements) and the anti-discrimination provisions of IRCA.

(f) No Seller is liable for any payment to any trust or other fund or to any Governmental Authority, with respect to unemployment compensation benefits, social security or other benefits or obligations for employees (other than routine payments to be made in the ordinary course of business and consistently with past practice). Except as set forth in Section 3.11(f) of the Disclosure Schedule, there are no pending claims against any Seller under any workers' compensation plan or policy or for long-term disability.

(g) To Sellers' Knowledge, no employee of any Seller is in violation, in any material respect, of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, noncompetition agreement or restrictive covenant to a former employer.

(h) Except as set forth in Section 3.11(h) of the Disclosure Schedule, no Seller is a party to, or otherwise bound by, any consent decree with, or citation by, any Governmental Authority relating to employees or employment practices. No Seller, including the officers thereof, has received within the past five years any written notice of intent by any Governmental Authority responsible for the enforcement of labor or employment laws to conduct an investigation relating to any Seller and, to Sellers' Knowledge, no such investigation is in progress.

(i) Except as set forth in Section 3.11(i) of the Disclosure Schedule, none of the execution and delivery of this Agreement or the consummation of any transaction contemplated hereby or any termination of employment or service in connection therewith at or prior to the Closing Date will (i) result in any payment (including severance, unemployment compensation, golden parachute, bonus or otherwise) becoming due to any Person, (ii) materially increase any benefits otherwise payable by any Seller, (iii) result in the acceleration of the time of payment or vesting of any such benefits, (iv) increase the amount of compensation due to any Person or (v) result in the forgiveness in whole or in part of any outstanding loans made by any Seller to any Person.

(j) To Sellers' Knowledge, no current director, officer, employee, manager or independent contractor of any Seller is a party to or is otherwise bound by, any agreement or arrangement, including any confidentiality, noncompetition or proprietary rights agreement, between such director, officer, employee, manager or independent contractor and any other Person that in any way materially and adversely affects (i) the performance of his or her duties as a director, officer, employee, manager or independent contractor of such Seller or (ii) the ability of such Seller to conduct its business as it is currently conducted and proposed to be conducted.

(k) Each Seller is in compliance with all Applicable Laws applicable to its respective employment and employment practices, including all Applicable Laws regarding terms and conditions of employment, health and safety, wages and hours, employee and independent contractor classifications, immigration, employment discrimination, disability rights or benefits, equal opportunity, plant closures and layoffs, affirmative action, workers' compensation, labor relations, employee leave issues and unemployment insurance. Except in the ordinary course of business, no Seller is delinquent in payments to any employee for any services or any amounts required to be reimbursed or otherwise paid.

3.12 Litigation or Proceedings. Except as set forth in Section 3.12 of the Disclosure Schedule, there are no claims, actions, suits, proceedings or, to Sellers' Knowledge, investigations ("**Litigation or Proceedings**") pending or, to any Sellers' Knowledge, threatened against or affecting any Seller with respect to the Business or the Purchased Assets, at law or in equity, before or by any court or federal, state, municipal or other governmental department, commission, board, bureau, agency or instrumentality wherever located. Except as otherwise set forth in Section 3.12 of the Disclosure Schedule, no matter disclosed in Section 3.12 of the Disclosure Schedule is reasonably anticipated by Sellers to result in any cost, expense, damage or liability (including court costs or attorneys' fees) to any Seller in an amount that exceeds the greater of $50,000 or the amount reserved by Sellers as set forth in the Financial Statements.

3.13 Special Funds. Except as set forth in Section 3.13 of the Disclosure Schedule, the Facilities are not subject to any liability in respect of amounts received for the purchase or improvement of the Facilities or any part thereof under restricted or conditioned grants or donations, including, without limitation, monies received under the Public Health Service Act, 42 U.S.C. Section 291 et seq.

3.14 Tax Matters. Except as set forth in Section 3.14 of the Disclosure Schedule:

(a) Each Seller is exempt from federal income tax as an organization described in Section 501(c)(3) of the Code by virtue of the fact that it is classified as an organization described in Section 501(c)(3) of the Code and is classified as a public charity under Section 509(a) of the Code. No Seller knows of any basis for a challenge by the Internal Revenue Service to revoke or terminate any such exemption from federal income taxation;

(b) All Tax Returns for periods ended prior to the Effective Date required to be filed by any Seller (collectively, the "**Seller Tax Returns**") have been filed within the time and in the manner provided by law (including any valid extensions thereof);

(c) None of the Seller Tax Returns is currently the subject of an audit;

(d) The Seller Tax Returns were correct in all material respects;

(e) All Taxes that are shown as due on the Seller Tax Returns have been paid or adequate reserves therefor have been established; and

(f) (i) no Tax Lien or Encumbrance exists with respect to any of the Purchased Assets except for Permitted Encumbrances, (ii) no Litigation or Proceeding is pending, or, to Sellers' Knowledge, threatened, against any Seller with respect to any Taxes, (iii) there are no matters under discussion between any Seller and any Governmental Authority relating to any Taxes in an amount in excess of $250,000 and (iv) there are no claims against any Seller for additional Taxes in an amount in excess of $250,000 asserted by any Governmental Authority.

3.15 Environmental Matters. Except as set forth in Section 3.15 of the Disclosure Schedule:

(a) each Seller has obtained all applicable permits, licenses and other authorizations required for Seller's operations at the Purchased Assets under applicable Environmental Laws (the "**Environmental Permits**") and has made all necessary filings for issuance or renewal of the Environmental Permits, and no actions are pending, or to Sellers' Knowledge, threatened, to amend, challenge, terminate, cancel, limit, restrict or appeal any such Environmental Permits that would have a Material Adverse Effect;

(b) each Seller and the operations of each Seller at the Purchased Assets are in compliance with all terms and conditions of the Environmental Permits and with all applicable Environmental Laws;

(c) no Seller has any Knowledge of or any basis to expect, nor has any of them, received, any citation, directive, inquiry, notice, order, summons, warning or other communication that relates to any alleged, actual or potential violation or failure to comply with any Environmental Law with respect to the Purchased Assets or with respect to any property or facility to which Hazardous Substances generated, manufactured, refined, transferred, imported, used or processed by Seller have been transported, treated, stored, handled, transferred, disposed, recycled or received;

(d) there are no conditions at, in, on, under or related to the Real Property that pose a hazard to human health or the environment other than such conditions that are in compliance with applicable Environmental Laws;

(e) there is no (nor has there been any) production, use, treatment, storage, transportation, handling, discharge, disposal, arrangement for disposal or release or threatened release of any Hazardous Substance or Solid Waste in violation of applicable Environmental Law at, in, on, under, from, over or related to the Real Property, or into or upon or over soil, surface water or groundwater at, on, under or related to the Real Property;

(f) there are no underground tanks, collection sumps or pits, land disposal facilities or surface impoundments at, on or under the Real Property;

(g) the Owned Real Property and to Sellers' Knowledge the Leased Real Property does not have any (i) asbestos containing material that is damaged or friable in a form or condition which requires removal, abatement or repair as of the date hereof under applicable Environmental Laws, (ii) electrical transformers or other equipment or machinery that contain PCBs in regulated concentrations or (iii) radon in indoor air in excess of four picocuries per liter;

(h) each Seller and the Real Property is in compliance with all applicable Environmental Laws; and

(i) no Seller has received written notice from any Governmental Authority regarding any investigation or proceeding concerning the presence or alleged presence of any Hazardous Substances or Solid Waste on the Real Property or violation of any applicable Environmental Law.

3.16 Insurance. Section 3.16 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of all insurance policies or self-insurance funds of any nature

whatsoever in effect that insure the business, operations or employees of each Seller or affect or relate to the ownership, use or operation of any of the Purchased Assets and Business and that have been issued to any Seller or issued to an Affiliate of any Seller for the benefit of any Seller, which such Section 3.16 of the Disclosure Schedule reflects the policies' numbers, terms, identity of insurers, amounts and coverages. No written notice of cancellation or termination has been received by any Seller with respect to any policy listed in Section 3.16 of the Disclosure Schedule and all such policies are in full force and effect. There is not outstanding any requirement or recommendation by any insurance company that issued any such policy or by any Board of Fire Underwriters or other similar body exercising similar functions or by any Governmental Authority exercising similar functions which requires or recommends any repairs or other work to be done to any of the Purchased Assets. Each Seller has given to its insurer in a timely manner all notices required to be given under its insurance policies with respect to all claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions or reserved its rights in respect of or rejected any such claims.

3.17 Brokers. No broker, finder, investment banker or other Person is entitled to any brokerage, finder's or other fee or commission in connection with this Agreement or the transactions contemplated hereby based upon any agreements, arrangements or commitments made by or on behalf of any Seller.

3.18 Solvency. After giving effect to the transactions contemplated hereby, (a) each Seller will be Solvent, and, to the Knowledge of each such Seller, reasonably expects to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up Sellers' affairs, and (b) Sellers have not, and do not believe that they will have, incurred debts or liabilities beyond Sellers' ability to pay as such debts and liabilities mature; provided, however, that the foregoing shall cease to be a representation and warranty of Sellers pursuant to Article 3 hereunder if Sellers obtain the Sale Order and either of (x) the Sale Order has become a Final Order or (y) the Final Order Exception applies. Notwithstanding any of the foregoing, none of the Sellers is entering into the transactions contemplated by this Agreement for the purpose of hindering, delaying or defrauding any of its creditors or Buyer.

3.19 Financial Statements. Section 3.19 of the Disclosure Schedule sets forth the following financial statements (collectively, the "**Financial Statements**"): (a) an unaudited balance sheet for each of the Sellers as of the Balance Sheet Date and unaudited statement of operations for each of the Sellers for the six-month period ended on the Balance Sheet Date (collectively, the "**March 31, 2011 Financial Statements**"); and (b) audited balance sheets of each of the Sellers as of September 30, 2009 and September 30, 2010 and the related statements of operations for the 12-month period then ended. The Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto and normal year end adjustments. The balance sheets included in the Financial Statements fairly present, in all material respects, the financial condition of such Seller as of the dates indicated thereon, and the statements of operations included in the Financial Statements fairly present, in all material respects, the results of operations of such Seller for the periods indicated thereon, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto

and normal year end adjustments. Except as set forth in Section 3.19 of the Disclosure Schedule, since the Balance Sheet Date, there have occurred no material adverse changes in the financial condition, results of operations or business of such Seller as reflected in such Financial Statements, other than changes in the ordinary course of business.

3.20 Assets; Sufficiency of Assets.

(a) Except as set forth in Section 3.20 of the Disclosure Schedule, each Seller, as applicable, owns good and marketable title to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances and HSR Financing Agreements, and, at the Closing, will sell, transfer and assign to Buyer, good and marketable title in and to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances.

(b) Except as set forth in Section 3.20 of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.20 of the Disclosure Schedule, all of the Purchased Assets are in good condition and repair except for ordinary wear and tear and are usable in the ordinary and normal course of business, consistent with past practices of Sellers, and the Purchased Assets include all assets necessary to conduct the Business in the ordinary and normal course of business, consistent with past practices of Sellers.

3.21 Equipment. Section 3.21 of the Disclosure Schedule sets forth a depreciation schedule as of March 31, 2011 that lists all the equipment associated with, or constituting any part of, the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, since March 31, 2011, no Seller has sold or otherwise disposed of any item of equipment having a replacement cost in excess of $250,000 constituting any part of the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, all of the Purchased Assets consisting of equipment, whether reflected in the Financial Statements or otherwise, are well maintained and in good operating condition, except for reasonable wear and tear. Except as set forth on Section 3.21 of the Disclosure Schedule, each Seller has good and marketable title to the equipment and all of such equipment is free and clear of any Lien or Encumbrance, except for Permitted Encumbrances. No person other than Sellers owns any equipment or other tangible assets situated on the Real Property.

3.22 Intellectual Property. Sellers have made available to Buyer complete and correct lists all of the patents, patent applications, names, trademark and trade name registrations and service mark registrations owned by any Seller (collectively, "**Intellectual Property Rights**"). Sellers own or have valid rights to use all such Intellectual Property Rights without conflict with the rights of others. The Intellectual Property Rights are not subject to any Liens or Encumbrances, except for Permitted Encumbrances. The Intellectual Property Rights are not subject to any restriction or limitation regarding use or disclosure other than pursuant to written license agreements. To Sellers' Knowledge, Sellers have not infringed upon or misappropriated any intellectual property or intellectual property rights of any other person. To Sellers' Knowledge, the conduct of the Business does not infringe upon any intellectual property owned or controlled by any other Person and no Person has made or, to Sellers' Knowledge, threatened to make, any claim that the operation of the Business or the use of the Intellectual Property

Rights is in violation of or infringes upon any patent, patent application, trademark, trade name, service mark or any other proprietary or trade rights of any third party.

3.23 Software. The operating and applications computer software programs and databases used by Sellers are listed and briefly described in Section 3.23 of the Disclosure Schedule (collectively, the "**Software**"). Sellers own outright or hold valid licenses to all copies of the Software used by Sellers. To Sellers' Knowledge, none of the Software, and no use thereof, infringes upon or violates any patent, copyright, trade secret or other proprietary right of any other Person, and no claim with respect to any such infringement or violation is threatened.

3.24 Absence of Default. Except as described on Section 3.24 of the Disclosure Schedule, no Seller is in default of any term or condition of any Indebtedness or liability, including any trade payable.

3.25 Charitable Funds. HSR and the Foundation have solicited, received, held, invested, expended and applied charitable funds donated to them, including the Charitable Funds (as defined below), in accordance with all restrictions placed thereon by donors, the terms of any applicable solicitation and Applicable Laws. No Seller has received written notice of any, whether actual or alleged, misuse of funds, failure to comply with any donor-imposed restriction, breach of duty related to the funds, or violation of any Applicable Laws, nor to Sellers' Knowledge, has any such misuse, failure, breach or violation occurred.

3.26 Bank Accounts. Section 3.26 of the Disclosure Schedule lists the name of each bank, savings and loan or other financial institution, in which an account, including cash contribution accounts, or a safe deposit box related the operations of any Seller is maintained and, to the extent practicable, the names of all persons authorized to draw thereon or to have access thereto.

3.27 No Undisclosed Liability. Except (a) as set forth on in Section 3.27 of the Disclosure Schedule, or as disclosed, set forth or reserved for in the Financial Statements (including the notes thereto), (b) for liabilities and/or obligations incurred in the ordinary course of business after the Balance Sheet Date or (c) for liabilities and/or obligations arising under any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which any Seller is a party that is entered into in the ordinary course of business (other than any such liabilities or obligations arising out of a breach by any Seller of any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which a Seller is a party), no Seller has any liability or obligation of any nature, whether or not accrued, contingent or otherwise.

3.28 No Untrue or Inaccurate Representations or Warranties. The representations and warranties of each Seller contained in this Agreement together with the Disclosure Schedule do not, and the statements of each Seller contained in the certificate delivered by Sellers to Buyer pursuant to Section 9.2(e) will not, contain any misstatement of a material fact or omit to state a material fact necessary in order to make the information contained therein not misleading.

ARTICLE 4. REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to Sellers that the statements contained in this Article 4 are correct and complete as of the Effective Date and will be correct and complete as of the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 4).

4.1 Organization; Authority. Buyer is a nonprofit corporation duly formed, validly existing and in good standing in the State of Connecticut and has the requisite power and authority to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts. Except as set forth in Section 4.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement by Buyer and the consummation of the transactions contemplated hereby by Buyer: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of Buyer and have been duly authorized by all appropriate corporate action; (b) do not and will not require any approval or consent of, or filing with, any governmental agency or authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any contract, agreement, indenture, mortgage, deed of trust, lease or other instrument to which Buyer is a party or by which Buyer is bound or subject; and (e) do not and will not violate any judgment, order or decree of any court or other governmental agency or authority to which Buyer may be subject. This Agreement has been duly executed and delivered by Buyer and constitutes a valid and binding obligation of Buyer, enforceable against it in accordance with its terms.

4.3 Brokers. No broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement based upon arrangements made by or on behalf of Buyer.

ARTICLE 5. CERTAIN COVENANTS OF SELLERS

5.1 Information. From the Effective Date to the Closing Date, each Seller shall continue to afford to those certain officers and representatives and agents of Buyer, designated by written notice to Sellers by Buyer, access upon reasonable notice and during normal business hours, to the Purchased Assets, including for purposes of conducting environmental and other property condition inspections, and, to the extent necessary, to Key Employees of Sellers, and all properties, books, contracts, commitments and records of each Seller relating to the Purchased Assets and the Business, the Retained Assets and the Retained Liabilities (regardless of where such information may be located), and promptly furnish Buyer with such additional available financial and operating data and other information relating to the same as Buyer may from time to time reasonably request, except to the extent any Seller is restricted from providing such information by Applicable Law or as a result of confidentiality agreements with third parties and except for Litigation or Proceedings where Buyer and Seller are both defendants. Buyer shall exercise its rights under this Section 5.1 in such a manner as not to interfere unreasonably with

the operation of Sellers. Any environmental and property condition inspections shall be limited to non-invasive testing unless Sellers have agreed to the scope of such invasive testing prior to commencement of the same; provided, however, that Buyer shall be permitted to perform Phase I Environmental Assessments and asbestos inspections of the Owned Real Property. If any Seller fails to fully, completely and promptly respond to Buyer's reasonable request for information and/or meetings with such Seller's officers to review the same, or any of such Seller's officers fail to fully, completely, honestly and promptly provide such requested information, the Agreement may be terminated as follows: Buyer's chief executive officer shall provide written notice to the chief executive officer of SRHS of Buyer's election to terminate this Agreement, and, upon the giving of such notice, Sellers shall be entitled to 15 business days after the receipt of such notice from Buyer to cure any such failure to respond to any request submitted by Buyer under this Section 5.1 so long as SRHS' chief executive officer provides Buyer's chief executive officer notice of such intention to cure within five business days of the receipt of Buyer's chief executive officer's election to terminate this Agreement. Seller's termination of employment of any non-compliant officer and the provision of the information requested if otherwise available to Seller shall constitute a cure. If (a) Sellers do not cure, within the aforementioned 15-day cure period (or such longer reasonable period permitted by Buyer's chief executive officer if such failure cannot be cured within 15 days and Sellers are diligently pursuing a cure within such 15-day period) any failure to respond to any request submitted by Buyer, or (b) Buyer, in the exercise of its reasonable judgment, determines that Sellers cannot cure such failure to respond, then Buyer may terminate this Agreement forthwith.

5.2 Operations. From the Effective Date through the Closing Date, except as otherwise contemplated by this Agreement, each Seller shall:

(a) carry on its business in substantially the same manner as such Seller has heretofore and not make any material change in personnel, operations, finance, accounting policies or real or Personal Property of the Business;

(b) maintain the Purchased Assets and all parts thereof in good working order and condition, ordinary wear and tear excepted, which shall include, without limitation, making capital expenditures in respect of the Facilities in the ordinary course of business consistent with past practices;

(c) perform all of its obligations under the Assumed Contracts, Assumed Leases and all agreements relating to or affecting the Purchased Assets or the Business, except where such failure would not reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(d) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between any Seller and any of the foregoing;

(e) take all actions necessary and appropriate to render title to the Purchased Assets free and clear of all Liens and Encumbrances (except for the Permitted Encumbrances)

and to obtain appropriate releases, consents, estoppels and other instruments as Buyer may reasonably request;

(f) keep in full force and effect present insurance policies or other comparable insurance;

(g) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be promptly provided to Buyer;

(h) conduct and provide to Buyer a quarterly update of the Wind Down Plan (commencing December 31, 2011);

(i) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the draft annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year and the final audited financial statement will be delivered by Sellers to Buyer within five business days of Seller's receipt of such statement from their auditor;

(j) provide Buyer with notice, and a description thereof, of any entry into, assumption, amendment or termination of any Physician Contract; and

(k) provide Buyer with notice, and a description thereof, of any grant of any increase in merit-based compensation or market adjustments to compensation with respect to any non-management employee(s).

5.3 Negative Covenants. Without limiting the generality or effect of Section 5.2, from the Effective Date to the Closing Date, except as expressly provided in this Agreement or as set forth in Section 5.3 of the Disclosure Schedule, no Seller shall, without requesting, in writing from the chief executive officer of SRHS, and receiving the written consent of Buyer's chief executive officer, not to be unreasonably withheld or delayed (and any failure by Buyer's chief executive officer to respond to any such request for consent within five business days will be deemed to be such written consent):

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to enter into or carry out its obligations hereunder or to own the Purchased Assets or operate the Business;

(b) enter into, assume, amend or terminate any Material Contract (other than Physician Contracts and agreements with third party payors) or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease, in accordance with any limitations and procedures mutually agreed upon by the parties' legal counsel;

(c) grant any material waiver or give any material consent with respect to any Material Contract or Lease or any Real Property Lease that is to be any Assumed Contract or Assumed Lease except in the ordinary course of business and except to the extent doing so would not have a Material Adverse Effect;

(d) assign, abandon, cancel or terminate before the stipulated expiration of its term any Material Contract or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease;

(e) acquire, make any investment in, or make any capital contributions to, any Person, except for another Seller, for a price or with a value in excess of $250,000;

(f) acquire or lease any material assets or sell, lease or otherwise dispose of any material asset or property, or create, assume or permit to exist any Lien or Encumbrance on any material asset or property constituting a part of the Purchased Assets, (other than any Permitted Encumbrance) in an amount in excess of $250,000, individually or in the aggregate;

(g) sell, lease or otherwise dispose to a third party of any assets other than in the ordinary course of business that have a value in excess of $50,000, individually or in the aggregate, and except for the disposition of obsolete or worn out assets;

(h) (i) incur any Indebtedness or (ii) make any loans or advances to any Person other than inter-company advances in the ordinary course of business to another Seller;

(i) enter into any compromise or settlement of any Litigation or Proceeding (other than any Litigation or Proceeding to which both Buyer and one or more Sellers are party) involving a payment by any Seller exceeding the greater of (i) $50,000 or (ii) the amount reserved, if any, with respect to such Litigation or Proceeding in Sellers' financial statements;

(j) grant or agree to grant to any of its non-management employees any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish for any of its employees new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans, except to preserve the status of the Church Plan, or as required by Applicable Law or technical, administrative or design amendments that do not increase the cost of providing benefits; provided, however, that any grant of any increase in merit-based compensation or market adjustments to compensation, in each case as consistent with past practices and in the ordinary course of business, shall not require Buyer's consent as long as Sellers provide notice of the same to Buyer;

(k) grant or agree to grant to any of its management employees (i.e., assistant vice president or above), directors or officers any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish any new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans;

(l) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(m) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables other than in the ordinary course of business;

(n) enter into any agreement that restrains, limits or impedes any Seller's ability to compete with or conduct any business or line of business;

(o) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates, except in the ordinary course of business or pursuant to a contract in existence on December 31, 2010 or to another Seller; or

(p) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 5.3.

Notwithstanding anything to the contrary contained in this Section 5.3, Sellers may, with the prior written consent of Buyer, liquidate the assets of the Foundation in accordance with the plan of liquidation set forth on Exhibit G.

5.4 Governmental Approvals. Without limiting the generality or effect of Section 5.7, each Seller shall use its reasonable best efforts to (a) obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities as are necessary for each Seller to consummate the transactions contemplated hereby, including, without limitation, the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda, and (b) assist Buyer, to the extent reasonably requested by Buyer, and to the extent they are legally transferable, in the transfer of each Seller's licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities other than those set forth in Section 5.4 of the Disclosure Schedule.

5.5 Charitable Funds. Buyer acknowledges and agrees that certain of the Sellers, including HSR and the Foundation, have received grants and hold other funds (the "**Charitable Funds**") for the benefit of Sellers or the Facilities. Buyer and Sellers acknowledge and agree that such Charitable Funds shall be used by Sellers to satisfy the Retained Liabilities of Sellers that exist after Closing. Sellers acknowledge and agree that, to the extent any Charitable Funds are available for transfer after Closing, Sellers shall work with Buyer to identify the Charitable Funds that may be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets at Closing, which such transferred Charitable Funds shall be used at or for the benefit of the Facilities. With respect to such Charitable Funds, Sellers acknowledge and agree that, to the extent permitted under Applicable Law, any Charitable Funds that cannot be transferred to Buyer or Buyer's Affiliate at Closing as part of the Purchased Assets shall be used by Sellers at or for the benefit of the Facilities; provided, however, that if such Charitable Funds cannot be used at or for the benefit of the Facilities, such Charitable Funds shall be used by Sellers to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. At Buyer's request, Sellers shall seek approval from donors, Governmental Authorities and courts of competent jurisdiction to permit the transfer and use of Charitable Funds as contemplated by this Agreement. With respect to any Charitable Funds identified by Buyer and Sellers pursuant to this Section 5.5 for which the stated or intended use thereof, or any restriction thereon, becomes unlawful, impracticable, impossible to achieve or wasteful as a result of this Agreement or otherwise, Sellers shall request that a court of competent jurisdiction provide relief to the parties

by applying cy pres to modify or terminate the instrument pursuant to which such Charitable Funds were or are to be transferred to Sellers in a manner such that any such funds may be transferred to and used by Buyer in a manner acceptable to Buyer or used to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. After the Effective Time, no Seller shall solicit grants, donations or other charitable funds.

5.6 Church Approvals. Without limiting the generality or effect of Section 5.7, from the Effective Date until the Closing Date, each Seller shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders (collectively, the "**Church Approvals**") of the Archdiocese of Hartford and the Holy See (collectively, the "**Church**") as are necessary for each Seller to consummate the transactions contemplated hereby.

5.7 Closing Conditions. From the Effective Date until the Closing Date, each Seller shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Buyer in doing, all things necessary, proper, or advisable to consummate, in a timely manner, the transactions contemplated hereby, including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

5.8 Payment of Obligations. Without limiting any other provision of this Agreement, each Seller shall, in the ordinary course of business: (a) pay all liabilities and obligations incurred by any Seller in connection with the ownership of the Purchased Assets and the operation of the Business, including, but not limited to, any and all liabilities and obligations arising under the HSR Financing Agreements and the Retained Liabilities; (b) maintain the Purchased Assets in good order and repair, normal wear and tear excepted; and (c) file all Tax Returns and pay on a timely basis Taxes owed, if any, as set forth on such Tax Returns.

5.9 No-Shop Clause. From the Effective Date until Closing, no Seller shall, without the prior written consent of Buyer: (a) offer for sale, or receive or consider any offer to purchase, the Purchased Assets (or any portion thereof) or any ownership or control interest of or in any Seller, (b) solicit, receive or consider offers to buy all or any portion of the Purchased Assets or any ownership or control interest of or in any Seller, (c) hold discussions with any Person or organization (other than Buyer) looking toward such an offer or solicitation or looking toward a merger or consolidation of or in any Seller or (d) enter into any agreement with any Person or organization (other than Buyer) with respect to the sale, management, operation or other disposition of the Purchased Assets (or any portion thereof) or any ownership or control interest in any Seller, or with respect to any merger, consolidation or similar transaction involving any Seller.

5.10 Transfer of Assets. In the event that the parties determine before or after Closing that any asset owned by any Seller or Affiliate of any Seller is used primarily in, or relates primarily to, the operation of the conduct of the Business, such Seller shall, or shall cause such Affiliate to, transfer, convey and deliver to Buyer such Seller's or such Affiliate's right, title and interest in, to and under such asset, free and clear of any Liens or Encumbrances, other than Permitted Encumbrances, at or after Closing, as applicable.

5.11 Real Property. Within 30 days of the Effective Date, Sellers shall (a) deliver to Buyer a certified rent roll for each parcel of Owned Real Property under lease to tenants; (b) provide to Buyer the most current operating expense information with respect to the Leased Real Property; (c) deliver to Buyer copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed as of the Effective Date; and (d) use their best efforts to obtain estoppel certificates in the form attached hereto as Exhibit M confirming lease information from third party tenants and landlords of the Leased Real Property, such best efforts of Sellers to continue after said 30-day period.

5.12 Insurance Coverage. Except as otherwise set forth on Section 5.12 of the Disclosure Schedule, Sellers shall maintain assignable reinsurance coverage applicable for all years during which professional or hospital liability claims may arise and for which the applicable statute of limitations has not run. At all times, Sellers shall continue to satisfy all required conditions of such reinsurance coverage, including, without limitation, carrier notification and cooperation requirements. Seller agrees to use its best efforts to cooperate with any regulatory approval from any Governmental Authority necessary for Buyer to acquire any interest of Sellers or their Affiliates in Lukan Indemnity Company, Ltd. ("**Lukan**") and Caritas Insurance Company ("**Caritas**").

5.13 Bankruptcy. In the event that one or more of Sellers commences or has commenced against it a case under title 11 of the United States Code, (the "**Bankruptcy Code**"), the applicable Seller(s) agree that each of them will: (a)(i) file a motion on the date of the entry of the order for relief, in form and substance reasonably acceptable to Buyer, seeking to assume this Agreement and approve the transaction pursuant to 11 U.S.C. Sections 363 and 365 (the "**Sale Motion**"); (ii) obtain entry of an order approving the Sale Motion (the "**Sale Order**") in form and substance reasonably acceptable to Buyer approving the Sale Motion within 45 days after the date of filing the Sale Motion or such further time as may be ordered by the bankruptcy court for cause; and (iii) take or cause to be taken any and all actions necessary or appropriate to cause the Sale Order to become a Final Order (including, but not limited to, vigorously defending any appeal that may be taken from the Sale Order) unless subsections (a) or (b) of the Final Order Exception applies; and (b)(i) file a motion on the date of the entry of the order for relief, in form and substance reasonably acceptable to Buyer, that approves the Break-Up Fee and Expense Reimbursement on the terms and conditions set forth in Section 11.3, Section 11.4 and Section 11.5 (the "**Bid Protection Motion**"); (ii) obtain entry of an order (the "**Bid Protection Order**") in form and substance reasonably acceptable to Buyer approving the Bid Protection Motion within 30 days after the date of filing the Bid Protection Motion or such further time as may be ordered by the bankruptcy court for cause but in any event before the entry of the Sale Order; and (iii) take or cause to be taken any and all actions necessary or appropriate to cause the Bid Protection Order to become a Final Order (including, but not limited to, vigorously defending any appeal that may be taken from the Bid Protection Order). In the event that Sellers fail to obtain the Bid Protection Order or the Bid Protection Order does not become a Final Order, Buyer shall retain (and shall not be deemed to waive) any right or claim for breach of warranty or for indemnification under this Agreement; once the Bid Protection Order has become a Final Order, Buyer's sole remedies shall be those set forth in Sections 11.2, 11.3, 11.4 and 11.5 of this Agreement.

5.14 Pharmacy License. Sellers agree to use reasonable best efforts to sell the Pharmacy License, on or before the Closing Date, to a third party that is not an Affiliate of any Seller.

5.15 Disclosure Supplements. From time to time at least as often as quarterly after the Effective Date and immediately prior to Closing, Sellers shall supplement or amend the Disclosure Schedule with respect to any matter first existing or occurring after the Effective Date that (a) if existing or occurring at or prior to the Effective Date, would have been required to be set forth or described in the Disclosure Schedule, or (b) is required to correct any information contained in the Disclosure Schedule or any representation or warranty of any Seller; provided, however, that if any such matter could reasonably be expected to result in a Material Adverse Effect or significant Loss, Sellers shall deliver such supplement or amendment promptly following their becoming aware of any such matter. In the event prior to Closing, there is damage or destruction to all or any portion of the Owned Real Property and such damage or destruction is not repaired by Sellers and for which there is insufficient insurance available to fund such repair, Seller shall deliver to Buyer supplement(s) or amendment(s) to the Disclosure Schedule disclosing the Losses resulting therefrom and the provisions of this Section 5.15 shall apply. The Disclosure Schedule shall be deemed modified in accordance with any such supplement or amendment for all purposes of this Agreement, provided that if any supplement(s) or amendment(s) to the Disclosure Schedules to this Agreement that discloses any matter or matters that could reasonably be expected to result in Losses, individually or in the aggregate, in excess of $15,000,000, Buyer shall have the right to terminate this Agreement, by giving written notice to Sellers of its election to so terminate within seven days of Buyer's receipt of such supplement or amendment; provided, however, that in the event Buyer so gives Sellers written notice of its election to terminate this Agreement, Sellers shall be entitled to 40 days after the effective date of such notice from Buyer to cure any such matter so disclosed by such supplement or amendment so long as Sellers provide Buyer notice of such intention to cure within five business days of Sellers' receipt of Buyer's election to terminate this Agreement. If Buyer, in the exercise of its reasonable judgment and taking into account Sellers' diligence in their attempt to cure, determines that Sellers cannot cure such deficiency, then Buyer may terminate this Agreement by written notice to Sellers within 30 days of Buyer's receipt of such supplement or amendment. If such deficiency is susceptible of cure, following the expiration of the aforementioned 40-day cure period, Buyer shall send Sellers a notice informing Sellers whether Buyer accepts or rejects the adequacy of Sellers' cure efforts (any such notice of rejection being referred to herein as a "**Rejection Notice**"). If Buyer accepts such cure efforts or fails to timely send a Rejection Notice, such Disclosure Schedule shall be modified as contemplated by such supplement or amendment for all purposes of this Agreement. If Buyer rejects any supplement or amendment to such Disclosure Schedule, then this Agreement shall be deemed terminated by Buyer pursuant to Section 11.1(g) and Buyer shall have no further rights relating to such deficiency or arising from such termination. If such deficiency is susceptible of cure and Sellers cure such deficiency within such 40-day period, the Disclosure Schedule shall be deemed modified for all purposes of this Agreement.

5.16 Continuation of Group Health Plan Coverage and COBRA Continuation Coverage. During the term of the Transition Services Agreements, Seller will continue to provide group health plan coverage to the employees of Seller. With respect to each group health plan that is subject to Code Section 4980B, Seller has complied with the continuation

coverage requirements contained in Code Section 4980B and Part 6 of Title I of ERISA. As of and after the Effective Time, Seller will provide group health plan coverage to all COBRA Qualified Beneficiaries of Seller (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4). To the extent that Seller ceases to provide any group health plan benefits to any employee of Seller or any organization in any controlled group that includes Seller (within the meaning of Code Section 414(b) or (c)), Buyer will provide group health plan coverage to all persons who are COBRA Qualified Beneficiaries of Buyer (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4).

5.17 Teamsters Plan. On or before the Closing Date, Seller shall cease making contributions to the Teamsters Plan and effect a total withdrawal from the Plan. As soon as reasonably possible after the Closing Date, Seller shall make all required total withdrawal liability contributions to the Teamsters Plan and secure a release form the Teamsters Plan that settles all withdrawal liability issues of Sellers with respect to the Teamsters Plan.

5.18 Notice of Breach. In the event that any Seller breaches, in any material respect, any of its covenants contained in this Article 5, such Seller shall immediately deliver written notice of such breach to Buyer in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by such party.

ARTICLE 6. CERTAIN COVENANTS OF BUYER

6.1 Governmental Approvals. Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any governmental agencies or authorities as are necessary for Buyer to consummate the transactions contemplated hereby and to operate the Business from and after the Closing Date, including, without limitation, the Hart-Scott-Rodino Act filing and filings relating to the approval of the Connecticut Department of Public Health, the Connecticut Office of Health Care Access and the Centers for Medicare and Medicaid Services for consolidation of the Facilities, other than Grimes Center, under Buyer's hospital license and Medicare, Medicaid, TRICARE and other provider agreements and identification numbers and, with respect to Grimes Center, for issuance of an approval letter to Buyer or Buyer's designee and certificate of need approval for a chronic and convalescent nursing home license to operate Grimes Center and for assignment of the Grimes Center Medicare and Medicaid provider agreements to Buyer or Buyer's designee, a filing with the appropriate Governmental Authority in the State of Vermont with respect to the Caritas SPA and a filing with the appropriate Governmental Authority in Bermuda with respect to the Lukan SPA.

6.2 Church Approvals. Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall cooperate with Seller, as is commercially reasonable, to obtain all Church Approvals pursuant to Section 5.6.

6.3 Closing Conditions. From the Effective Date until the Closing Date, Buyer shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Sellers in doing, all things necessary, proper or

advisable to consummate, in a timely manner, the transactions contemplated hereby including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

6.4 **Notice of Breach**. In the event that Buyer breaches, in any material respect, any of its covenants contained in this Article 6, Buyer shall immediately deliver written notice of such breach to Sellers in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by Buyer.

6.5 **Real Property Reports**. Upon Sellers' reasonable request, Buyer shall provide Seller with copies of any property condition and environmental reports of the Real Property, excluding any portion of such reports which contain financial data or financial analysis, in Buyer's possession or control to the extent not already disclosed, including, without limitation, any reports created by or at the direction of Buyer through and including Closing.

ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer hereunder are subject to the satisfaction or written waiver, on or prior to the Closing Date, of the following conditions:

7.1 **Representations/Warranties**. The representations and warranties of each Seller contained in this Agreement (as supplemented or amended as provided in Section 5.15) that are qualified by materiality or reference to "Material Adverse Effect" shall be true in all respects, and those that are not so qualified shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

7.2 **Covenants**. Each covenant contained in this Agreement to be complied with or performed by each Seller on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects. Each Seller shall have duly performed and complied in all material respects with all agreements and conditions required by this Agreement to be performed or complied with by it prior to or on the Closing Date.

7.3 **Officers' Certificate**. Buyer shall have received from each Seller an officers' certificate, executed on behalf of each such party by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date and stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, as the case may be, that the conditions in Section 7.1 and Section 7.2 have been satisfied.

7.4 **Litigation or Proceedings**. No Litigation or Proceedings before a court or any other Governmental Authority or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions

contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

7.5 **Governmental Approvals**. All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, certificates of need, approvals, authorizations, clearances, qualifications or orders required to be obtained prior to Closing by Buyer or any Seller from, any Governmental Authority for the consummation of the transactions contemplated hereby, including, without limitation, such notices, reports, filings, licenses, permits, consents, certificates of need, approvals, authorizations, qualifications and orders set forth in Section 6.1, shall have been made or obtained.

7.6 **Church Approvals.** All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by any Seller from, the Church for the consummation of the transactions contemplated hereby shall have been made or obtained.

7.7 **Closing Deliveries.** Each Seller shall have made the deliveries required to be made by it under Section 9.2.

7.8 **Third Party Consents**. Each Seller shall have obtained consents from third parties for the assignment of the Assumed Contracts and Assumed Leases listed in Section 7.8 of the Disclosure Schedule.

7.9 **Satisfaction of Retained Liabilities.** At Closing, Sellers shall have submitted to Buyer, in writing and in form and substance reasonably satisfactory to Buyer, a plan for the orderly and timely satisfaction of all Retained Liabilities of each Seller substantially in the form of Exhibit N (the "**Wind Down Plan**"). Any portion of the Purchase Price or any other amounts held by Sellers, including any interest or earnings on or attributable to the Purchase Price or such other amounts that are at any time determined to be in excess of the amount necessary to satisfy the Retained Liabilities, shall be promptly paid by Sellers to Buyer or returned to Buyer as soon as legally permissible after any such determination.

7.10 **Charitable Funds.** Between the Effective Date and the Closing Date, Seller and Buyer shall have identified the Charitable Funds, and Seller shall have developed, in writing and in a form and substance reasonably satisfactory to Buyer, and implemented to the reasonable satisfaction of Buyer, a plan for the disposition of such Charitable Funds.

7.11 **Grimes Center Medical Rate.** Sellers shall have obtained all necessary approvals and waivers from the Connecticut Office of Policy and Management and the Connecticut Department of Social Services, pursuant to Connecticut General Statutes Section 17b-340(a), to prevent the rescission and recovery for affected rate years of any interim Medicaid rate established for Grimes Center, including without limitation, the Grimes Center interim Medicaid rate established effective July 1, 2008; provided, however, that the satisfaction of the condition set forth in this Section 7.11 shall be a condition only to Buyer's obligation to (a) purchase from Grimes Center the Purchased Assets owned by Grimes Center and (b) assume the Assumed Liabilities of Grimes Center.

7.12 Solvency Upon Closing.

(a) After giving effect to the transactions contemplated hereby, each Seller is Solvent, and, to the Knowledge of each such Seller, reasonably expects to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up Sellers' affairs; provided, however, that the foregoing shall cease to be a condition precedent to the obligations of Buyer pursuant to Article 7 hereunder if the Sale Order is entered and either of (i) the Sale Order has become a Final Order or (ii) the Final Order Exception applies. If the Buyer consummates the transactions contemplated herein without the Sale Order having become a Final Order, no notice of such waiver of this or any other condition to the Closing need be given except to the Sellers, it being the intention of the parties hereto that Buyer shall be entitled to, and is not waiving, the protections of Section 363(m) of the Bankruptcy Code, the mootness doctrine and any similar statute or body of law if the Closing occurs in the absence of the Sale Order being a Final Order.

(b) Within 30 days of the receipt of all necessary Government Authority approvals and the expiration of all Government Authority-required waiting periods, Sellers shall provide Buyer in writing with a preliminary conclusion as to the Solvency of each Seller at Closing. If Buyer does not agree with Sellers' preliminary view of whether each Seller will be Solvent at Closing, then Buyers and Sellers shall mutually engage and equally share the cost of a financial advisor with recognized hospital industry financial expertise (the "Financial Advisor") to determine in a written report and in accordance with customary industry practices and procedures whether each Seller will be Solvent at Closing. If Sellers or the Financial Advisor determines that any Seller other than HSR, SRHSAP or the Foundation will not be Solvent at Closing, unless Buyer otherwise agrees in writing and expressly waives all Solvency requirements with respect to such Seller (including those contained in Sections 3.18 and 7.12(a)), that Seller will no longer be a party to this Agreement, and its assets and liabilities shall no longer be Purchased Assets and Assumed Liabilities as set forth in Article 2. The parties shall be entitled to rely on, and will be bound by, any determination of the Financial Advisor as to the Solvency of any Seller at Closing.

7.13 Captives' Assets. The aggregate Net Assets of Caritas, Lukan, and HSR as set forth on the certificate delivered pursuant to Section 9.2(u) shall be equal to or greater than $11,700,000 on the Closing Date.

ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS

The obligations of Sellers hereunder are subject to the satisfaction, on or prior to the Closing Date, of the following conditions:

8.1 Representations/Warranties. The representations and warranties of Buyer contained in this Agreement shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

8.2 Covenants. Each covenant contained in this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects.

8.3 Officers' Certificate. Sellers shall have received from Buyer an officers' certificate, executed by Buyer by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date, stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, that the conditions in Section 8.1 and Section 8.2 have been satisfied.

8.4 Litigation or Proceedings. No Litigation or Proceedings before a court or any other governmental agency or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

8.5 Governmental Approvals. All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, any Governmental Authority in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

8.6 Closing Deliveries. Buyer shall have made the deliveries required to be made by it under Section 9.3.

8.7 Church Approvals. All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, the Church in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

ARTICLE 9. CLOSING

9.1 Closing. Subject to the satisfaction or waiver of all the conditions set forth in Article 7 and Article 8, the consummation of the sale and purchase of the Purchased Assets contemplated by this Agreement ("**Closing**") shall take place at the offices of Wiggin and Dana LLP, One Century Tower, 265 Church Street, New Haven, Connecticut, at 10:00 a.m., local time, on or before the 60th day following the satisfaction or waiver of the conditions set forth in Article 7 and Article 8 (other than those conditions that are to be fulfilled at Closing) or at such other location and/or on such other date as the parties hereto may mutually designate in writing (the "**Closing Date**"). The Closing shall be effective as of 12:01 a.m., local time, on the day following the Closing Date (the "**Effective Time**").

9.2 Actions of Sellers at Closing. At Closing, each Seller, as applicable, shall deposit into escrow with the Title Company Escrow Agent the following:

(a) a copy of the Assignment and Assumption of Leases executed by each Seller, together with necessary consents to such assignments, as applicable;

(b) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by each Seller, as applicable;

(c) copies of the Deeds executed by each Seller, as applicable, together with a signed standard seller's affidavit sufficient for the Title Policies to delete exceptions for third parties in possession (other than the Assumed Leases with respect to the Owned Real Property) and mechanic's liens and a Real Estate Conveyance Tax for each Deed;

(d) copies of resolutions duly adopted by the members and boards of directors of each Seller, authorizing and approving its performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of each Seller;

(e) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that the conditions set forth in Article 7 have been satisfied;

(f) a FIRPTA certificate executed by each Seller, as applicable;

(g) certificates of incumbency for the respective officers or directors, as the case may be, of each Seller executing this Agreement or certificates delivered to Buyer pursuant to this Section 9.2;

(h) all such termination statements and releases as are necessary to remove from the Purchased Assets all Liens and Encumbrances, other than the Permitted Encumbrances;

(i) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that all approvals of each Seller and their Affiliates have been obtained that are necessary to consummate the transactions contemplated by this Agreement;

(j) a written good faith estimate of Sellers setting forth, in sufficient detail acceptable to Buyer, the aggregate amount of Indebtedness of Sellers as of the Closing Date as well as the Retained Liabilities as of the Closing Date (the "**Financial Certificate**");

(k) evidence that all closing conditions set forth in Article 8 of the Caritas SPA have been satisfied or waived in accordance with the terms therein;

(l) evidence that all closing conditions set forth in Article 8 of the Lukan SPA have been satisfied or waived in accordance with the terms therein;

(m) copies of the Transition Services Agreement and Wind Down Services Agreement executed by SRHS;

(n) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that each such Seller has paid in full to the Continuing Employees any and all liabilities incurred and due to be paid to such Continuing Employees through the Closing Date;

(o) a certified rent roll for each parcel of Owned Real Property under lease to tenants specifying in addition to rent due and owing, any other outstanding amounts due between landlord and tenant, including, without limitation, amounts relating to tenant improvements;

(p) copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed;

(q) a letter to all tenants notifying them of the change of ownership of the Owned Real Property and directing such tenants to pay all future rentals to Buyer or Buyer's designee and further advising tenants that specific security deposits, advance rents and interest thereon, if any, have been transferred to Buyer (the "**Notice to Tenants**"), executed by Sellers;

(r) a certificate of the president and/or chief financial officer of SRHS and HSR, respectively, certifying that to their Knowledge, after giving effect to the consummation of the transactions contemplated hereby, each Seller is Solvent and reasonably expects to remain Solvent through the winding up of its affairs, and will be able to timely satisfy its Retained Liabilities in full, as such Retained Liabilities become due and payable, based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up such Seller's affairs; provided, however, that this Section 9.2(r) shall cease to be a delivery required by (i) such Sellers if the Sale Order is entered and either of (A) the Sale Order has become a Final Order or (B) the Final Order Exception applies or (ii) any Seller that ceases to be a Seller, or as to which Seller Buyer has waived the Solvency requirement, pursuant to Buyer's election under Section 7.12(b);

(s) the Wind Down Plan;

(t) copies of the Caritas SPA and Lukan SPA executed by SRHS;

(u) A certificate of the president or chief financial officer of Caritas, Lukan and HSR (solely in his or her capacity as such), dated as of the Closing Date, setting forth the Net Assets as of the Closing Date, presented in substantially the form attached hereto as Exhibit O;

(v) A release from each Seller of all claims and causes of action that any of them may hold against Caritas and Lukan, in such form and substance as SRHS and Buyer shall mutually determine; and

(w) such other certificates, instruments, and documents as Buyer may reasonably request.

9.3 Actions of Buyer at Closing. At Closing, Buyer shall deposit into escrow with the Title Company Escrow Agent the following:

(a) (i) an amount equal to the amount required to be paid at Closing in accordance with Section 2.3, (ii) conveyance taxes due in connection with the Deeds, (iii) prorations pursuant to Section 9.4(c), (iv) the cost of the Owner's Title Policy and any endorsements thereto, (v) the cost of recording the Deeds to the Owned Real Property, (vi) Title Company Escrow Agent's fee, and (vii) survey costs;

(b) a copy of the Assignment and Assumption of Leases executed by Buyer;

(c) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by Buyer;

(d) copies of resolutions duly adopted by the governing board of Buyer, authorizing and approving Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of Buyer;

(e) a certificate of Buyer, dated as of the Closing Date and signed by an authorized officer of Buyer, certifying that the conditions set forth in Article 8 have been satisfied;

(f) certificates of incumbency for the respective officers of Buyer executing this Agreement or any certificates delivered to Sellers pursuant to this Section 9.3;

(g) copies of the Transition Services Agreement and Wind Down Services Agreement executed by Buyer;

(h) a Notice to Tenants executed by Buyer;

(i) copies of the Caritas SPA and Lukan SPA executed by Buyer; and

(j) such other certificates, instruments and documents as Sellers may reasonably request.

9.4 Close of Title Company Escrow.

(a) The Title Company Escrow Agent will close escrow (the "**Close of Escrow**") on the Closing Date if all conditions specified in this Agreement have been satisfied or waived by (i) delivering the Deeds for recording, with instructions to deliver the Deeds to Buyer after recording, (ii) paying to each appropriate Seller the portion of the Title Company Escrow Funds due to such Seller, by wire transfer of immediately available funds to an account designated by SRHS, (iii) delivering to Sellers the deliveries required to be made by Buyer under Section 9.3 and (iv) delivering to Buyer the deliveries required to be made by Sellers under Section 9.2 (other than the Deed) and a copy of the Deed.

(b) Simultaneously with the Close of Escrow, Seller will deliver to Buyer, outside of the closing escrow, originals or, if originals are not in Sellers' possession, copies of (i) all service contracts assigned to Buyer, (ii) only to the extent in Sellers' possession, certificates of occupancy for the Owned Real Property, and documents evidencing other permits,

licenses, approvals, utility rights, development rights and similar rights related to the Owned Real Property, if any, transferred to Buyer that are in the possession of Sellers, (iii) all Leases and all Guarantees of Leases, if any, (iv) all assignable warranties and Guarantees covering all or any part of the Owned Real Property that are transferred to Buyer, if any, and (v) keys and security codes for all security devices necessary to the operation and maintenance of the Owned Real Property.

(c) Sellers and Buyer shall prorate between them as of the Closing Date all income and expense related to the normal operation, maintenance and repair of the Owned Real Property and, as applicable, the Leased Real Property, with the following clarifications and Encumbrances:

(i) The following are to be apportioned as of 12:01 a.m., local time, on the Closing Date:

(A) Real property and personal property taxes upon the Owned Real Property and Personal Property for the current calendar or fiscal year shall be prorated as of the Closing Date, Sellers' pro rata portion of such taxes shall be based upon taxes actually assessed for the current calendar or fiscal year. If, for any reason, such taxes for the current calendar year have not been assessed on the Owned Real Property, such proration shall be estimated based upon such taxes for the immediately preceding calendar or fiscal year, and thereafter adjusted when actual amounts become available;

(B) With respect to the Owned Real Property, water charges, storm water charges and sewer charges on the basis of the calendar year for which assessed;

(C) With respect to the Owned Real Property, fuel, including steam, oil and coal, if any, at the price charged therefor by Sellers' supplier;

(D) Amounts paid or payable under service contracts and similar agreements affecting the Owned Real Property;

(E) With respect to the Owned Real Property, rents, not in arrears, and any prepaid rent under the Assumed Leases; and

(F) With respect to the Leased Real Property, rents, any prepaid rent, any additional rent, escalations, taxes, utility payments and other payments made under the Real Property Leases.

(ii) Buyer shall be credited at Closing with an amount equal to the security deposits, if any, in connection with the Assumed Leases relating to the Owned Real Property, or Sellers shall turn such security deposits over to Buyer at Closing.

(iii) Sellers shall be credited at Closing with an amount equal to the security deposits, if any, and any utility deposits in connection with the Real Property Leases.

(iv) All charges for electric and gas service supplied to the Owned Real Property prior to the Closing Date shall be the obligation of Sellers, and Sellers agree to pay the invoices rendered in connection with such services promptly upon receipt thereof, whether such receipt is received before or after the Closing.

(v) If there is a water meter on the Owned Real Property, Sellers shall furnish a reading or readings to a date not more than three days before the Closing Date and the unfixed meter charge and sewer rent, if any, shall be apportioned on the basis of such last reading.

(vi) Sellers shall have the option to credit Buyer as an adjustment of the cash portion of the Purchase Price with the amount of any unpaid water charges and sewer rents, together with any interest and penalties thereon.

(vii) Real estate tax refunds and credits received after the Closing Date which are attributable to the fiscal or calendar year during which the Closing occurs shall be apportioned between Sellers and Buyer, after deducting reasonable expenses of collection thereof; provided, that Buyer shall not be obligated to pay Sellers their share of the same to the extent that Buyer determines, in the exercise of its reasonable judgment, that tenants under the Assumed Leases are entitled to the same and Buyer pays the same to such tenants.

(viii) Any errors or omissions in computing apportionments at the Closing shall be corrected as soon after discovery as possible. The provisions of this Section 9.4(c) shall survive the Closing for a period of 12 months.

(ix) Sellers shall forthwith turn over to Buyer any rental, additional rental and any other amounts received by Sellers in respect of the Owned Real Property at any time after the Closing and properly allocable to the period after the Closing. Buyer shall forthwith turn over to the Sellers any rental, additional rental and other amounts received by Buyer in respect of the Owned Real Property and properly allocable to the period prior to the Closing. Buyer shall use reasonable efforts after the Closing for a period of one year to collect delinquent rents for the period up to the Closing Date. If any tenant of Owned Real Property is in arrears in the payment of rent on the Closing Date, rents received from such tenant after the Closing shall be applied in the following order of priority: (A) first to the month preceding the month in which the Closing occurred; (B) then to the month in which the Closing occurred; (C) then to any month or months following the month in which the Closing occurred; and (D) then to the period prior to the month preceding the month in which the Closing occurred. If rents or any portion thereof received by Sellers or Buyer after the Closing are payable to the other party by reason of this allocation, the appropriate sum, less the proportionate share of any reasonable attorneys' fees, costs and expenses of collection thereof,

shall be promptly paid to the other party, which obligation shall survive the Closing. Buyer shall provide to Sellers an accounting of such collection activities 60 days thereafter for a period of one year from the Closing Date. Sellers shall have the right to pursue any delinquent rents for the period up to the Closing Date provided Sellers shall not have the right to commence any dispossess actions against such tenants.

(x) Brokerage commissions and tenant costs shall be apportioned and such obligations shall be assumed by Buyer as set forth on the rent roll for each Owned Real Property, as updated for Closing.

(xi) All prorations and payments to be made under the foregoing provisions shall be made on the basis of a written statement or statements delivered to Buyer by Sellers and approved by Buyer. In the event any prorations, apportionments or computation shall prove to be incorrect for any reason, then either party shall be entitled to an adjustment to correct the same, provided that it makes written demand on the one from who it is entitled to such adjustment within one year after Closing. The provisions of this Section 9.4(c) shall survive the Closing.

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS

10.1 Operations Transition.

(a) YNHH Board. Upon the Effective Time, Buyer shall continue to be governed by a local Board of Trustees, to which three lay individuals and one member of SOC, mutually determined by Sellers and Buyer, shall be appointed to serve in accordance with the rights and responsibilities set forth in the bylaws of Buyer and established by Connecticut law, until his or her removal, resignation or retirement.

(b) Medical Staff and Medical Staff Bylaws. The medical staff of HSR at Closing shall continue their service as of the Effective Time and will become members of and combined with and become a part of the medical staff of Buyer (the "**Combined Medical Staff**"). The Combined Medical Staff will operate in accordance with the Bylaws, Rules and Regulations and Fair Hearing Plan, each as adopted by Buyer at Closing (collectively, the "**Combined Medical Staff Bylaws**"). Buyer shall ensure that the Combined Medical Staff Bylaws provide that the resources of Buyer will be available to all members of the Combined Medical Staff, without regard to whether they are university-based physicians or community-based physicians.

(c) Medical Staff Leadership.

(i) Medical Board. As of the Effective Time, Buyer will include on the Medical Board of the Combined Medical Staff certain individuals from the Medical Staff of HSR, including, at a minimum, the President and President Elect as of the Closing Date, such individuals to serve as two of the 12 community physician members of the Medical Board, filling vacancies in such membership. Each such individual shall, in accordance with the Combined Medical Staff

Bylaws and subject to removal or re-election in accordance with the terms thereof, serve for a term of three years or until the first election of community physician members to the Medical Staff thereafter.

(ii) Medical Staff Committees. Buyer will include representation of the Medical Staff of HSR as of the Closing Date on each of the following committees of the Combined Medical Staff, each such member to be identified by HSR and approved by Buyer in its reasonable discretion and to serve for a term of one year from the Effective Time:

(A) Credentials Committee;

(B) Perioperative Executive Leadership Committee;

(C) Institutional Practice Quality and Peer Review Committee;

(D) Bioethics Committee;

(E) Medical Record and Clinical Information Committee;

(F) Pharmacy and Therapeutics Committee;

(G) Pathology and Tissue Committee; and

(H) Utilization Review and Discharge Planning Committee.

(d) Medical Directorships. Buyer shall, effective as of the Effective Time, appoint a member of the Medical Staff of HSR as of the Closing Date to serve as Medical Director of each of the following services performed at the Facilities (each, a "**Medical Director**"), each such member to be identified by HSR and approved by Buyer in its reasonable discretion:

(i) Cardiology;

(ii) General Surgery;

(iii) Internal Medicine;

(iv) Obstetrics and Gynecology;

(v) Orthopedic Surgery; and

(vi) Psychiatry.

Each Medical Director shall provide oversight of the identified clinical services at the Facilities for a period of five years after the Effective Time, in accordance with and subject to the terms and conditions as established by Buyer prior to Closing.

(e) **Employed Physicians.** At Closing, Buyer or its designee will offer job opportunities, pursuant to terms and conditions of employment to be established by Buyer or its designee, to the employed physicians of HSR who are in good standing with HSR as of the Closing Date and who agree to become employed under Buyer's, or its designee's, terms and conditions of employment (the "**Continuing Physicians**"). Such offers of employment will be subject to the following objective eligibility criteria: (i) the U.S. Department of Health and Human Services OIG "excluded persons list" and (ii) the validation of licensure and other necessary qualifications where applicable. With respect to the Continuing Physicians, Buyer or its designee will provide compensation and benefits that is the same as what is provided by Buyer or its designee to its physicians in similar roles at the Closing Date. The Continuing Physicians' length of service at HSR shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise will be structured commensurate with those benefits offered to any newly-hired physician by Buyer or its designee at that time. Buyer or its designee will not assume any liability for any accrued vacation, severance or sick leave expenses of the Continuing Physicians who become employed by Buyer or its designee, and in connection therewith, HSR will be solely responsible for ensuring that any such amounts owing to the Continuing Physicians are paid upon the closing.

(f) **Site Directorships**. Buyer shall, effective as of the Effective Time, appoint a member of the Medical Staff of HSR as of the Closing Date to serve as Site Director of each of the following services performed at the Facilities (each, a "**Site Director**"), each such member to be identified by HSR and approved by Buyer in its reasonable discretion:

(i) Perioperative Services;

(ii) Diagnostic Radiology;

(iii) Anesthesia;

(iv) Emergency Department;

(v) Pathology; and

(vi) Radiology Oncology.

Each Site Director shall provide oversight of the identified clinical services at the Facilities for a period of five years after the Effective Time, in accordance with and subject to the terms and conditions as established by Buyer prior to Closing.

(g) **Hospital Services.** HSR is a party to various agreements (the "**Hospital Based Service Agreements**") pursuant to which community Physician groups provide hospital-based services, including anesthesia, radiology, radiation therapy and clinical and anatomic pathology services (the "**Hospital Based Services**"), to HSR patients. On or before the Closing Date, HSR shall cause each Hospital Based Service Agreement to be terminated or amended as of the Effective Time, in a manner directed by Buyer, in order to do one of the following, as determined by Buyer in its sole discretion: (i) terminate the Hospital Based Service Agreement without penalty to HSR, on the condition that the physicians providing services thereunder (the "**Hospital Based Physicians**") satisfy the requirements of and become full-time faculty members

of the Yale School of Medicine in order that services may be provided on and after the Effective Time as integrated services under the direction of the Yale School of Medicine; (ii) terminate or amend the Hospital Based Service Agreement without penalty to HSR, on the condition that the Hospital Based Physicians agree to the terms of a subcontract arrangement with the Yale School of Medicine in order that services may be provided on and after the Effective Time as services under subcontract with the Yale School of Medicine; or (iii) terminate the Hospital Based Service Agreement without penalty to HSR, on the condition that the Hospital Based Physicians become employed by Northeast Medical Group, Inc. in order that services may be provided on and after the Effective Time as services under subcontract between Northeast Medical Group, Inc. and the Yale School of Medicine. Any such amendment or termination shall be in form and substance satisfactory to Buyer, and may contain terms that require Hospital Based Physicians or any additional Physicians engaged on or after the Effective Time to provide Hospital Based Services to be or become full-time faculty members of the Yale School of Medicine.

(h) **Graduate Medical Education.** Buyer intends to integrate Seller's "entire program" into its graduate medical education programs as described in applicable federal regulations. In furtherance thereof:

(i) HSR shall assist Buyer in transferring the following residency and/or fellowship programs to Buyer (including the obtaining of any approvals required by any Residency Review Committee of the Accreditation Council for Graduate Medical Education), in order for such residency and/or fellowship programs to be integrated with the existing residency and/or fellowship programs operated by Buyer:

(A) Surgery;

(B) Diagnostic Radiology;

(C) Geriatrics;

(D) Nephrology;

(E) Cardiology;

(F) Oral and Maxillofacial Surgery; and

(ii) On or after the Effective Date, Buyer shall integrate is Primary Care residency program with the Internal Medicine residency program operated by HSR, and HSR shall obtain any required approvals (including any approvals required by the applicable Residency Review Committee of the Accreditation Council for Graduate Medical Education for HSR's Internal Medicine residency program to be integrated with Buyer's Primary Care residency program.

10.2 Preservation of Catholic Heritage. In light of the parties' understanding of and respect for the commitment of Sellers to the principle that care for the sick, the poor and the dying has deep roots in its Catholic ministry, Buyer will continue to provide patient care at the

Facilities in a manner that respects its Catholic heritage and this ethical principle as described herein. Buyer agrees that it will, after the Effective Time:

(a) cause the appointment of a Catholic Heritage Committee. The Catholic Heritage Committee shall be formed to ensure that the clinical services provided at the Facilities are consistent with the Directives, as adapted to the conditions of modern science and medicine and as deemed appropriate by SOC from time to time. The Catholic Heritage Committee will engage in self-evaluation, education and policy review, and may collaborate with other community organizations around mutually held goals. The Catholic Heritage Committee shall meet no less than twice annually and shall review clinical services provided at the Facilities, including, if applicable, any inquiry made by an employee, physician, patient or other regarding such clinical services. The Catholic Heritage Committee shall be composed of five staff members, including three staff members nominated by SOC. The Yale-New Haven Hospital Executive for Catholic Heritage and Pastoral Care shall serve on the Catholic Heritage Committee as one of the five staff members;

(b) modify the existing Community Advisory Committee in order to continue to support the parties' shared mission to provide services to improve access to health care services by including members nominated by SOC. Such members shall compose not less than 25% of the membership of the Community Advisory Committee;

(c) engage an individual selected by Buyer in consultation with SOC as the Executive for Catholic Heritage and Pastoral Care at the Facilities, whose duties will include mission and values. The Executive shall also have responsibility for Catholic heritage and pastoral care activities at the Facilities and shall be a member of Buyer senior team;

(d) amend the medical staff bylaws, employee code of conduct and other documents, as appropriate and as agreed to by the parties, to state the requirement to adhere to the Directives at the Facilities;

(e) provide annual education for medical staff members and other personnel at the Facilities concerning the Directives;

(f) maintain the Chapel at the Facilities as a place for Catholic, ecumenical and interreligious services as needed and appropriate for the benefit of staff, patients and families, and maintain appropriate signage and other symbols of Catholic identity at the Facilities, including, but not limited to, the name "The Hospital of Saint Raphael in the tradition of the Sisters of Charity of Saint Elizabeth" to the fullest extent permitted by 42 CFR Section 413.65 and other applicable state or federal law. Such Chapel, signage and religious symbols as SOC wishes to remain both within and on the external walls of the Facilities will so remain; provided, however, that in the event such signage and religious symbols cease to be used for any reason, they shall be transferred to SOC; and

(g) host a celebration of Founder's Day at the Facilities on an annual basis in order to honor SOC.

The commitments set forth in this Section 10.2 shall continue except as may be modified in accordance with this paragraph. If, as a result of changes in clinical services or programs,

practices or locations, or as a result of changes in the interpretation of the Directives, Buyer finds, acting reasonably and in good faith, that continued compliance with certain Directives will create a significant operational or patient care burden on Buyer, then Buyer shall work in good faith with the Catholic Heritage Committee to mitigate the burden while preserving the other commitments described in this Section 10.2. If, after working together for a period of at least 90 days, Buyer and the Catholic Heritage Committee have not found a practical way to reconcile mitigation of the burden with compliance with the Directives at issue, then the matter will be presented to Buyer's board of trustees for consideration and resolution. The decision by Buyer's board of trustees with respect to such matter shall be final. SOC may, at any time, terminate the mutual commitments set forth in this Section 10.2 by providing 90 days prior written notice to Buyer's board of trustees. Upon the effect of such termination, SOC may reclaim any religious symbols utilized at the Facilities.

10.3 Preservation and Access to Records After Closing.

(a) With regard to patient records relating to the Business, from and after the Effective Time, Buyer shall maintain the patient records held at the Facilities as of the Effective Time relating to periods prior to Closing in accordance with Applicable Law, and in a manner consistent with the policies and procedures of Buyer governing maintenance of patient records generated at the Facilities after the Effective Time.

(b) Each party acknowledges that, as a result of operating the Facilities, it will gain access to patient and other information that is subject to statutes, laws, rules and regulations regarding confidentiality, and agrees to abide by such statutes, laws, rules and regulations with regard to such confidential information.

(c) Each party hereto acknowledges that subsequent to Closing, the other parties may need access to information or documents in the control or possession of such party for the purposes of concluding the transactions contemplated hereby, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, each Seller, on one hand, and Buyer, on the other hand, agree that after Closing each shall make reasonably available to the other's representatives or agents, independent auditors and/or governmental agencies or authorities, upon written request, consistent with Applicable Law, and at the expense of the requesting party, such documents and information as may be available relating to the Business for periods prior and subsequent to Closing to the extent necessary to facilitate concluding the transaction herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

10.4 Employee Matters.

(a) As of Closing, Buyer or its designee will offer job opportunities to substantially all of the Non-Bargaining Unit Employees of Seller(s) (other than those covered by Section 10.4(b) and Section 10.4(c) below) who (i) are in Good Standing with their respective Seller-employer(s) as of the Closing Date, (ii) agree to become employed under Buyer's, or its designee's, terms and conditions of employment and (iii) agree to waive and release their rights to payment for any accrued vacation, sick leave or other paid time off to which they would have otherwise been entitled from Seller(s) at their termination with such employer (the "**Continuing**

Non-Bargaining Unit Employees"). Such offers of employment will further be subject to the following objective eligibility criteria: (x) the U.S. Department of Health and Human Services OIG "excluded persons list" and (y) the validation of licensure and other necessary qualifications where applicable. With respect to the Continuing Non-Bargaining Unit Employees, Buyer or its designee will provide compensation and benefits that are consistent with what is provided by Buyer or its designee to employees in similar roles with Buyer, or its designee, at the Effective Time. The Continuing Non-Bargaining Unit Employees' length of service with their respective employer as of the Effective Time shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise be structured commensurate with those benefits offered to any newly-hired employee by Buyer or its designee at the Effective Time. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Non-Bargaining Unit Employees accrued as of the Effective Time, and in connection therewith, HSR or Grimes Center, as applicable, will be solely responsible for ensuring that any such amounts owed are paid upon Closing; provided, however, that the Continuing Non-Bargaining Unit Employees shall be afforded credit for accrued vacation days in accordance with Buyer's paid time off personnel policies.

(b) At Closing, Buyer or its designee will offer job opportunities to substantially all of the Bargaining Unit Employees who are in Good Standing with their respective Seller-employer(s) as of the Closing Date and who agree to become employed under Buyer's, or its designee's, terms and conditions of employment (the "**Continuing Bargaining Unit Employees**"). Such offers of employment will be subject to the following objective eligibility criteria: (i) the U.S. Department of Health and Human Services OIG "excluded persons list" and (ii) the validation of licensure and other necessary qualifications where applicable. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Bargaining Unit Employees accrued as of the Effective Time, and in connection therewith, HSR or Grimes Center, as applicable, will be solely responsible for ensuring that any such amounts owed are paid upon Closing. Neither Buyer nor its designee will assume any of the existing collective bargaining agreements in effect between any of the Sellers and the Teamsters. If Continuing Bargaining Unit Employees constitute a majority of the employees in an appropriate bargaining unit or units at the Facilities at the time that Buyer or its designee has hired the majority of the workforce in such unit(s), Buyer or its designee will recognize the Teamsters as the collective bargaining agent for such unit(s) and will enter into good faith negotiations with the Teamsters regarding a new collective bargaining agreement for such unit(s).

(c) At Closing, Buyer or its designee will offer job opportunities, to substantially all of the employees of Sellers (other than HSR and Grimes Center) (the "**Additional Employees**") who (i) are in Good Standing with their respective Seller-employer as of the Closing Date, (ii) agree to become employed under Buyer's, or its designee's, terms and conditions of employment and (iii) agree to waive and release their rights to any accrued vacation, sick leave or other paid time off to which they would have otherwise been entitled from Seller(s) at their termination with such employer (the "**Additional Continuing Employees**"). Such offers of employment will be subject to the following objective eligibility criteria: (x) the U.S. Department of Health and Human Services OIG "excluded persons list" and (y) the validation of licensure and other necessary qualifications where applicable. With respect to the Additional Continuing Employees, Buyer or its designee will provide compensation and benefits

that are consistent with what is provided by Buyer or its designee to its employees in similar roles with Buyer, or its designee, at the Effective Time. The Additional Continuing Employees' length of service with Sellers as of the Effective Time shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise will be structured commensurate with those benefits offered to any newly-hired employee by Buyer or its designee at the Effective Time. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Additional Employees accrued as of the Effective Time, and in connection therewith, each Seller will be solely responsible for ensuring that any such amounts owed are paid upon Closing; provided, however, that the Additional Continuing Employees shall be afforded credit for accrued vacation days in accordance with Buyer's paid time off personnel policies.

(d) The employment offers to the Continuing Employees shall provide for commencement of employment at the Effective Time. Nothing in this Section 10.4 is intended to or shall obligate Buyer or its designee(s) to employ or cause any person to employ any Continuing Employee(s) for any particular period of time.

(e) The provisions of this Section 10.4 are for the sole benefit of the parties to this Agreement and nothing herein, expressed or implied, is intended or shall be construed to confer upon or give to any Person (for the avoidance of doubt, including, but not limited to, any current or former directors, officers, employees, managers or independent contractors of any Seller, any of their Affiliates or any labor organization representing any of the Sellers' employees) any legal, equitable or other rights or remedies as third-party beneficiaries of this Agreement or any of the terms contained herein, or to expand the rights or terms of employment of such employees under any existing contracts, agreements or understandings, if any, with Buyer or its designee or Affiliates.

(f) At Buyer's reasonable discretion, after consultation with Sellers, it may in writing prior to the closing, receive and obtain control over all of the assets held as funds for "estimated workers' compensation liabilities." Further, Buyer has the right to assume all such funds or to choose to assume only those funds set forth in the "trust fund" or the workers' compensation funds held by a bank or financial institution as cash collateral for the "performance bond." If Buyer chooses to exercise this right it will notify Seller at least five days before Closing and also assume all liabilities and obligations under any agreement related to these funds as well as for all outstanding and future workers' compensation liabilities of any present or former Seller employee, regardless if said employee is employed in the future by Buyer.

(g) Sellers acknowledge and agree that they shall use their best efforts to cause any renewal or extension of (i) the Prefunding Deductible Reimbursement and Security Agreement, effective effective April 17, 2011, by and among SRHS and Pennsylvania Manufacturers' Association Insurance Company, Manufacturers Alliance Insurance Company, and/or Pennsylvania Manufacturers Indemnity Company (the "**Security Agreement**") and/or (ii) the Agreement for Third Party Claims Handling Services, dated March 30, 2011, by and among HSR and PMA Management Corp. of New England, Inc. and Pennsylvania Manufacturers Indemnity Company (the "**TPC Agreement**") (collectively, the Security Agreement and TPC Agreement are referred to herein as the "**PMA Agreement**"), to expire or terminate as of Closing. Notwithstanding the foregoing or any provision of this Agreement, including the

Disclosure Schedule, to the contrary, under no circumstances shall the PMA Agreement constitute an Assumed Contract if, at Closing, the then-existing term of the PMA Agreement is for a period of greater than two years.

10.5 Tax Matters.

(a) From and after Closing, in connection with the preparation of Tax Returns, audit examinations and any administrative or judicial proceedings relating to any Tax liabilities imposed on any Seller or Buyer for Pre-Closing Tax Periods, Buyer shall cooperate with Sellers, and Sellers shall cooperate with Buyer, including, without limitation, furnishing or making available during normal business hours records, personnel (as reasonably required and at no cost to the other party), books of account, powers of attorney or other materials necessary or helpful for the preparation of such Tax Returns, the conduct of audit examinations, or the defense of claims by Tax authorities as to the imposition of Taxes. From and after Closing, Sellers shall retain all Tax Returns, schedules and work papers and all material records or other documents relating to all Taxes of Sellers for the Pre-Closing Tax Periods until the later of (i) the expiration of the statute of limitations of the taxable periods to which such Tax Returns and other documents relate, without regard to extension, except to the extent notified by another party in writing of such extensions for the respective taxable periods, or (ii) seven years following the due date (without extension) for such Tax Returns, and Sellers shall maintain such Tax Returns, schedules, work papers, records and documents in the same manner and with the same care it currently uses in maintaining its Tax Returns, schedules, work papers, records and documents. Sellers shall give Buyer reasonable written notice prior to destroying or discarding any such books or records and, if the notified party so requests, the notified party shall be permitted to take possession of such books and records. Any information obtained under this Section 10.5(a) shall be kept confidential, except as may be otherwise necessary in connection with the filing of Tax Returns or claims for refund or in conducting an audit or other proceeding.

(b) Buyer shall pay, and indemnify Sellers from and against, to the extent paid by Sellers, any sales, use, transfer, value added, stamp, registration, real property transfer or gains, recording or other similar Taxes, together with any conveyance fees, recording charges and other charges, payable as a result of the transactions provided for by this Agreement. Sellers shall cooperate with Buyer to the extent reasonably requested to reduce or eliminate such Taxes, fees or charges. Buyer and Sellers, as applicable, at Buyer's own expense, shall file or cause to be filed all necessary Tax Returns and other documentation with respect to all such Taxes.

10.6 Sellers' Cost Reports. Sellers shall be solely responsible for and shall prepare and timely file all cost reports and all other filings which are required to be filed with any Governmental Authority under the Medicare, Medicaid or TRICARE programs with respect to the operation of the Business preceding the Effective Time. Sellers shall be solely responsible for any pending or potential audit or examination, and any and all payments, interest, fines and penalties related to any such cost reports and filings.

10.7 Allocation of Purchase Price. The payments made by Buyer pursuant to Section 2.3 shall be allocated among the Purchased Assets as mutually agreed between the Parties prior to Closing (the "**Section 1060 Allocation**"). The parties agree that any Tax Returns shall be prepared and filed consistently with such agreed upon Section 1060 Allocation. In this

regard, the parties agree that, to the extent required, they will each properly prepare and timely file Form 8594 in accordance with the agreed upon Section 1060 Allocation.

10.8 Patient Receivables.

(a) Sellers hereby authorize Buyer or Buyer's designee, and Buyer agrees to perform or cause its designee to perform, the services specified herein with respect to the Patient Receivables relating to the rendering of services and provision of medicine, drugs and supplies by Sellers after the Effective Date and prior to the Effective Time to patients admitted to the Facilities on or before the Effective Time but from whom payment has not been received as of the Effective Time. In connection therewith, on or before Closing, Buyer and Sellers shall establish an account of Sellers at a financial institution in New Haven, Connecticut selected by Sellers and reasonably acceptable to Buyer. After Closing, the Patient Receivables shall be received in Sellers' name and on Sellers' behalf, and Buyer or its designee shall deposit in such account cash, checks, drafts or other similar items of payment allocable to Sellers' Patient Receivables.

(b) Sellers shall be the owner of the account and shall have control over that account. However, Sellers shall execute a standing transfer order causing amounts on deposit in the account to be swept on a periodic basis (designated by Buyer) to an account owned and controlled solely by Buyer. Amounts deposited into the account are to be swept to Buyer's designated account.

(c) Sellers shall cooperate with Buyer in the execution of such documents, instruments, authorizations and consents as Buyer reasonably may request from time to time to carry out the purposes and intent of this Section 10.8. Neither Buyer nor its designee shall have any duty with respect to the Patient Receivables other than as specifically set forth herein.

10.9 Return of Payments. If Sellers or Buyer receives any amount from patients or third-party payors which under the terms of this Agreement, belongs to the other party, the party receiving such amount shall , upon confirmation of ownership of the amount, remit within 10 business days said full amount to the other party.

10.10 Title.

(a) Sellers shall be obligated to remove or bond over all liens and monetary encumbrances to title (meaning mortgages and deeds of trust, mechanics liens and judgments) other than non-delinquent real property taxes prior to the Closing and to remove any encumbrances to title created by Sellers between the Effective Date and the Closing Date unless approved by Buyer in writing. Sellers may utilize the closing proceeds to secure release of any such lien or monetary encumbrance.

(b) The title herein required to be furnished by the Seller shall be marketable, subject only to the items set forth in Schedule A of Disclosure Schedule 3.9(a) Part A and the Permitted Encumbrances, and the marketability thereof shall be determined in accordance with those provisions of the Connecticut General Statutes addressing marketability of title and the Standards of Title of the Connecticut Bar Association. Any and all defects in or encumbrances against the title which come within the scope of such provisions of the General Statutes and/or

the Standards of Title shall not constitute valid objections on the part of the Buyer, if such Statutes or Standards do not so provide, and provided the Seller furnishes any affidavits or other instruments which may be required by the applicable Statutes or Standards, and further provided title will be insurable at standard premiums by the Title Company or such other title insurance company licensed in the State of Connecticut reasonably satisfactory to Buyer.

10.11 Property Planning Review.

(a) Buyer shall have the right to conduct, at its sole expense, a property planning review of the Owned Real Property after the Effective Date. Such review may include environmental inspections and site assessments, a survey of the Owned Real Property, a review of the status of compliance of the Owned Real Property with applicable laws, ordinances, codes and regulations, architectural and engineering inspections and tests, soils, building condition, zoning status, real estate tax bills, review of leases, and any and all other matters relating to the Owned Real Property and its condition, legal status and operations and such other tests and inspections as Buyer determines in consultation with Buyer's consultants, subject to the provisions of clause (b) of this Section.

(b) Upon reasonable advance notice to Sellers, Sellers shall grant Buyer, or Buyer's agent, the right to enter upon the Owned Real Property during normal business hours at times mutually acceptable to Buyer and Sellers for the purposes of the performance of any of the inspections, tests or evaluations set forth above. No invasive testing or boring shall be done without prior notification to Sellers of the scope of the invasive testing and Sellers' written permission of the same, which permission shall not be unreasonably conditioned, withheld or delayed. Buyer will not interfere unreasonably with the activity of tenants or any persons occupying or providing service at the Owned Real Property. Buyer shall be liable for any damages resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents during the period of Buyer's inspection, testing of, and access to, the Owned Real Property. Within 30 days following the completion of any such inspections, tests or evaluations or such earlier date in the event this Agreement is terminated, Buyer shall make such repairs and perform such restoration with respect to portions of the Owned Real Property affected by the activities or inspections of Buyer to the same condition as existed prior to such activities or inspections performed by or on behalf of Buyer.

(c) Prior to commencement of any investigative activities on the Owned Real Property, Buyer shall obtain at Buyer's sole cost and expense a policy of commercial general liability insurance with limits of not less than $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage liability, containing the insurer's standard provision regarding waiver of subrogation and shall name Sellers as an additional insureds. Buyer shall provide a certificate of insurance reasonably approved by Sellers, which such approval shall not be unreasonably withheld. Sellers approve GEI as Buyer's enviornmental consultant. Any consultants retained by Buyer shall be reasonably satisfactory to Sellers. If Buyer retains consultants to perform investigative activities on the Owned Real Property, Buyer shall cause consultant(s) to provide certificates of insurance from each consultant prior to entering the Owned Real Property. Consultant(s) certificates of insurance shall provide limits of insurance not less than $1,000,000 combined single limit for bodily injury and property damage

and, if appropriate, professional liability with limits of not less than $1,000,000 and shall name Buyer and Sellers as additional insureds. Certificates of insurance and the insurance carrier providing those certificates shall be reasonably satisfactory to Sellers. Buyer shall also cause such consultants to provide evidence of workmens' compensation insurance and to enter into indemnification agreements in form and substance reasonably acceptable to Sellers.

(d) Buyer shall protect, indemnify, defend and hold the Owned Real Property, Sellers and Sellers' officers, directors, shareholders, participants, affiliates, employees, representatives, invitees, agents and contractors free and harmless from and against any and all claims, damages, liens, stop notices, liabilities, losses, costs and expenses, including reasonable attorney's fees and court costs for personal injury or property damage resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents (collectively, the "**Claims**") including, without limitation, repairing any and all damages to any portion of the Owned Real Property arising out of or related (directly or indirectly) to Buyer's conducting such inspections, surveys, tests, and evaluations, but Buyer shall not be liable for any diminution in Owned Real Property value resulting from Buyer's discovery of any matters by such inspection and testing nor shall Buyer be liable for any existing conditions or for any personal injury or property damage attributable to the negligence or misconduct of Sellers or its representatives. Buyer shall keep the Owned Real Property free and clear of any mechanic's liens or materialmen's liens related to Buyer's right of inspection and the activities contemplated by this Section. Notwithstanding anything to the contrary contained in this Agreement, the Buyer's indemnification obligations set forth herein shall survive the Closing or termination of this Agreement prior to the Closing for a period of two years.

10.12 Confidentiality. It is understood by the parties hereto that this Agreement, the information, documents and instruments exchanged by the parties or the parties' agents in connection with the transactions contemplated hereby, and the information, documents and instruments delivered in connection with the transactions contemplated hereby (collectively, the "**Confidential Information**") are of a confidential and proprietary nature. Each of the parties hereto agrees that, to the extent permitted by Applicable Law, both prior and subsequent to Closing, they shall maintain the confidentiality of the Confidential Information and, without the prior written consent of the other party, shall disclose the Confidential Information only to their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them and applicable Governmental Authorities), exercising the same care in handling such Confidential Information as would be exercised by such party in connection with similar information of its own. Each of the parties hereto further agrees that if the transactions contemplated hereby are not consummated or if this Agreement is terminated in accordance with its terms, it shall return any and all written Confidential Information and all copies thereof in the possession of their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them) to the other party to this Agreement at such other party's request. Each of the parties hereto recognizes that any breach of this Section 10.12 would result in irreparable harm to the other parties to this Agreement and their Affiliates and that therefore either 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 their other legal and equitable remedies. Prior to Closing, except as otherwise required by law or legal process, any release to the public of information respecting the matters set forth herein (including, without limitation, press releases and other media

contacts), will be made only in the form and manner approved by the parties and their respective counsel (which approval may be withheld only for good reason or cause). If Closing fails to occur for any reason or if this Agreement is terminated in accordance with its terms, the parties hereto agree to keep confidential and not disclose the Confidential Information for a period of five years from the Effective Date.

10.13 Tail Insurance.

(a) At Buyer's expense, Sellers shall arrange or shall cause its Affiliates to arrange for Buyer to either (i) purchase tail insurance policies for the insurance policies listed in Section 10.13(a) of the Disclosure Schedule providing continued coverage for a period of three years following the Closing (the "**Tail Insurance Policies**"), or (ii) be named as an additional insured on the Tail Insurance Policies. Buyer shall be entitled to file claims and receive payment pursuant to the terms of the Tail Insurance Policies after Closing.

(b) Except as otherwise agreed to by Buyer, HSR shall cause Lukan to offer a Tail Insurance Policy to each Physician (other than Physicians employed by Sellers) on commercially reasonable terms and conditions.

10.14 Press Releases. Buyer and Sellers shall jointly determine and agree upon the form, timing and content of all public announcements, press releases or other public statements concerning the transactions described in this Agreement, and neither Buyer nor Sellers shall independently make such statements without the prior consent of the other.

10.15 Compliance with the Transfer Act. Buyer and Sellers acknowledge that the property located at 1450 Chapel Street, New Haven is an "establishment" as that term is defined in the Transfer Act. Buyer agrees to be solely responsible for compliance with the Transfer Act and the performance of all obligations under the Transfer Act and specifically covenants to perform the following acts:

(a) determine the applicability of the Transfer Act;

(b) sign and file any appropriate Transfer Act form with the Connecticut Department of Environmental Protection as a "Certifying Party" and make all required submissions in connection with the Transfer Act;

(c) pay any Transfer Act form filing fee and all other related fees and costs; and

(d) conduct any additional environmental assessment, remediation and/or monitoring that may be required pursuant to the Transfer Act.

10.16 Post Effective Time Operations. From the Effective Time through the winding down of the affairs of each Seller, each such Seller shall:

(a) wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) conduct and provide to Buyer a quarterly update of the Wind Down Plan;

(c) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between and Seller and any of the foregoing;

(d) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the final annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year; and

(e) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be immediately provided to Buyer.

10.17 Post Effective Time Negative Covenants. Without limiting the generality or effect of Section 10.16, from the Effective Time through the winding down of the affairs of each Seller, no such Seller shall, except in accordance with the Wind Down Plan or with the written consent of Buyer:

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) acquire, make any investment in, or make any capital contributions to any Person;

(c) acquire or lease any material assets;

(d) sell, lease or otherwise dispose to a third party of any assets;

(e) (i) incur any Indebtedness or (ii) make any loans or advances to any Person;

(f) enter into any compromise or settlement of any Litigation or Proceeding involving a payment by any Seller exceeding $50,000;

(g) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(h) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables;

(i) enter into any agreement that restrains, limits or impedes any Seller's authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(j) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates; or

(k) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 10.17.

10.18 Restrictive Covenants.

(a) Sellers recognize and acknowledge that: (i) Buyer's entering into this Agreement is induced because of the covenants and assurances made by Sellers hereunder; (ii) the covenant not to compete of Sellers and their Affiliates is necessary to insure the continuation of the business of Buyer in respect of the Purchased Assets subsequent to Closing; and (iii) irreparable harm and damage will be done to Buyer in the event that any Seller or any of their Affiliates compete with Buyer within the area or areas specified in this Section 10.18. Therefore, in consideration of the premises and as a necessary inducement for Buyer to enter into this Agreement and consummate the transactions set forth herein, Sellers, on their own behalf and on behalf of their Affiliates (collectively, the "**Restricted Entities**"), agree that for a period of five years from and after the Closing Date (the "**Noncompete Period**"), the Restricted Entities shall not, directly or indirectly, in any capacity own, manage, operate, control, participate in the management or control of, be employed by, extend credit to, provide consulting services for or maintain or continue any interest whatsoever in any enterprise that is located within 35 miles of any of the Facilities and which is engaged in any health care services other than community outreach services provided without reimbursement as part of a charitable, educational or religious mission.

(b) Sellers agree and acknowledge that the restrictions contained in this Section 10.18 are reasonable in scope and duration, and are necessary to protect Buyer. If any Seller breaches or violates any provision of this Section 10.18, the Noncompete Period shall be extended by the amount of time that such breach or violation continues, as determined by Buyer in its reasonable discretion. Sellers agree and acknowledge that any breach of this Section 10.18 will cause irreparable injury to Buyer and upon any breach or threatened breach of any provision of this Section 10.18, Buyer shall be entitled to injunctive relief, specific performance or other equitable relief, without the necessity of posting bond; provided, however, that this shall in no way limit any other remedies which Buyer may have as a result of such breach, including the right to seek monetary damages. Sellers further acknowledge and agree that the payment of the Purchase Price shall constitute, among other things, full consideration for the restrictive covenants contained in this Section 10.18. The parties agree that Buyer may assign, without limitation, the foregoing restrictive covenants to any successor of Buyer. The provisions of this Section 10.18 shall be construed as an agreement on the part of Sellers independent of any other part of this Agreement or any other agreement, and the existence of any claim or cause of action of any Seller against Buyer, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement by Buyer of the provisions of this Section 10.18.

ARTICLE 11. TERMINATION

11.1 Termination. This Agreement shall have a term commencing on the Effective Date and continuing through the winding up of the affairs of the Sellers. This Agreement may be terminated as follows:

(a) by the mutual written consent of Sellers and Buyer;

(b) by Sellers or Buyer, if Closing shall not have occurred on or before March 1, 2013, other than as a result of any breach of any provision of this Agreement by the party seeking to terminate this Agreement; provided, however, that, if an appeal is taken of the Sale Order, this date shall be extended until 30 days following the final resolution or disposition of all such appeals;

(c) by Buyer prior to Closing, upon an injunction issued by a court of competent jurisdiction preventing the consummation of the transactions contemplated by the Agreement;

(d) by Sellers prior to Closing, by written notice to Buyer, if Buyer shall have (i) breached any of its representations or warranties contained in this Agreement that are qualified by reference to "Buyer Effect", (ii) breached in any respect any of its representations or warranties that are not so qualified if such breach could reasonably be expected to have a Buyer Effect or (iii) breached in any material respect any of its covenants contained in this Agreement, in each case which breach cannot be or has not been cured within 30 calendar days after the giving of written notice to Buyer;

(e) by Buyer prior to Closing, by written notice to Sellers, if any Seller shall have (i) breached any of its representations or warranties contained in this Agreement that are qualified by reference to "Material Adverse Effect", (ii) breached in any respect any of its representations or warranties that are not so qualified if such breach could reasonably be expected to have a Material Adverse Effect or (iii) breached in any material respect any of its covenants contained in this Agreement, in each case which breach cannot be or has not been cured within 30 calendar days after the giving of written notice to such party;

(f) by Buyer, prior to Closing, pursuant to Section 5.1;

(g) by Buyer prior to Closing, pursuant to Section 5.15;

(h) by Buyer if an Alternative Transaction is consummated or any Seller or court of competent jurisdiction enters into or approves, as applicable, any agreement for an Alternative Transaction; or

(i) notwithstanding anything to the contrary in this Section 11.1, by Buyer prior to Closing by written notice to Sellers, if (i) after giving effect to the transactions contemplated hereby, (A) Sellers or the Financial Advisor have determined that HSR, SRHSAP or the Foundation will not be Solvent at Closing, and (B) to any Seller's Knowledge, HSR, SRHSAP or the Foundation does not reasonably expect to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and

assumption concerning competitive and regulatory conditions affecting the Business of such Seller including the length of time it may take to wind up such Seller's affairs; or (ii) any Seller fails to commence a bankruptcy case under title 11 of the United States Code, as contemplated by the terms of Section 3.18, Section 5.13 and Section 7.12, within 45 days following Sellers' or the Financial Advisor's determination that such Seller is no longer Solvent.

11.2 Effect of Termination. In the event of the termination of this Agreement and the abandonment of the transactions contemplated hereby pursuant to Section 11.1, this Agreement shall forthwith become void and have no effect, without any liability on the part of any party hereto, and all rights and obligations of all parties under this Agreement shall cease; provided, however, that (a) Section 10.12, this Section 11.2, Section 11.3, Section 11.4, Section 11.5 and Article 13 shall survive any such termination and abandonment and (b) nothing contained in this Section 11.2 shall relieve any party from liability for fraud or any breach of any covenant in this Agreement.

11.3 Break-Up Fee and Expense Reimbursement. In consideration of Buyer's due diligence, good faith negotiations of and entering into this Agreement and as reimbursement of Buyer's expenses incurred in connection with the transactions contemplated hereunder, the Sellers shall pay to Buyer in accordance with Section 11.4 and Section 11.5 the following:

(a) a break-up fee in the amount equal to three and one-half percent of the Purchase Price (the "**Break-Up Fee**"); and

(b) notwithstanding anything contained to the contrary in Section 13.3, Buyer's expenses incurred in connection with this Agreement (including any other agreements, exhibits and schedules contemplated hereunder) and the transactions contemplated herein and therein, including, but not limited to, Buyer's legal and accounting expenses, due diligence (including travel expenses), all work performed by Buyer to prepare the Purchased Assets and the related servicing for transition to Buyer upon or soon after Closing and the prosecution and filing of the Hart-Scott-Rodino Act filing (the "**Expense Reimbursement**").

11.4 Conditions for and Payment of Break-Up Fee and Expense Reimbursement. Buyer shall earn (a) the Break-Up Fee and the Expense Reimbursement upon one or more Sellers (or any Affiliate thereof) accepting a bid or offer for an Alternative Transaction, and (b) the Expense Reimbursement upon the failure of the condition in Section 7.12 due to (i) any Seller's failing to commence a bankruptcy case under title 11 of the United States Code, as contemplated by the terms of Section 3.18, Section 5.13 and Section 7.12, within 45 days following Sellers' or the Financial Advisor's determination that such Seller is no longer Solvent or (ii) any Seller's failure to comply with the covenants in Section 5.13. The Break-Up Fee shall be paid by wire transfer of immediately available funds to an account designated in writing by Buyer on the date that an Alternative Transaction is consummated. The Expense Reimbursement shall be paid by wire transfer of immediately available funds to an account designated in writing by Buyer within five business days of the Sellers' receiving from Buyer evidence of such expenses; provided, however, that, if an appeal is taken of the Sale Order, the Expense Reimbursement shall not be payable until (and Buyer shall receive payment of any Expense Reimbursement upon) any final resolution or disposition of such appeal. Notwithstanding anything to the contrary set forth in this Agreement, unless the Bid Protection Order is entered and has become a Final Order, this

Section 11.4 shall not be deemed or construed to limit any rights or remedies, at law or in equity, Buyer may have against the Sellers and/or any of their Affiliates, principals, shareholders or members in connection with any violation or breach of (whether actual or anticipatory), or default under, this Agreement; once the Bid Protection Order has become a Final Order, Buyer's sole remedies shall be those set forth in Sections 11.2, 11.3, 11.4 and 11.5 of this Agreement. In no event shall Buyer be entitled to receive or retain the Break-Up Fee or the Expense Reimbursement if the transactions contemplated by this Agreement are consummated, whether or not pursuant to a Sale Order.

11.5 Joint and Several Liability of Sellers for Break-Up Fee and Expense Reimbursement. The Sellers' obligation to pay the Break-Up Fee and the Expense Reimbursement pursuant to Section 11.4(a) and Section 11.4(b) shall be joint and several. To the extent (a) consummation of any Alternative Transaction is made pursuant to a sale authorized pursuant to title 11 of the United States Code, a plan of reorganization, plan of liquidation or other plan of arrangement under applicable law, or (b) the Expense Reimbursement is earned pursuant to Section 11.4(b)(ii), the Sellers shall undertake reasonable best efforts to seek approval from a court of competent jurisdiction to have the Break-Up Fee and the Expense Reimbursement owed to Buyer pursuant to Section 11.4(a) and Section 11.4(b)(ii), respectively, deemed to be (w) an allowed administrative expense claim, (x) paid out of and constitute a first priority secured claim, to the extent applicable, against (i) any deposit paid by the purchaser in such Alternative Transaction or (ii) any deposit paid by any competing purchaser in any Alternative Transaction and retained by an escrow agent in compliance with the applicable court-approved bidding procedures, (y) an additional carve-out that attaches to and is prior in ranking to the priority Liens of the Sellers' lenders on the assets and (z) be paid prior to any distributions to any party.

ARTICLE 12. INDEMNIFICATION

12.1 Indemnification by Sellers. Subject to the other provisions of this Article 12, from and after the Closing Date, Sellers, jointly and severally, shall defend and indemnify Buyer and its Affiliates (the "**Buyer Indemnified Parties**") and hold the Buyer Indemnified Parties wholly harmless from and against any and all Losses that a Buyer Indemnified Party incurs as a result of (i) any breach of any representation and warranty of any Seller contained in this Agreement; (ii) any breach of any covenant of any Seller contained in this Agreement; (iii) any failure of any Seller to pay, perform or otherwise satisfy or discharge any of the Retained Liabilities; (iv) the ownership of the Purchased Assets, the operation of the Facilities and the conduct of the Business prior to the Effective Time; and (v) any breach of any representation, warranty or covenant of HSR contained in (A) the Lukan SPA or (B) the Caritas SPA.

12.2 Indemnification by Buyer. Subject to the other provisions of this Article 12, from and after the Closing Date, Buyer shall defend and indemnify Sellers and its Affiliates (the "**Seller Indemnified Parties**") and hold the Seller Indemnified Parties wholly harmless from and against any and all Losses that a Seller Indemnified Party incurs as a result of or with respect to (a) any breach of any representation and warranty of Buyer contained in this Agreement, (b) any breach of any covenant of Buyer contained in this Agreement, (c) any failure of Buyer to pay, perform or otherwise discharge any of the Assumed Liabilities, except to the extent that such

Losses arise from events that entitle a Buyer Indemnified Party to indemnification by Sellers pursuant to Section 12.1.

12.3 Time and Amount Limitations.

(a) The representations and warranties made by the parties in or pursuant to this Agreement (except Section 3.1, Section 3.2, Section 3.6, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a)) or in any document delivered pursuant hereto shall survive the Closing until, and will expire upon, the second anniversary of the Closing Date; provided, however, that the representations and warranties made in Section 3.6 shall survive the Closing until, and will expire upon, the fourth anniversary of the Closing Date; provided, further, that the representations and warranties made in Section 3.1, Section 3.2, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a) shall survive until the expiration of the applicable statute of limitations with respect to the subject matter relating thereto. All covenants and agreements made or created herein shall, unless otherwise specifically provided herein, survive the Closing.

(b) Except as specified in Section 12.3(f), the aggregate liability of any Seller for indemnification pursuant to Section 12.1(i) or Section 12.1(iv) shall not exceed the Purchase Price (the "**Maximum Liability Amount**"), and the aggregate liability of Buyer for indemnification pursuant to Section 12.2 shall not exceed the Maximum Liability Amount.

(c) Except as specified in Section 12.3(f), no claim for indemnification pursuant to this Article 12 shall be made unless the Losses incurred by Sellers or Buyer (as applicable) as a result of a single breach (or, multiple breaches arising from the same facts or circumstances) exceed $50,000 (the "**De Minimis Threshold**"). Notwithstanding the foregoing, no Seller will have any liability to any one or more of the Buyer Indemnified Parties until the aggregate amount payable by Sellers to the Buyer Indemnified Parties in respect of all such Losses sustained by such Buyer Indemnified Parties exceeds $1,600,000 (the "**Basket Amount**"), in which case the Sellers will be obligated to indemnify the Buyer Indemnified Parties for the aggregate amount of all such Losses, regardless of the De Minimis Threshold.

(d) Neither Sellers nor Buyer shall have any obligation or liability under Section 12.1 or Section 12.2, respectively, with respect to any Losses that are caused, contributed to or exacerbated by the actions of Buyer Indemnified Parties (in the case of Sellers' indemnification obligations and liabilities) or Seller Indemnified Parties (in the case of Buyer's indemnification obligations and liabilities). Any exclusion, recovery or offset contemplated by the immediately preceding sentence shall reduce the amount of Losses incurred by any Indemnified Party for all purposes of this Agreement, including Section 12.3(c).

(e) After Closing, except for any nonmonetary, equitable relief to which either of the parties hereto may be entitled and except for the rights and remedies to which either of the parties hereto may be entitled based on a claim against the other for fraud in connection with the execution and delivery of this Agreement or the consummation of the transactions contemplated hereby, the rights and remedies set forth in this Article 12 shall constitute the sole and exclusive rights and remedies of the parties hereto under or with respect to the subject matter of this Agreement.

(f) Notwithstanding anything contained in this Agreement to the contrary, the limitations on recovery of Losses set forth in this Section 12.3 shall not apply to reduce the obligation of Sellers to (i) make payments or deliver checks or funds under Section 10.8, or (ii) indemnify the Buyer Indemnified Parties under Section 12.1(ii), Section 12.1(iii) or 12.1(v). It is the intent of the parties that any payment required to be made pursuant to such sections shall not be limited by this Section 12.3.

12.4 Notice and Control of Litigation.

(a) Notice of Asserted Liability. As soon as is reasonably practicable after a Seller Indemnified Party or a Buyer Indemnified Party becomes aware of any direct or third party claim that such party has under this Article 12 that may result in Losses for which such party is entitled to indemnification hereunder (a "**Liability Claim**"), such party (the "**Indemnified Party**") shall give notice of such Liability Claim (a "**Claims Notice**") to the other party (the "**Indemnifying Party**"). A Claims Notice must describe the Liability Claim in reasonable detail and must indicate the amount, calculated in good faith and to the extent feasible, of the Losses that have been or may be suffered by the Indemnified Party. No delay in or failure to give a Claims Notice by the Indemnified Party to the Indemnifying Party pursuant to this Section 12.4(a) will adversely affect any of the other rights or remedies that the Indemnified Party has under this Agreement or alter or relieve the Indemnifying Party of its obligation to indemnify the Indemnified Party to the extent that such delay or failure has not materially prejudiced the Indemnifying Party.

(b) Opportunity to Defend. The Indemnifying Party has the right, exercisable by written notice to the Indemnified Party within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12, to assume and conduct the defense of such Liability Claim in accordance with the limits set forth in this Agreement with counsel selected by the Indemnifying Party and reasonably acceptable to the Indemnified Party, provided that the (i) defense of such Liability Claim by the Indemnifying Party will not, in the reasonable judgment of the Indemnified Party, have a material adverse effect on the Indemnified Party; (ii) the Liability Claim solely seeks (and continues to seek) monetary damages; (iii) the Liability Claim does not include criminal charges; and (iv) the Indemnifying Party expressly acknowledges in writing its responsibility for all Losses relating to such Liability Claim (the conditions set forth in clauses (i) through (iv) are, collectively, the "**Litigation Conditions**"). If the Indemnifying Party does not assume the defense of a Liability Claim in accordance with this Section 12.4(b) within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12 the Indemnified Party may continue to defend the Liability Claim. The Indemnifying Party or the Indemnified Party, as the case may be, has the right to participate in (but not control), at its own expense, the defense of any Liability Claim that the other is defending as provided in this Agreement. The Indemnifying Party, if it has assumed the defense of any Liability Claim as provided in this Agreement, may, with the prior written consent of the Indemnified Party, not to be unreasonably withheld, consent to a settlement of, or the entry of any judgment arising from, any such Liability Claim; provided, however, that the Indemnifying Party may not consent to any such settlement or judgment to the extent that any such settlement or judgment (I) does not include as an unconditional term thereof the giving by the claimant or

the plaintiff to the Indemnified Party of a complete and irrevocable release from all liability in respect of such Liability Claim, (II) grants any injunctive or equitable relief or (III) may reasonably be expected to have an adverse effect on the affected business of the Indemnified Party. The Indemnified Party has the right to settle any Liability Claim, the defense of which has not been assumed by the Indemnifying Party.

(c) Jurisdiction; Process. Each party consents to the non-exclusive jurisdiction of any court in which a Proceeding is brought by another Person not party to this Agreement against any Indemnified Party for purposes of any claim that such Indemnified Party may have under this Agreement with respect to the Proceeding or the matters alleged therein. Each party consents and agrees that process may be served on it with respect to such a claim anywhere in the United States of America.

ARTICLE 13. GENERAL

13.1 Choice of Law. THE PARTIES AGREE THAT THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF CONNECTICUT, REGARDLESS OF LAWS THAT MIGHT OTHERWISE GOVERN UNDER APPLICABLE PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

13.2 Assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns. No party may assign, delegate or otherwise transfer its rights and obligations under this Agreement; provided, however, Buyer has the right to assign, delegate or otherwise transfer, in whole or in part, its rights and obligations under this Agreement to any of its Affiliates. Notwithstanding the foregoing, to the extent that Buyer assigns, delegates or otherwise transfer any of its rights and obligations to any of its Affiliates, Buyer shall remain liable for the performance of all such rights and obligations in accordance with the terms of this Agreement.

13.3 Cost of Transaction. Except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, whether or not the transactions contemplated hereby shall be consummated and except as otherwise provided herein, the parties agree as follows: (a) Sellers shall pay the fees, expenses and disbursements of Sellers and their agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing the consummation of such transaction; and (b) Buyer shall pay: (i) the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing consummation of such transaction; (ii) conveyance taxes due in connection with the Deeds; (iii) prorations pursuant to Section 9.4(c); (iv) the cost of the Owner's Title Policy and any endorsements thereto; (v) the cost of recording the Deeds to the Owned Real Property; (vi) Title Company Escrow Agent's fee; (vii) survey costs; and (viii) all other costs and expenses associated with the transactions contemplated by this Agreement not otherwise expressly set forth in this Section 13.3. Each party shall be responsible for their respective filing fees associated with the Hart-Scott-Rodino Act. Notwithstanding the foregoing and except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, Buyer and Sellers have agreed to bear the fees and expenses of jointly retained consultants as set forth on Exhibit K.

13.4 Notice. Any notice, demand or communication required, permitted or desired to be given hereunder shall be in writing and deemed effectively given when personally delivered in hand, or when received if sent by a nationally recognized overnight delivery service, addressed as follows:

Buyer or YNHHS:

Marna P. Borgstrom
President and Chief Executive Officer
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

cc (which shall not constitute notice):

William J. Aseltyne
Senior Vice President and General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Any Seller:

Christopher M. O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System, Inc./Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

cc (which shall not constitute notice):

Janeanne C. Lubin-Szafranski, Esq.
Vice President/General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511-4405

Jeffrey L. Heidt, Esq.
Verrill Dana, LLP
One Boston Place, Suite 2330
Boston, MA 02108

or to such other address, and to the attention of such other person or officer, as any party may designate. Receipt of a courtesy copy shall not be necessary in order for the notice, demand or communication to be deemed to have been effectively given.

13.5 Severability. In the event any term or other provision of this Agreement is held by any court or other tribunal of competent jurisdiction to be invalid, illegal or unenforceable for any reason and 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, and enforceable in accordance with its terms so long as the

economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adversely to any party.

13.6 Gender, Number and Inferences. 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. 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, any party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such party.

13.7 Divisions and Headings. The division of this Agreement into articles and sections 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.

13.8 No Third-Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of the parties hereto and their respective permitted successors or 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, including but not limited to a Sponsoring Organization, any current or former employee of the Sellers, or any labor organization representing any of the Sellers' current or former employees.

13.9 Entire Agreement. Unless the context clearly otherwise requires, as used herein, the term "Agreement" means this Agreement, the Exhibits hereto and the Disclosure Schedules, as supplemented in accordance with Section 5.15. This Agreement and the agreements referenced as Exhibits to this Agreement supersede and constitute the entire agreement existing between the parties with respect the subject matter hereof and thereof, and no party shall be entitled to benefits other than those specified herein or therein. As between the parties, no oral statement or prior written material not specifically incorporated herein shall be of any force and effect. The parties specifically acknowledge that in entering into this Agreement and the agreements referenced as Exhibits to this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and the agreements referenced as Exhibits to this Agreement and no others. This Agreement may be amended, supplemented or modified only by an agreement in writing signed by each of the parties hereto. All Exhibits attached to or delivered in connection with this Agreement are integral parts of this Agreement as if fully set forth herein.

13.10 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.

13.11 Amendment. This Agreement may not be amended or modified except with the written consent of all of the parties hereto and compliance herewith may not be waived except in writing by the party waiving compliance.

13.12 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 other provision hereof. No waiver of any provision or

condition of this Agreement shall be valid unless in writing signed by such party or operational by the terms of this Agreement.

13.13 Other Interpretative Matters. In this Agreement, unless the context otherwise requires: (a) words such as "herein" and "hereof" refer to the entire Agreement and not to a particular article or section of this Agreement; (b) references to articles and sections are references to articles and sections of this Agreement; and (c) references to any party to this Agreement shall include references to its successors and permitted assigns. ALL RELEASES, DISCLAIMERS, LIMITATIONS ON LIABILITY AND INDEMNITIES SET FORTH IN THIS AGREEMENT SHALL APPLY AND OPERATE IN ACCORDANCE WITH THEIR RESPECTIVE TERMS NOTWITHSTANDING ANY SOLE, JOINT AND/OR CONCURRENT NEGLIGENCE, STRICT LIABILITY OR OTHER FAULT OR BASIS FOR LIABILITY OF THE PARTY WHOSE LIABILITY IS RELEASED, DISCLAIMED, LIMITED OR INDEMNIFIED. The Disclosure Schedule referred to herein is hereby incorporated in and made a part of this Agreement as if set forth in full herein.

13.14 Reproduction of Documents. This Agreement and all documents relating thereto, including, without limitation, (a) consents, waivers, amendments and modifications that may hereafter by executed, (b) the documents delivered at Closing and (c) other written information previously or hereafter furnished to any party, may be reproduced by such party by any photographic, photostatic, microfilm, micro-card, miniature photographic or other similar process and the parties may destroy any original documents so reproduced. The parties agree and stipulate that any such reproduction shall be admissible in evidence as the original itself in any Litigation or Proceeding (whether or not the original is in existence and whether or not such reproduction was made by any party in the regular course of business) and that any enlargement, facsimile or further reproduction of such reproduction shall likewise be admissible in evidence.

13.15 Waiver of Jury Trial. Each of the parties hereto hereby knowingly, voluntarily and intentionally, after opportunity for consultation with independent counsel, waives its right to trial by jury in any action or proceeding to enforce or defend any rights or obligations under this Agreement. No party hereto will seek to consolidate any such action in which a jury trial has been waived with any other action in which a jury trial has not been or cannot be waived. The provisions of this Section 13.15 have been fully negotiated by the parties hereto, and these provisions shall be subject to no exceptions. No party hereto has in any way agreed with or represented to any other party that the provisions of this Section 13.15 will not be fully enforced in all instances; and this Section 13.15 is a material inducement for the Buyer to enter into this Agreement.

13.16 Time of the Essence. The parties agree that time is of the essence in the execution and performance of this Agreement.

[*Remainder of page intentionally left blank. Signature pages follow.*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers or directors, as the case may be, all as of the Effective Date.

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

By: _____
Name: _____
Title: _____

SAINT REGIS HEALTH CENTER, INC. D/B/A SISTER ANNE VIRGINIE GRIMES HEALTH CENTER

By: _____
Name: _____
Title: _____

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC. D/B/A AFFILIATED PHYSICIANS OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

DEPAUL HEALTH SERVICES CORPORATION, INC.

By: _____
Name: _____
Title: _____

SAINT RAPHAEL FOUNDATION, INC.

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HEALTH SERVICES CORPORATION D/B/A YALE NEW HAVEN HEALTH SYSTEM

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: _____
Title: _____

YALE NEW HAVEN HEALTH

November 7, 2012

Lisa Davis, MBA, BSN, RN
Deputy Commissioner
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06137

RECEIVED
NOV 13 2012
DEPT OF PUBLIC HEALTH
OFFICE OF THE COMMISSIONER

Re: Docket Number 12-31747-CON
"Yale-New Haven Hospital's Acquisition of the Hospital of Saint Raphael Healthcare System, Inc."

Dear Deputy Commissioner Davis:

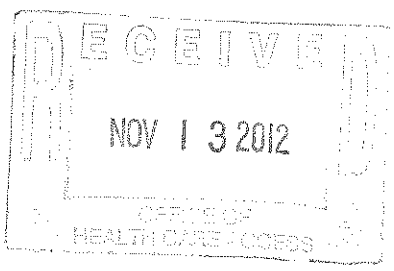
In accordance with the agreed upon settlement to the above referenced Certificate of Need, please find attached a signed unredacted copy of the Asset Purchase Agreement, which was provided as Attachment 3 to the CON application. It is our understanding that this unredacted copy will be entered as part of the permanent record in this proceeding.

Thank you very much for your attention to this matter.

Gayle Capozzalo
Executive Vice President
Strategy & System Development

GC/lm/eg

RECEIVED
NOV 13 2012
Department of Public Health
Office of the Commissioner



ASSET PURCHASE AGREEMENT

BY AND AMONG

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

HOSPITAL OF SAINT RAPHAEL

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC.

DEPAUL HEALTH SERVICES CORPORATION, INC.

SAINT RAPHAEL FOUNDATION, INC.

SAINT REGIS HEALTH CENTER, INC.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

YALE-NEW HAVEN HOSPITAL, INC.

Dated as of September 26, 2011

TABLE OF CONTENTS

Page

ARTICLE 1. DEFINITIONS 2
ARTICLE 2. PURCHASE AND SALE OF ASSETS 13
2.1 Purchase and Sale of Assets 13
2.2 Assumption of Liabilities 15
2.3 Purchase Price 15
2.4 Title Company Escrow 15
ARTICLE 3. REPRESENTATIONS AND WARRANTIES OF SELLERS 16
3.1 Organization; Authority 16
3.2 Powers; Consents; Absence of Conflicts 16
3.3 Absence of Certain Changes 16
3.4 Compliance with Laws 17
3.5 Licenses 18
3.6 Accreditation; Government Reimbursement Programs 18
3.7 Medical Staff Matters 19
3.8 Contracts and Leases 19
3.9 Real Property; Condition of Facilities 20
3.10 Personal Property 22
3.11 Labor and Employee Matters 22
3.12 Litigation or Proceedings 24
3.13 Special Funds 24
3.14 Tax Matters 25
3.15 Environmental Matters 25
3.16 Insurance 26
3.17 Brokers 27
3.18 Solvency 27
3.19 Financial Statements 27
3.20 Assets; Sufficiency of Assets 27
3.21 Equipment 28
3.22 Intellectual Property 28
3.23 Software 28

TABLE OF CONTENTS
(continued)

Page

3.24	Absence of Default	28
3.25	Charitable Funds	28
3.26	Bank Accounts	29
3.27	No Undisclosed Liability	29
3.28	No Untrue or Inaccurate Representations or Warranties	29
ARTICLE 4.	REPRESENTATIONS AND WARRANTIES OF BUYER	29
4.1	Organization; Authority	29
4.2	Powers; Consents; Absence of Conflicts	29
4.3	Brokers	30
ARTICLE 5.	CERTAIN COVENANTS OF SELLERS	30
5.1	Information	30
5.2	Operations	31
5.3	Negative Covenants	32
5.4	Governmental Approvals	33
5.5	Charitable Funds	34
5.6	Church Approvals	34
5.7	Closing Conditions	34
5.8	Payment of Obligations	34
5.9	No-Shop Clause	35
5.10	Transfer of Assets	35
5.11	Real Property	35
5.12	Insurance Coverage	35
5.13	Bankruptcy	35
5.14	Pharmacy License	36
5.15	Disclosure Supplements	36
5.16	Continuation of Group Health Plan Coverage and COBRA Continuation Coverage	37
5.17	Notice of Breach	37
ARTICLE 6.	CERTAIN COVENANTS OF BUYER	37
6.1	Governmental Approvals	37

TABLE OF CONTENTS
(continued)

Page

6.2 Church Approvals 38
6.3 Closing Conditions 38
6.4 Notice of Breach 38
6.5 Real Property Reports 38
ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER 38
7.1 Representations/Warranties 38
7.2 Covenants 39
7.3 Officers' Certificate 39
7.4 Litigation or Proceedings 39
7.5 Governmental Approvals 39
7.6 Church Approvals 39
7.7 Closing Deliveries 39
7.8 Third Party Consents 39
7.9 Satisfaction of Retained Liabilities 39
7.10 Charitable Funds 40
7.11 Grimes Center Medical Rate 40
7.12 Solvency Upon Closing 40
ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS 41
8.1 Representations/Warranties 41
8.2 Covenants 41
8.3 Officers' Certificate 41
8.4 Litigation or Proceedings 41
8.5 Governmental Approvals 41
8.6 Closing Deliveries 41
8.7 Church Approvals 41
ARTICLE 9. CLOSING 42
9.1 Closing 42
9.2 Actions of Sellers at Closing 42
9.3 Actions of Buyer at Closing 44
9.4 Close of Title Company Escrow 44

TABLE OF CONTENTS
(continued)

Page

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS 47
10.1 Operations Transition 47
10.2 Preservation of Catholic Heritage 50
10.3 Preservation and Access to Records After Closing 52
10.4 Employee Matters 52
10.5 Tax Matters 54
10.6 Sellers' Cost Reports 55
10.7 Allocation of Purchase Price 55
10.8 Patient Receivables 55
10.9 Return of Payments 56
10.10 Title and Survey Contingency 56
10.11 Due Diligence Contingency 57
10.12 Confidentiality 58
10.13 Tail Insurance 59
10.14 Press Releases 59
10.15 Compliance with the Transfer Act 59
10.16 Post Effective Time Operations 60
10.17 Post Effective Time Negative Covenants 60
10.18 Restrictive Covenants 61
ARTICLE 11. TERMINATION 62
11.1 Termination 62
11.2 Effect of Termination 63
11.3 Break-Up Fee and Expense Reimbursement 63
11.4 Conditions for and Payment of Break-Up Fee and Expense Reimbursement 63
11.5 Joint and Several Liability of Sellers for Break-Up Fee and Expense Reimbursement 64
ARTICLE 12. INDEMNIFICATION 64
12.1 Indemnification by Sellers 64
12.2 Indemnification by Buyer 65
12.3 Time and Amount Limitations 65

TABLE OF CONTENTS
(continued)

Page

12.4 Notice and Control of Litigation 66
ARTICLE 13. GENERAL 67
13.1 Choice of Law 67
13.2 Assignment 67
13.3 Cost of Transaction 67
13.4 Notice 68
13.5 Severability 69
13.6 Gender, Number and Inferences 69
13.7 Divisions and Headings 69
13.8 No Third-Party Beneficiaries 69
13.9 Entire Agreement 69
13.10 Counterparts 70
13.11 Amendment 70
13.12 Waiver of Breach 70
13.13 Other Interpretative Matters 70
13.14 Reproduction of Documents 70
13.15 Waiver of Jury Trial 70
13.16 Time of the Essence 71

EXHIBITS

Exhibit A	Facilities
Exhibit B	Assignment and Assumption of Leases Agreement
Exhibit C	Bill of Sale, Assignment and Assumption Agreement
Exhibit D	Caritas SPA
Exhibit E	Deeds
Exhibit F	Lukan SPA
Exhibit G	Foundation Liquidation Plan
Exhibit H	[Not Utilized]
Exhibit I	A – Wind Down Services Agreement
	B – Transition Services Agreement
Exhibit J	Title Insurance
Exhibit K	Jointly Retained Consultant Fees
Exhibit L	Purchase Price Payment Schedule
Exhibit M	Form of Estoppel Certificates
Exhibit N	Wind Down Plan
Exhibit O	Captives' Net Assets Certificate

ASSET PURCHASE AGREEMENT

THIS ASSET PURCHASE AGREEMENT (this "**Agreement**") is made and entered into as of September 26, 2011 (the "**Effective Date**"), by and among: (a) Saint Raphael Healthcare System, Inc., a Connecticut nonstock corporation ("**SRHS**"), (b) Hospital of Saint Raphael, a Connecticut nonstock corporation ("**HSR**"), (c) Saint Raphael Healthcare System Affiliated Physicians, Inc. d/b/a Affiliated Physicians of Saint Raphael, a Connecticut nonstock corporation ("**SRHSAP**"), (d) DePaul Health Services Corporation, Inc., a Connecticut nonstock corporation ("**DHSC**"), (e) Saint Raphael Foundation, Inc., a Connecticut nonstock corporation (the "**Foundation**"), (f) Saint Regis Health Center, Inc. d/b/a Sister Anne Virginie Grimes Health Center, a Connecticut nonstock corporation ("**Grimes Center**" and each of SRHS, HSR, SRHSAP, DHSC, Foundation and Grimes Center, a "**Seller**" and, collectively, the "**Sellers**"), Yale-New Haven Health Services Corporation d/b/a Yale New Haven Health System, a Connecticut nonstock corporation ("**YNHHS**") and Yale-New Haven Hospital, Inc., a Connecticut nonstock corporation or its designee in accordance with Section 13.2 ("**Buyer**").

RECITALS

A. SRHS is the tax-exempt parent company of the Sellers;

B. Sellers, through the operation of the Hospital (as defined below) and the other health care facilities and businesses identified on Exhibit A hereto and all of their health care related businesses operating in the State of Connecticut (together with the Hospital, the "**Facilities**"), are in the business of, and are dedicated to, assuring the promotion of health and the provision of the continuum of health care services, ranging from wellness programs to acute care and long-term care (the "**Business**");

C. HSR, under the control of SRHS, owns and is engaged in the business of operating, a 511-bed general acute care community and teaching hospital facility in New Haven, Connecticut (the "**Hospital**");

D. YNHHS, through its several delivery networks, including Buyer, provides comprehensive, cost-effective, advanced patient care, educates health professionals and advances clinical care in affiliation with the Yale University School of Medicine;

E. Buyer owns and is in the business of operating a 966-bed tertiary medical center in New Haven, Connecticut that provides comprehensive, multidisciplinary, family-focused care and is the primary teaching hospital for the Yale University School of Medicine;

F. HSR desires to sell to Buyer, and Buyer desires to purchase from HSR, certain of the assets used by HSR in the operation of the Hospital on the terms and subject to the conditions set forth in this Agreement.

G. Sellers desire to sell to Buyer, and Buyer desires to purchase from Sellers, certain of the assets used by Sellers in the operation of the Business on the terms and subject to the conditions set forth in this Agreement; and

H. Sellers desire to assign to Buyer, and Buyer desires to assume from Sellers, certain liabilities of Sellers incurred in the operation of the Business on the terms and subject to the conditions set forth in this Agreement.

AGREEMENT

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1. DEFINITIONS

The following terms used in this Agreement shall have the respective meanings ascribed to them in this Article 1:

"**Additional Continuing Employees**" has the meaning set forth in Section 10.4(c).

"**Additional Employees**" has the meaning set forth in Section 10.4(c).

"**Affiliate**" means, as to the entity in question, any Person that directly or indirectly controls, is controlled by, or is under common control with, the entity in question; and the term "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, membership interests, by contract, the power to appoint directors or trustees or otherwise.

"**Agreement**" has the meaning set forth in the introductory paragraph.

"**Alternative Transaction**" means any of the following transactions with a Person other than Buyer, or an Affiliate thereof, involving any of the Sellers or any Affiliates of the Sellers: (a) sale, transfer or other disposition of the ownership or direct or indirect control of any of the Sellers or any of their Affiliates; (b) merger, reorganization, consolidation, affiliation or other business combination or similar transaction involving any of the Sellers or their Affiliates; (c) sale, lease, exchange, transfer or other disposition of a substantial portion of the assets or the Purchased Assets of any of the Sellers or their Affiliates; or (d) agreement with any Person or organization (other than Buyer and its Affiliates) with respect to any ownership or control interest in any Seller or the management or operation of the Purchased Assets or any material portion thereof (other than any employment contract entered into with any management employee in the ordinary course of business). For the avoidance of doubt, an Alternative Transaction shall include any transactions arising under a sale authorized pursuant to title 11 of the United States Code, a plan of reorganization, plan of liquidation or other plan of arrangement under applicable law, in each case, that provides for the sale or restructuring of all, substantially all or any substantial portion of the assets of the Business.

"**Applicable Law**" means any constitution, law, ordinance, principle of common law, code, statute, act, treaty or order of general applicability of any Governmental Authority, including the rules and regulations promulgated thereunder.

"**Assignment and Assumption of Leases**" means an assignment and assumption of leases agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit B.

"**Assumed Contracts**" means the Contracts listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Leases**" means the Leases listed in Section 2.1(a) of the Disclosure Schedule.

"**Assumed Liabilities**" has the meaning set forth in Section 2.2(a).

"**Balance Sheet Date**" means March 31, 2011.

"**Bankruptcy Code**" has the meaning set forth in Section 5.13.

"**Bargaining Unit Employees**" means the employees of HSR and Grimes Center currently represented by the Teamsters.

"**Basket Amount**" has the meaning set forth in Section 12.3(c).

"**Benefit Liabilities**" means the liabilities with respect to the frozen accrued pension benefits under the Church Plan and the liabilities incurred by HSR under its post-retirement medical benefits plan.

"**Benefit Plans**" has the meaning set forth in Section 3.11(a).

"**Bid Protection Motion**" has the meaning set forth in Section 5.13.

"**Bid Protection Order**" has the meaning set forth in Section 5.13.

"**Bill of Sale, Assignment and Assumption Agreement**" means a bill of sale, assignment and assumption agreement, dated as of the Closing Date, by and between each Seller, as applicable, and Buyer substantially in the form of Exhibit C.

"**Break-Up Fee**" has the meaning set forth in Section 11.3(a).

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

"**Buyer**" has the meaning set forth in the introductory paragraph.

"**Buyer Effect**" means a material adverse effect on the ability of Buyer to perform its obligations under this Agreement or to consummate the transactions contemplated hereby.

"**Buyer Indemnified Parties**" has the meaning set forth in Section 12.1.

"**Caritas**" has the meaning set forth in Section 5.12.

"**Caritas SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit D.

"**Charitable Funds**" has the meaning set forth in Section 5.5.

"**Church**" has the meaning set forth in Section 5.6.

"**Church Approvals**" has the meaning set forth in Section 5.6.

"**Church Plan**" means The Retirement Plan for Employees of The Hospital of Saint Raphael, a frozen defined benefit pension plan that qualifies as a church plan described in Section 414(e) of the Code.

"**Claims**" has the meaning set forth in Section 10.11(d).

"**Claims Notice**" has the meaning set forth in Section 12.4(a).

"**Close of Escrow**" has the meaning set forth in Section 9.4(a).

"**Closing**" has the meaning set forth in Section 9.1.

"**Closing Date**" has the meaning set forth in Section 9.1.

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

"**Combined Medical Staff**" has the meaning set forth in Section 10.1(b).

"**Combined Medical Staff Bylaws**" has the meaning set forth in Section 10.1(b).

"**Commitment Period**" means the period of time beginning at the Effective Time and continuing until the five-year anniversary of the Effective Time.

"**CON Filing**" means the filings, application and process by and pursuant to which Certificate of Need authorization is requested from the State of Connecticut Office of Health Care Access and any other Governmental Authority with respect to this Agreement and the transactions contemplated hereunder.

"**Confidential Information**" has the meaning set forth in Section 10.12.

"**Continuing Employees**" means, collectively, the Additional Continuing Employees, the Continuing Bargaining Unit Employees and the Continuing Non-Bargaining Unit Employees.

"**Continuing Bargaining Unit Employees**" has the meaning set forth in Section 10.4(b).

"**Continuing Non-Bargaining Unit Employees**" has the meaning set forth in Section 10.4(a).

"**Contracts**" means all rights, benefits and interests of any Seller in, to and under all contracts relating to the conduct of the Business, including, without limitation, physician agreements, agreements with third party payors, joint venture or partnership agreements, supply purchase agreements, employment agreements, tenant leases, equipment leases, equipment maintenance agreements, agreements with municipalities and labor organizations, settlement

agreements, loan agreements, bonds, mortgages, liens or other security agreements, but excluding the Leases.

"**Cost Reports**" means all cost and other reports related to the Sellers filed pursuant to the requirements of the Government Reimbursement Programs for cost-based payments or reimbursement due to or claimed by the Sellers from the Government Reimbursement Programs or their fiscal intermediaries or payor agents, including all Cost Report receivables or payables and all related appeals and appeal rights and other forms or claims filed or submitted by the Sellers to the Government Reimbursement Programs or their fiscal intermediaries or payor agents for payment or reimbursement due to or claimed by the Sellers on a fee-for-service, prospective payment, fee schedule or other similar basis.

"**Deeds**" means the special warranty deeds for each parcel of the Owned Real Property, dated as of the Closing Date, executed by each Seller, as applicable, substantially in the form of Exhibit E.

"**DHSC**" has the meaning set forth in the introductory paragraph.

"**De Minimis Threshold**" has the meaning set forth in Section 12.3(c).

"**Directives**" means Catholic ethical tradition as referenced in the Ethical and Religious Directives for Catholic Health Care Services (Fifth Edition).

"**Disclosure Schedule**" means the disclosure schedule, dated as of the date hereof, that is attached hereto and incorporated in and made a part of this Agreement.

"**Effective Date**" has the meaning set forth in the introductory paragraph.

"**Effective Time**" has the meaning set forth in Section 9.1.

"**Environmental Laws**" means all statutes, laws, rules, regulations, codes, ordinances, standards, guidelines, authorizations and orders of any federal, state or local public agency or authority having jurisdiction over the Purchased Assets that deal with Solid Waste, toxic or hazardous waste, wastewater discharges, water quality, drinking water, air emissions, air quality, Hazardous Substances (including Medical Hazards), lead-based paint or employee health, safety or community right-to-know.

"**Environmental Permits**" has the meaning set forth in Section 3.15(a).

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

"**Expense Reimbursement**" has the meaning set forth in Section 11.3(b).

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

"**Final Order**" means an order or judgment of the bankruptcy court, or other court of competent jurisdiction, as entered on the docket in a Seller's chapter 11 case or the docket of any other court of competent jurisdiction, that has not been reversed, stayed, modified or amended,

and as to which the time to appeal or petition for certiorari or move for a new trial, reargument or rehearing has expired, and as to which no appeal or petition for certiorari or other proceeding for a new trial, reargument or rehearing that has been timely taken is pending, or as to which any appeal that has been taken or any petition for certiorari that has been timely filed has been withdrawn or resolved by the highest court to which the order or judgment was appealed or from which certiorari was sought or the new trial, reargument or rehearing shall have been denied or resulted in no modification of such order.

"**Final Order Exception**" shall mean any of the following: (a) Buyer and Sellers shall have consummated the transactions contemplated in this Agreement; (b) Buyer shall have, in its sole and absolute discretion, waived in writing the requirement that the Sale Order shall have become a Final Order; or (c) any appeal from the Sale Order that does not (i) involve an appeal by any party or parties in interest as to which the matter in dispute in the appeal with respect to that party, or in the aggregate by all parties taking an appeal, is in excess of $3,000,000, (ii) involve an appeal by the United States Trustee or any regulatory or governmental agency involving a matter in dispute in the appeal that could prevent consummation of or result in the unwinding of the transactions contemplated by this Agreement or (iii) in any way threaten or challenge Buyer's protection under Section 363(m) of the Bankruptcy Code.

"**Financial Advisor**" has the meaning set forth in Section 7.12(b).

"**Financial Certificate**" has the meaning set forth in Section 9.2(j).

"**Financial Statements**" has the meaning set forth in Section 3.19.

"**Foundation**" has the meaning set forth in the introductory paragraph.

"**GAAP**" means generally accepted accounting principles in the United States.

"**Good Standing**" with respect to individuals employed by Sellers shall mean that such individual is legally eligible to work in the State of Connecticut and, within the 12 months immediately preceding the Effective Time, the individual has (a) not received a written warning or higher-level of discipline pursuant to Sellers' progressive disciplinary process, (b) not been placed on a performance improvement plan or similar process, and (c) received at least a satisfactory performance evaluation on the last such evaluation. In offering employment to Sellers' employees, Buyer shall reasonably determine their good standing based on their official personnel file where the foregoing information is retained by Sellers.

"**Government Reimbursement Programs**" means the Medicare program, the Connecticut Medicaid program, the federal TRICARE program, and any other, similar or successor federal, state or local health care payment programs with or sponsored by Governmental Authorities, including without limitation, current federal and Connecticut disproportionate share "DSH" reimbursement or adjustments applicable to Sellers, and federal reimbursement or adjustments for or related to the Sellers' graduate medical education programs.

"**Governmental Authority**" means any federal, state, local or any foreign governmental unit, agency, commission or authority.

"**Guarantee**" by any Person means any obligation, contingent or otherwise, of such Person directly or indirectly guaranteeing or otherwise supporting in whole or in part the payment of any Indebtedness or other obligation of any other Person and, without limiting the generality of the foregoing, any obligation, direct or indirect, contingent or otherwise, of such Person (a) to purchase or pay (or advance or supply funds for the purchase or payment of) such Indebtedness or other obligation of such other Person (whether arising by virtue of partnership arrangements, by agreements to keep well, to purchase assets, goods, securities or services, to take or pay, or to maintain financial statement conditions or otherwise) or (b) entered into for the purpose of assuring in any other manner the obligee of such Indebtedness or other obligations of the payment of such Indebtedness or to protect such obligee against loss in respect of such Indebtedness (in whole or in part). The term "Guarantee" used as a verb has a correlative meaning.

"**Hart-Scott-Rodino Act**" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations promulgated thereunder.

"**Hazardous Substances**" means asbestos, radioactive substances, radon, PCBs, petroleum, Medical Hazards and any chemical, substance or material that is listed or regulated under Environmental Laws as a hazardous or toxic substance, material, chemical substance, pollutant, waste, pesticide or fungicide or that under applicable Environmental Laws requires special handling or notification of any federal, state or local governmental agency or authority in its collection, storage, treatment, recycling or disposal.

"**Healthcare Laws**" means, collectively, any and all federal, state or local statutes, rules, regulations and administrative manuals, orders, guidelines and requirements of law of any Governmental Authority governing the licensure of or regulating healthcare providers, professionals, facilities or payors or otherwise governing or regulating the provision of, or payment for, healthcare services, the sale of controlled substances or other pharmaceuticals, medical devices or supplies and the like. Without limiting the generality of the foregoing, Healthcare Laws include, without limitation, state corporate practice of medicine laws, statutes and regulations, Section 1128B(b) of the Social Security Act, as amended, 42 U.S.C. Section 1320a 7(b) (Criminal Penalties Involving Medicare or State Health Care Programs), commonly referred to as the "Federal Anti-Kickback Statute," Section 1877 of the Social Security Act, as amended, 42 U.S.C. Section 1395nn and related regulations (Prohibition Against Certain Referrals), commonly referred to as "Stark Law", the federal False Claims Act, 31 U.S.C. Section 3729 et seq., corresponding state laws and other state and federal fraud and abuse laws.

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

"**HSR**" has the meaning set forth in the introductory paragraph.

"**HSR Financing Agreements**" means the agreements associated with the CHEFA Hospital of Saint Raphael Series H, L and M bond financing and the Master Financing Agreement, dated January 1, 2006, by and among Chase Equipment Leasing Inc., State of Connecticut Health and Education Facilities Authority and HSR.

"**Improvements**" means means all buildings, structures, parking areas, sidewalks, landscaping and other improvements located on the Owned Real Property.

"**Indebtedness**" of any Person means either (a) any liability of such Person (i) for borrowed money (including the current portion thereof), (ii) under any reimbursement obligation relating to a letter of credit, bankers' acceptance or note purchase facility, (iii) evidenced by a bond, note, debenture or similar instrument (including a purchase money obligation), (iv) for the payment of money relating to any lease that is required to be classified as a capitalized lease obligation in accordance with GAAP, (v) for all or any part of the deferred purchase price of property or services (other than trade or accounts payables), including any "earnout" or similar payments or any noncompete payments, (vi) under interest rate swap, hedging or similar agreements or (vii) for any credit card payables with respect to charges having a transaction date of 30 days or more prior to the Closing Date or related to non-business related activities; or (b) any liability of others described in the preceding clause (a) that such Person has Guaranteed, that is recourse to such Person or any of its assets or that is otherwise its legal liability or that is secured in whole or in part by the assets of such Person. For purposes of this Agreement, "Indebtedness" includes (A) any and all accrued interest, success fees, prepayment premiums, make whole premiums or penalties and fees or expenses actually incurred (including attorneys' fees) associated with the prepayment of any Indebtedness, (B) all "cut" but uncashed checks issued by any Seller that are outstanding as of the Closing Date, (C) cash, book or bank account overdrafts and (D) any and all amounts owed by any Seller to any of its Affiliates. The Financial Certificate sets forth the entire amount of Sellers' Indebtedness (indicating the amount of each individual component of Indebtedness and the Person to whom such Indebtedness is owed).

"**Indemnified Party**" has the meaning set forth in Section 12.4(a).

"**Indemnifying Party**" has the meaning set forth in Section 12.4(a).

"**Intellectual Property Rights**" has the meaning set forth in Section 3.22.

"**IRCA**" has the meaning set forth in Section 3.11(e).

"**Key Employee**" means, with respect to each Seller, the president and/or chief executive officer and his direct reports and the chief financial officer and his assistant vice presidents.

"**Knowledge**" shall, with respect to the particular provision it qualifies, mean (a) all matters with respect to which any such Person or its Affiliates have received written notice, or (b) with respect to any Seller, (i) the actual knowledge of such Seller's president and/or chief executive officer and chief financial officer, including, with respect to each, the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer or chief financial officer, as the case may be, or (ii) the actual knowledge of any member of the congregation of SOC appointed to the governing board or any office of such Seller.

"**Leased Real Property**" has the meaning set forth in Section 3.9(a).

"**Leases**" means all rights, benefits and interests of any Seller, as the case may be, as the lessor, lessee or sublessee, as the case may be, in, to or under any lease or sublease relating to real property or the conduct of the Business.

"**Liability Claim**" has the meaning set forth in Section 12.4(a).

"**Lien**" **or** "**Encumbrance**" means any lien, pledge, claim, liability, interest, restriction or other encumbrance.

"**Litigation or Proceedings**" has the meaning set forth in Section 3.12.

"**Litigation Conditions**" has the meaning set forth in Section 12.4(b).

"**Loss**" or "**Losses**" means any debt, loss, damage, diminution in value, adverse claim, fines, penalties, liability or obligation (whether direct or indirect, known or unknown, asserted or unasserted, absolute or contingent, accrued or unaccrued, matured or unmatured, determined or determinable, disputed or undisputed, liquidated or unliquidated, or due or to become due, and whether in contract, tort, strict liability or otherwise), and including all costs and expenses relating thereto (including all fees, disbursements and expenses of legal counsel, experts, engineers and consultants and costs of investigation) to the extent not covered by insurance proceeds actually received.

"**Lukan**" has the meaning set forth in Section 5.12.

"**Lukan SPA**" means that certain Stock Purchase Agreement to be entered into by and between SRHS and Buyer prior to Closing, substantially in the form attached hereto as Exhibit F.

"**March 31, 2011 Balance Sheet**" means the balance sheet included in the March 31, 2011 Financial Statements.

"**March 31, 2011 Financial Statements**" has the meaning set forth in Section 3.19.

"**Material Adverse Effect**" means any occurrence, condition, change, development, circumstance, effect, event or fact, occurring after the Effective Date (a "**Matter**"), that individually or in the aggregate, has resulted in, would result in or could reasonably be expected to result in (a) the inability of Sellers to timely and fully perform their obligations under this Agreement or to timely and fully consummate the transactions contemplated hereby; or (b) the inability of Sellers, after giving effect to the transactions contemplated hereby, to satisfy the Retained Liabilities. Any Matter specifically disclosed on the Disclosure Schedules at the Effective Time shall not be deemed to constitute a Material Adverse Effect and shall not be considered in determining whether a Material Adverse Effect has occurred.

"**Material Contracts and Leases**" has the meaning set forth in Section 3.8.

"**Maximum Liability Amount**" has the meaning set forth in Section 12.3(b).

"**Medical Hazards**" means all biological and chemical materials that under applicable Environmental Laws or industry standards are required to be handled in accordance with certain

procedures, and all other materials that may contain or be contaminated with such biological or chemical materials, and all devices or materials that could puncture or cut the skin (including, without limitation, those commonly known as "sharps").

"**Net Assets**" means Total Assets less Total Liabilities.

"**Nonassignable Contract**" has the meaning set forth in Section 2.1(b).

"**Non-Bargaining Unit Employees**" means such employees of HSR and Grimes Center who are not represented by any union or bargaining unit, including the Teamsters.

"**Noncompete Period**" has the meaning set forth in Section 10.18(a).

"**Notice to Tenants**" has the meaning set forth in Section 9.2(q).

"**Owned Real Property**" has the meaning set forth in Section 3.9(a).

"**Patient Receivables**" means accounts receivable of HSR arising from the provision of services, drugs, items and supplies to patients at the Facilities through Closing and relating to Government Reimbursement Programs or other third party payors.

"**Permitted Encumbrances**" means (a) Liens or Encumbrances created by Buyer or securing any indebtedness specifically assumed by Buyer as an Assumed Liability; (b) Liens or Encumbrances for Taxes, assessments or other similar governmental charges which are not due and payable as of the Closing Date; (c) Liens or Encumbrances set forth on Schedule 3.9(a) Part A, and (d) rights of counterparties under Assumed Contracts and Assumed Leases.

"**Person**" means any individual, sole proprietorship, partnership, corporation, limited liability company, limited partnership, joint venture, unincorporated society or association, trust, estate or other entity or organization, or any division of such Person.

"**Personal Property**" means tangible personal property (including, without limitation, equipment, fixtures, vehicles, furniture, tools, furnishings, machinery, instruments, spare parts, supplies, pharmacueticals and inventory).

"**Pharmacy License**" means HSR's license to operate a retail pharmacy issued by the Connecticut Department of Consumer Protection's Commission of Pharmacy.

"**Physician**" means any licensed doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry or chiropractor, or any group, partnership, corporation, of whatever form, made up of one more such persons.

"**Physician Contract**" means any Contract, direct or indirect, including unwritten or unexecuted financial arrangements and agreements, regardless of amount or payment, entered between or among parties, one of which is a Seller or an Affiliate thereof, and the other of which is one or more Physician(s), Physician group(s) and/or other entities owned in whole or in part, by one or more Physicians (or any member of the Immediate Family of a Physician) and/or Physician groups, where one or more Physicians makes Referrals, including, without limitation,

physician employment agreements, medical director agreements, administrative services agreements, professional services agreements, teaching services agreements, preceptorship agreements, call coverage agreements, moonlighting agreements, per-diem services agreements, research agreements, any lease agreement, (including leases of space or equipment), recruitment agreements, income guarantee arrangements, loan agreements, loan guarantee arrangements, billing services agreements, practice support agreements, management services agreements, agreements for the provision of personnel, agreements for the sale or purchase of assets, joint venture arrangements of any structure and risk-sharing or shared-savings agreements. For purposes of this definition "Referral" means a request or order for any item or services, including the request for a consultation with another Physician (and any test or procedure ordered by or performed by or under the supervision of the other Physician), provided to patients. For purposes of this definition, "Immediate Family" means husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister- in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

"**PMA Agreement**" has the meaning set forth in Section 10.4(g).

"**Pre-Closing Tax Period**" means a taxable period or portion thereof that ends on or prior to the Closing Date; if a taxable period begins on or prior to the Closing Date and ends after the Closing Date, then the portion of the taxable period that ends on and includes the Closing Date shall constitute a Pre-Closing Tax Period.

"**Purchase Price**" has the meaning set forth in Section 2.3.

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

"**Real Property**" has the meaning set forth in Section 3.9(a).

"**Real Property Lease**" has the meaning set forth in Section 3.9(a).

"**Rejection Notice**" has the meaning set forth in Section 5.15.

"**Restricted Entities**" has the meaning set forth in Section 10.18(a).

"**Retained Assets**" has the meaning set forth in Section 2.1(c).

"**Retained Liabilities**" has the meaning set forth in Section 2.2(b).

"**Sale Motion**" has the meaning set forth in Section 5.13.

"**Sale Order**" has the meaning set forth in Section 5.13.

"**Section 1060 Allocation**" has the meaning set forth in Section 10.7.

"**Security Agreement**" has the meaning set forth in Section 10.4(g).

"**Seller**" and "**Sellers**" have the meanings set forth in the introductory paragraph.

"**Seller Indemnified Parties**" has the meaning set forth in Section 12.2.

"**Seller Tax Returns**" has the meaning set forth in Section 3.14(b).

"**SOC**" means the Sisters of Charity of Saint Elizabeth, a New Jersey nonprofit corporation.

"**Software**" has the meaning set forth in Section 3.23.

"**Solid Waste**" means any substance deemed under any applicable federal or state law or regulations as waste.

"**Solvent**" or "**Solvency**" means, with respect to the Sellers and each of them: (a) the fair value of the Seller's assets exceeds the fair value of the Seller's liabilities, including contingent liabilities; (b) the Sellers, and each of them, do not have, and are not incurring debts or liabilities beyond the applicable Seller's ability to pay as such debts and liabilities mature; (c) the Sellers are generally able to pay their debts as they become due and payable and are, in fact, paying such debts as they become due and payable; and (d) the Sellers, and each of them, are not engaged in a business or transaction, and are not about to engage in a business or transaction, for which the Sellers' property would constitute unreasonably small capital to carry on each of their businesses as it is then conducted. The amount of contingent liabilities at any time shall be computed as the amount that, in light of all the facts and circumstances existing at the time, represents the amount that can reasonably be expected to become an actual or matured liability.

"**Sponsoring Organization**" means (a) SRHS as the sponsor of the Church Plan or (b) an organization designated and maintained by SRHS that shall be controlled by, or associated with, the Church.

"**SRHS**" has the meaning set forth in the introductory paragraph.

"**SRHSAP**" has the meaning set forth in the introductory paragraph.

"**Tail Insurance Policies**" has the meaning set forth in Section 10.13.

"**Tax**" or "**Taxes**" means all taxes, fees, levies or other assessments imposed by the United States or any state, country, local or foreign government or subdivision or agency thereof, including, without limitation, income, gross receipts, excise, real and personal property, premiums, municipal, capital, value-added, goods and services, consumption, sales, transfer, license, payroll and franchise taxes, and such term shall include any interest, penalties or additions to tax attributable to such taxes, fees, levies or other assessments.

"**Tax Returns**" means any report, return or other information required to be supplied to any federal, state or local taxing authority in connection with Taxes.

"**Teamsters**" means the Teamsters Local 443, affiliated with the International Brotherhood of Teamsters.

"**Teamsters Plan**" means the multiemployer pension plan to which SRHS or HSR is obligated to make contributions to or for the benefit of Bargaining Unit Employees.

"**Title Company**" means First American Title Insurance Company.

"**Title Company Escrow Agent**" means First American Title Insurance Company in its capacity as closing escrow agent.

"**Title Company Escrow Funds**" means an amount equal to the amount required to be paid by Buyer to Sellers at Closing in accordance with Section 2.3 and as adjusted by Section 9.4 and Section 13.3.

"**Title Policies**" means ALTA Form Owner's Policy (6/17/06) owner policies of title insurance covering each of the Owned Real Property in the amounts set forth on Exhibit J, naming Buyer as the insured, and containing as exceptions to title only the Permitted Encumbrances.

"**Total Assets**" means, in the case of Caritas and Lukan, total assets per financial statements less premiums receivable, and in the case of HSR, restricted assets set aside for malpractice, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

"**Total Liabilities**" means, in the case of Caritas and Lukan, total liabilities less unearned premiums on premiums receivable, and in the case of HSR, its tail liability, in each case as reflected on the balance sheet of such company and calculated pursuant to the same methodology and level of confidence used in preparing the March 31, 2011 Financial Statements.

"**TPC Agreement**" has the meaning set forth in Section 10.4(g).

"**Transfer Act**" means the Connecticut Transfer Act, Connecticut General Statutes Sections 22a-134 et seq.

"**Transition Services Agreements**" means the Transition Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and Buyer, substantially in the form attached hereto as Exhibit I-B.

"**Wind Down Plan**" has the meaning set forth in Section 7.9.

"**Wind Down Services Agreement**" means the Wind Down Services Agreement, to be dated as of the Closing Date, to be entered into by and between SRHS and YNHH, substantially in the form attached hereto as Exhibit I-A.

"**YNHHS**" has the meaning set forth in the introductory paragraph.

ARTICLE 2. PURCHASE AND SALE OF ASSETS

2.1 Purchase and Sale of Assets.

(a) On the terms and subject to the conditions set forth in this Agreement, at Closing, Buyer shall purchase from each Seller, and each Seller shall sell, assign, transfer, convey and deliver to Buyer or Buyer's Affiliate, all of each Seller's right, title and interest in, to and under all of the rights, properties and assets of every kind, character or description, wherever located and whether real, personal or mixed, or fixed, contingent or otherwise, that are owned, used or held for use by such Seller in the conduct of the Business, including, but not limited to, those assets identified in Section 2.1(a) of the Disclosure Schedule, but excluding the Retained Assets (collectively, the "**Purchased Assets**"), free and clear of any Liens or Encumbrances, other than the Permitted Encumbrances. Without limiting the generality or effect of the foregoing, at Closing, HSR shall transfer, convey and deliver to Buyer (i) good and marketable title to the Owned Real Property, together with all fixtures and Improvements thereon, (ii) all of each Seller's leasehold interests in the Leased Real Property (subject to the terms of the applicable leases and related instruments governing such interests, and (iii) all right, title and interest of each Seller to the other Purchased Assets (subject to the terms of any applicable Assumed Contract or Assumed Lease), in each case free and clear of any Liens or Encumbrances, other than Permitted Encumbrances.

(b) To the extent that any Assumed Contract or Assumed Lease to be assigned pursuant to the terms of Section 2.1(a) is not capable of being assigned without the consent of a third party or if such assignment or attempted assignment would constitute a breach thereof or a violation of any law (any such Assumed Contract or Assumed Lease being referred to herein as a "**Nonassignable Contract**"), nothing in this Agreement shall constitute an assignment or an attempted assignment thereof prior to the time at which all consents necessary for such assignment shall have been obtained. Each Seller shall use commercially reasonable efforts to obtain the consent to the assignment of any Nonassignable Contracts and Buyer shall reasonably cooperate with each Seller's efforts to obtain such consent. To the extent that such consents are not obtained, if and to the extent requested by Buyer, such Seller shall, during the term of the affected Nonassignable Contract, use reasonable best efforts to (i) provide to Buyer the benefits under any such Nonassignable Contract, (ii) cooperate in any reasonable and lawful arrangement designed to provide such benefits to Buyer, and (iii) enforce, at the written request of Buyer, for the account of Buyer, any rights of such Seller under the affected Nonassignable Contract (including the right to elect to terminate such Nonassignable Contract in accordance with the terms thereof upon the direction of Buyer). Buyer shall reasonably cooperate with such Seller in order to enable such Seller to provide the benefits contemplated by the immediately preceding sentence to Buyer. Buyer shall perform the obligations of each Seller arising under the affected Nonassignable Contracts, but only if and to the extent that such Seller provides to Buyer the benefits thereof pursuant to this Section 2.1(b).

(c) For purposes of this Agreement, the term "**Retained Assets**" means all of each Seller's right, title and interest in, to and under the following:

(i) the corporate record books of each Seller (other than medical records, all of which shall be Purchased Assets);

(ii) the Benefit Plans;

(iii) the Medicare, Medicaid and any other payor agreements and provider numbers of each Seller except for the Medicare, Medicaid and other payor agreements and provider numbers of Grimes Center identified as Purchased Assets in Section 2.1(a) of the Disclosure Schedule;

(iv) cash, cash equivalents, certificates of deposit, treasury bills, securities, accounts and accounts receivable (except for the amount held by HSR for the satisfaction of malpractice tail liabilities and except as otherwise set forth in Section 10.8 with respect to Patient Receivables);

(v) the Pharmacy License;

(vi) HSR's general acute care hospital license issued by the Connecticut Department of Public Health;

(vii) any surety bonds issued to cover workers' compensation claims with respect to any Seller;

(viii) any other assets identified in Section 2.1(c) of the Disclosure Schedule; and

(ix) all contracts and leases of any Seller that are not Assumed Contracts or Assumed Leases.

2.2 **Assumption of Liabilities**.

(a) At and after the Effective Time, Buyer agrees to assume, satisfy, discharge and perform as and when due, and to hold each Seller harmless against, the future payment and performance of only the following obligations and liabilities of each Seller related to the Purchased Assets (collectively, the "**Assumed Liabilities**"):

(i) all obligations and liabilities arising from and after the Effective Time under the Assumed Contracts and Assumed Leases;

(ii) all obligations and liabilities with respect to the ownership and operation of the Purchased Assets that arise from and after the Effective Time;

(iii) all workers' compensation liabilities;

(iv) the HSR malpractice tail liability; and

(v) all obligations and liabilities set forth on Section 2.2(a) of the Disclosure Schedule.

(b) Each Seller shall retain and be responsible and liable for, and Buyer shall not assume or be responsible or liable for, all of its obligations and liabilities that are not Assumed Liabilities (the "**Retained Liabilities**"), including, without limitation, (i) the obligations and liabilities described in Section 2.2(b) of the Disclosure Schedule; (ii) all contracts

and leases of any Seller that are not Assumed Contracts or Assumed Leases; and (iii) the Benefit Liabilities.

2.3 **Purchase Price**. In consideration of the purchase and sale of the Purchased Assets and consummation of the transactions contemplated by this Agreement, Buyer hereby agrees to pay (or cause to be paid) to Sellers an amount equal to $160,000,000 (the "**Purchase Price**"). The Purchase Price shall be paid in accordance with the payment schedule set forth on Exhibit L.

2.4 **Title Company Escrow.** At or before Closing, Buyer shall deliver to the Title Company Escrow Agent, by wire transfer of immediately available funds to the account designated for such purpose by the Title Company Escrow Agent, the Title Company Escrow Funds, and such Title Company Escrow Funds shall be paid to each appropriate Seller upon satisfaction of all conditions precedent to the Closing as described herein.

ARTICLE 3. REPRESENTATIONS AND WARRANTIES OF SELLERS

In order to induce Buyer to purchase the Purchased Assets it is purchasing hereunder, each Seller, jointly and severally, represents and warrants to Buyer that the statements contained in this Article 3 are correct and complete in all material respects as of the Effective Date and, subject to Section 5.15, will be correct and complete in all material respects through and including the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 3); provided, however, that the statements contained in Section 3.18 will be made only as of the Closing Date and not as of the Effective Date.

3.1 **Organization; Authority.** Each Seller is a corporation duly formed, validly existing and in good standing under the laws of its state of incorporation and has the requisite power and authority to conduct its Business as now being conducted. Each Seller is duly qualified or licensed to do business and is in good standing in each jurisdiction in which the nature of its business or the ownership or leasing of its properties makes such qualification or licensing necessary.

3.2 **Powers; Consents; Absence of Conflicts.** Except as set forth in Section 3.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement, the Caritas SPA, the Lukan SPA and the Transition Services Agreements by each Seller, as applicable, and the consummation of the transactions contemplated hereunder and thereunder by such Sellers: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of each Seller and have been duly authorized by all appropriate corporate action (including by any Affiliate, as applicable); (b) do not and will not require any approval or consent of, or filing with, any Governmental Authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any Contract or Lease to which any Seller is a party or by which any Seller or any Purchased Asset is bound or subject; and (e) do not and will not

violate any judgment, order or decree of any court or other Governmental Authority to which any Seller or any Purchased Asset may be subject. This Agreement has been duly executed and delivered by each Seller and, as to each Seller, is valid and binding on each such Seller with respect to its obligations hereunder, enforceable against it in accordance with its terms, except to the extent enforceability may be limited by bankruptcy, insolvency, moratorium or similar laws affecting creditors rights and remedies.

3.3 Absence of Certain Changes. Except as otherwise set forth in Section 3.3 of the Disclosure Schedule, since September 30, 2010, each Seller has operated the Business in the ordinary course of business and there has not been any:

(a) damage to, destruction or loss of, any portion of the Purchased Assets having an aggregate value of $250,000 or more, whether or not covered by insurance;

(b) sale, lease or other disposition of any portion of the Purchased Assets having an aggregate value of $250,000 or more (except in the ordinary course of business and the disposition of obsolete and worn out equipment or materials), or imposition of any material Lien or Encumbrance on any of the Purchased Assets other than Permitted Encumbrances;

(c) grant by any Seller to any of its non-management employees or independent contractors of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits or establishment of any new compensation or benefit plans or arrangements or amendment to any existing plans, except in the ordinary course of business or as may be contemplated under any existing agreements or required by Applicable Law;

(d) grant by any Seller to any of its management employees (i.e., assistant vice president or above), directors or officers of any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, except in the ordinary course of business or as may be contemplated by existing agreements or required by Applicable Law;

(e) entry into, termination of or receipt of written notice of termination of (i) any material license, joint venture, credit or similar agreement, or (ii) any Material Contract or Lease or Real Property Lease except such terminations as are non-discretionary and contemplated by the terms of the Material Contract, Lease or Real Property Lease;

(f) any merger or consolidation with, any material capital investment in, any material loan to, any material advance to or material acquisition of the securities, assets or Indebtedness of, any other Person;

(g) any distribution of cash or other property by a Seller to its members, or any payment or transfer of cash or other property to any of its Affiliates;

(h) change in any method of accounting or accounting practice or policy;

(i) receipt of a notice of deficiency from any Governmental Authority or other regulator, including any consent orders or corrective action requests from the Connecticut Department of Public Health; or

(j) agreement, whether oral or written, by any Seller to do any of the foregoing.

3.4 Compliance with Laws. Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers are in compliance with all Applicable Laws that do not constitute Healthcare Laws. Except as set forth in Section 3.4 of the Disclosure Schedule, Sellers have at all times during the past seven years operated the Business in accordance with all Healthcare Laws. Each Seller has timely filed all reports, data and other information required to be filed with Governmental Authorities with respect to the conduct of the Business or to the ownership and use of any of the Purchased Assets. Except as set forth in Section 3.4 of the Disclosure Schedule, Seller nor any Affiliate of any Seller has, with respect to the operation of the Business, received written notice from a Governmental Authority with respect to the operation of the Business, that it is under investigation with respect to any violation or alleged violation of, or that it has any obligation to take remedial action under: (a) any Applicable Law or Healthcare Laws, (b) any license, certificate or certificate of need issued or (c) any order, judgment or decree entered by any Governmental Authority relating to the Business.

3.5 Licenses. Section 3.5 of the Disclosure Schedule sets forth a list, as of the Effective Date, of all material licenses and permits held by each Seller in connection with the operation of the Business. Sellers have held and hold all licenses, permits, certifications, consents, approvals, authorizations, qualifications and orders of any Governmental Authority as are necessary for Sellers' conduct of the Business and ownership and use of the Purchased Assets. Except as set forth in Section 3.5 of the Disclosure Schedule, each such license, permit, certification, consent, approval, authorization, qualification and order is valid and in full force and effect, and each Seller is in compliance in all material respects with each such license, permit, certification, consent, approval, authorization, qualification and order. Except as set forth in Section 3.5 of the Disclosure Schedule, as of the Effective Date, no Seller has received any written notice from any Governmental Authority regarding (a) any non-compliance or alleged non-compliance under any such license, permit, certification, approval, authorization, qualification or order or any investigation or potential investigation of any Seller in connection with any such non-compliance or alleged non-compliance or (b) any obligation or alleged obligation of any Seller to take remedial action under any such license, permit, certification, approval, authorization, qualification or order.

3.6 Accreditation; Government Reimbursement Programs.

(a) Except as set forth in Section 3.6(a) of the Disclosure Schedule, each Seller, as applicable, is duly accredited by the Joint Commission for the period indicated in Section 3.6(a) of the Disclosure Schedule. No Seller has been excluded, debarred or otherwise deemed ineligible to participate in Medicare, Medicaid or any other federal or state health care programs or in any federal or state procurement or non-procurement programs, nor has any Seller been convicted of a criminal offense related to the provision of federal health care items or

services, nor, to Sellers' Knowledge, is an investigation or proceeding regarding the foregoing pending or threatened.

(b) Except as set forth in Section 3.6(b) of the Disclosure Schedule, each of the Sellers that provides services to beneficiaries of Government Reimbursement Programs is (i) qualified for participation in, and has current and valid provider contracts with, the Government Reimbursement Programs and/or their fiscal intermediaries or paying agents and is in material compliance with the conditions of participation or requirements applicable with respect to such participation and (ii) eligible for payment under the Government Reimbursement Programs for services rendered to qualified beneficiaries.

(c) The Cost Reports for each of the Sellers that provide services to beneficiaries of Government Reimbursement Programs were filed when due, and have been audited (with Notices of Program Reimbursement issued), for the Cost Report periods described in Section 3.6(c) of the Disclosure Schedule.

(d) Except as set forth in Section 3.6(d) of the Disclosure Schedule, all amounts shown as due from any of the Sellers in the Cost Reports either were remitted with such Cost Reports or will be remitted when required by Applicable Law, and all amounts shown in the Notices of Program Reimbursement as due have been or prior to Closing will be paid when required by Applicable Law. Except to the extent liabilities and contractual adjustments with respect to the Sellers under the Government Reimbursement Programs have been properly reflected and adequately reserved in the Financial Statements, or as set forth in Section 3.6(d) of the Disclosure Schedule, the Sellers have not received or submitted any claim for payment to the Government Reimbursement Programs (or their fiscal intermediaries or paying agents) in excess of the amount provided by Applicable Law or applicable provider contracts, and the Sellers have not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding any of the Sellers and the Government Reimbursement Programs or the participation by any of the Sellers in such programs.

(e) The Sellers have no, and are not subject to or the beneficiary of any, outstanding loan, grant or loan guarantee pursuant to the Hill Burton Act (42 U.S.C. Section 291a, et seq.).

3.7 Medical Staff Matters.

(a) Each Seller, as applicable, has previously delivered or made available to Buyer, with respect to the Business, (i) the forms generally used as of the Effective Date with respect to medical staff privilege and membership application, and (ii) all medical staff bylaws, policies, rules and regulations, as in effect on the Effective Date.

(b) Section 3.7(b) of the Disclosure Schedule sets forth a true and correct list as of the Effective Date of the name and specialty of each member of the medical staff of the Facilities. Except as set forth in Section 3.7(b) of the Disclosure Schedule and actions and appeals as to which disclosure is prohibited by federal or state law, there are no, and there have not been at any time during the five years prior to the Effective Date, (i) any pending or threatened disciplinary or corrective actions or appeals by any Seller with respect to its medical

staff members, other professional staff members or applicants to the medical staff of the Facilities or, to Sellers' Knowledge, with respect to such medical staff members, professional staff members or applicants at any other facility at which such member or applicant has or has applied for privileges; or (ii) any pending or threatened challenges to any decisions of the medical staff relating to delineation of privileges at the Facilities.

3.8 Contracts and Leases. Section 3.8 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of (a) all Leases, excluding Real Property Leases, involving annual payments of $250,000 or more and (b) all Contracts to which any Seller is a party or to which any of their assets are bound (i) governing the borrowing of money or the Guarantee or the repayment of Indebtedness of any Seller or granting of Liens on any property or asset of any Seller (including any such contract under which any Seller has incurred any Indebtedness); (ii) providing for the employment of any Person and, to the extent not subject to confidentiality restrictions, any settlements relating thereto; (iii) containing covenants limiting the freedom of any Seller to compete in any line of business or with any Person or in any geographic area or market; (iv) concerning the use of or restricting the use of any Intellectual Property Rights or other intellectual property; (v) with any members, trustees, directors, officers, employees of any Seller or their respective Affiliates or Affiliates of any Seller; (vi) providing for the purchase, maintenance or acquisition or the sale or furnishing, of materials, supplies, merchandise, equipment or services (including computer hardware, software, online hosting arrangements or other property or services) involving payments in excess of $250,000; (vii) granting to any Person a first refusal, first offer or similar preferential right to purchase or acquire any right, asset or property of any Seller; (viii) pertaining to the lease of equipment or other Personal Property and involving annual payments of $250,000 or more; (ix) providing for any offset, countertrade or barter arrangement; (x) involving a distributor, sales representative, broker, franchise or advertising arrangement; (xi) involving a joint venture, partnership or similar arrangement; (xii) involving non-employee management services, consulting services, independent contractor services, support services or any other similar services involving annual payments of $250,000 or more, including service agreements under which any Seller is required to provide services to insurers, self-insured employees or any governmental or private health plan, managed care plan or other similar Person; (xiii) involving the acquisition of any business enterprise whether via stock or asset purchase or otherwise; (xiv) as to which the breach, nonperformance, cancellation or failure to renew by any party thereto would have a Material Adverse Effect; (xv) concerning any Physician, Physician group or medical practice entity; and (xvi) with respect to Grimes Center, resident admission agreements and any other written agreements with residents (collectively, the "**Material Contracts and Leases**"). Each Seller has delivered or made available to Buyer true and correct copies of the Material Contracts and Leases. Except as set forth in Section 3.8 of the Disclosure Schedule, no Seller is in breach of, or has any Knowledge of any material breach or default under, any of the Material Contracts and Leases that are Assumed Contracts or Assumed Leases or has received any written notice from any party of the same, and, to Sellers' Knowledge, no other party to any such Assumed Contract or Assumed Lease is in breach thereof. Each Assumed Lease listed in Section 3.8 of the Disclosure Schedule (w) was negotiated on an arms-length basis, (x) is valid and existing in full force and effect, and (y) is not in default nor has any tenant thereunder received a written notice of default.

3.9 Real Property; Condition of Facilities.

(a) Part A of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property owned by Sellers in fee simple as more particularly described in the legal descriptions for such real property attached to such Disclosure Schedule as Schedule A (the "**Owned Real Property**"). Part B of Section 3.9(a) of the Disclosure Schedule contains a true and correct list of all real property with respect to which a Seller holds a leasehold interest as to all or a portion of such real property, as applicable (the "**Leased Real Property**") (subject to the terms of the applicable leases and related instruments governing such interest, collectively the "**Real Property Leases**"). The Owned Real Property and the Leased Real Property are referred to herein collectively as the "**Real Property**".

(b) Except as set forth in Section 3.9(b) of the Disclosure Schedule, there are no outstanding violations of any Applicable Law, order, or any condemnations, liens, pledges, claims or similar recorded liabilities or assessments, relating to any material portion of the Owned Real Property and Seller has not received any written notice of the same and to Sellers' Knowledge, there are no outstanding violations of any Applicable Law, order or any condemnations, Liens or assessments, relating to any material portion of the Leased Real Property and Seller has not received any written notice of the same.

(c) Except as set forth in Section 3.9(c) of the Disclosure Schedule, the Owned Real Property, and to Sellers' Knowledge, the Leased Real Property is in compliance with all Applicable Laws relating to zoning and land use, regulations and ordinances, including, but without limitation, all Applicable Laws relating to parking and Connecticut State Traffic Certificates.

(d) All water, sewer, gas, electricity, telephone and other utilities required for the use, occupancy, operation and maintenance of the Owned Real Property are connected thereto and are adequate to service the normal operations of the Owned Real Property, are supplied directly to the Owned Real Property by facilities of public utilities and the cost of installation and connection of such utilities has been fully paid.

(e) Seller has not received any written notice from any insurance company or inspection or rating bureau setting forth any requirements as a condition to the continuation of any insurance coverage on or with respect to the Real Property or the continuation thereof at premium rates existing at present which have not been remedied or satisfied.

(f) Except as set forth in Section 3.9(f) of the Disclosure Schedule, no services, material or work have been supplied to or have been performed in connection with, as applicable, the Owned Real Property, or in the case of the Leased Real Property, to Sellers with respect to the relevant leased premises, for which payment has not been made in full in a timely manner.

(g) Except as set forth in Section 3.9(g) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.9(g) of the Disclosure Schedule, (i) each of (A) the heating, ventilation and air conditioning system

(HVAC), (B) the mechanical, electrical and plumbing system (MEP) and (C) the roof of each Owned Real Property, and to Sellers' Knowledge the roof of each Leased Real Property, is in good working condition, was constructed in a good and workmanlike manner and is free from defects which would render it unfit for continued use in the manner in which it is presently used, subject, however, to ordinary wear and tear and (ii) the foundation, walls and all structural components of the buildings and other improvements of the Owned Real Property, and to Sellers' Knowledge of the Leased Real Property, are structurally sound and no Seller has Knowledge of any material defects or material damage to any of the foregoing.

(h) Each of the Real Property Leases and each of the leases relating to an Owned Real Property (i) was negotiated on an arms-length basis, (ii) is valid and existing in full force and effect and (iii) to Sellers' Knowledge, is not in default nor has any Seller received a written notice of default from the applicable landlord of such Leased Real Property.

3.10 Personal Property.

(a) Except as set forth in Section 3.10(a) of the Disclosure Schedule, all Personal Property used by Sellers in the operation of the Business is either owned by a Seller or leased by a Seller under a Lease.

(b) Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, there are no pending claims in an amount in excess of $250,000 by any Seller against a manufacturer, distributor or lessor of any Personal Property for warranty, repair, return or defective condition. All inventory and supplies, including pharmaceuticals, (i) are, and have been throughout their possession by Sellers, properly stored, inventoried and labeled, and are usable in accordance with their intended use, (ii) have been maintained in the ordinary course of business and (iii) at the Effective Time, shall be at levels consistent with operation of the Business in accordance with past practices of Sellers. Except as set forth in Section 3.10(b) of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.10(b) of the Disclosure Schedule, the improvements on the Real Property and the Personal Property have been reasonably maintained in the ordinary course of business, are in good operating condition (ordinary wear and tear excepted), and are reasonably suitable for the uses for which they are intended.

3.11 Labor and Employee Matters.

(a) Section 3.11(a) of the Disclosure Schedule sets forth each pension, profit sharing, deferred compensation or other employee pension or health or welfare benefit plan or arrangement, as defined in Section 3(3) of ERISA (or each such plan that is a church plan as defined in Section 414(e) of the Code), relating to the Business that is currently in effect or that has been in effect at any time during the past three years (the "**Benefit Plans**"). Except as set forth in Section 3.11(a) of the Disclosure Schedule: (i) no Benefit Plan is subject to Title IV of ERISA and no Benefit Plan is a Multiemployer Pension Plan within the meaning of Section 3(37) of ERISA; (ii) no prohibited transaction as defined in Section 4975 of the Code,

has occurred with respect to any Benefit Plan and there are no pending or, to any Seller's Knowledge, threatened claims by, on behalf of or against the Benefit Plans or by any employee of any Seller alleging a breach or breaches of fiduciary duties or violations of other applicable state or federal law that could result in liability on the part of any Seller or the Benefit Plans under ERISA or any state law applicable to any church plan listed in Section 3.11(a) of the Disclosure Schedule, nor to Sellers' Knowledge is there any basis upon which such a claim can reasonably be anticipated; and (iii) all returns, reports, disclosure statements and premium payments required to be made under ERISA and the Code with respect to the Benefit Plans have been timely filed or delivered.

(b) Except as specified in Section 3.11(b) of the Disclosure Schedule, (i) no Seller is a party to or bound by any union contract, collective bargaining agreement, employment contract, independent contractor agreement, consultation agreement or other similar type of contract; (ii) no Seller has agreed to recognize any union or other collective bargaining representative; (iii) no union or collective bargaining representative has been certified as representing the employees of any Seller; and (iv) to Sellers' Knowledge, no labor union or collective bargaining representative has made any attempt or threatened to organize any employees of any Seller. No Seller has experienced any labor strike, dispute, slowdown or stoppage or any other material labor difficulty during the past five years, and to Sellers' Knowledge, there are no facts or circumstances that might reasonably be expected to lead to any such labor dispute. Sellers have provided Buyer true and complete copies of all agreements listed on Section 3.11(b) of the Disclosure Schedule.

(c) Sellers have provided Buyer with a complete list of all employees and independent contractors of each Seller, their respective positions, locations, exempt or non-exempt status, applicable independent contractor agreements, information on the bases for concluding that any such Person qualifies as an independent contractor rather than an employee of the Seller(s), and the rates of all regular and additional compensation and commissions payable to each such Person in any and all capacities and any regular or special compensation or commissions that will be payable to each such Person in any and all capacities as of the Closing Date other than the then-current accrual of regular payroll compensation. Except as set forth in Section 3.11(c) of the Disclosure Schedule, the employees of each Seller are "at will," and no Seller employs or engages any employee or independent contractor who, subject to compliance with Applicable Law, cannot be dismissed immediately, whether currently or immediately after the Effective Time, without notice and without further liability to such Seller.

(d) With respect to the employees of Sellers, during the last 12 months, there has been no mass layoff, plant closing or shutdown that triggers application of the Worker Adjustment & Retraining Notification Act of 1988, as amended, or any similar law.

(e) Each Seller has completed and retained to the extent required by the Immigration Reform and Control Act of 1986 ("**IRCA**") the employment verification paperwork for all current and former employees. Further, at all times prior to the Effective Date, each Seller was in material compliance with both the employment verification provisions (including the paperwork and documentation requirements) and the anti-discrimination provisions of IRCA.

(f) No Seller is liable for any payment to any trust or other fund or to any Governmental Authority, with respect to unemployment compensation benefits, social security or other benefits or obligations for employees (other than routine payments to be made in the ordinary course of business and consistently with past practice). Except as set forth in Section 3.11(f) of the Disclosure Schedule, there are no pending claims against any Seller under any workers' compensation plan or policy or for long-term disability.

(g) To Sellers' Knowledge, no employee of any Seller is in violation, in any material respect, of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, noncompetition agreement or restrictive covenant to a former employer.

(h) Except as set forth in Section 3.11(h) of the Disclosure Schedule, no Seller is a party to, or otherwise bound by, any consent decree with, or citation by, any Governmental Authority relating to employees or employment practices. No Seller, including the officers thereof, has received within the past five years any written notice of intent by any Governmental Authority responsible for the enforcement of labor or employment laws to conduct an investigation relating to any Seller and, to Sellers' Knowledge, no such investigation is in progress.

(i) Except as set forth in Section 3.11(i) of the Disclosure Schedule, none of the execution and delivery of this Agreement or the consummation of any transaction contemplated hereby or any termination of employment or service in connection therewith at or prior to the Closing Date will (i) result in any payment (including severance, unemployment compensation, golden parachute, bonus or otherwise) becoming due to any Person, (ii) materially increase any benefits otherwise payable by any Seller, (iii) result in the acceleration of the time of payment or vesting of any such benefits, (iv) increase the amount of compensation due to any Person or (v) result in the forgiveness in whole or in part of any outstanding loans made by any Seller to any Person.

(j) To Sellers' Knowledge, no current director, officer, employee, manager or independent contractor of any Seller is a party to or is otherwise bound by, any agreement or arrangement, including any confidentiality, noncompetition or proprietary rights agreement, between such director, officer, employee, manager or independent contractor and any other Person that in any way materially and adversely affects (i) the performance of his or her duties as a director, officer, employee, manager or independent contractor of such Seller or (ii) the ability of such Seller to conduct its business as it is currently conducted and proposed to be conducted.

(k) Each Seller is in compliance with all Applicable Laws applicable to its respective employment and employment practices, including all Applicable Laws regarding terms and conditions of employment, health and safety, wages and hours, employee and independent contractor classifications, immigration, employment discrimination, disability rights or benefits, equal opportunity, plant closures and layoffs, affirmative action, workers' compensation, labor relations, employee leave issues and unemployment insurance. Except in the ordinary course of business, no Seller is delinquent in payments to any employee for any services or any amounts required to be reimbursed or otherwise paid.

3.12 Litigation or Proceedings. Except as set forth in Section 3.12 of the Disclosure Schedule, there are no claims, actions, suits, proceedings or, to Sellers' Knowledge, investigations ("**Litigation or Proceedings**") pending or, to any Sellers' Knowledge, threatened against or affecting any Seller with respect to the Business or the Purchased Assets, at law or in equity, before or by any court or federal, state, municipal or other governmental department, commission, board, bureau, agency or instrumentality wherever located. Except as otherwise set forth in Section 3.12 of the Disclosure Schedule, no matter disclosed in Section 3.12 of the Disclosure Schedule is reasonably anticipated by Sellers to result in any cost, expense, damage or liability (including court costs or attorneys' fees) to any Seller in an amount that exceeds the greater of $50,000 or the amount reserved by Sellers as set forth in the Financial Statements.

3.13 Special Funds. Except as set forth in Section 3.13 of the Disclosure Schedule, the Facilities are not subject to any liability in respect of amounts received for the purchase or improvement of the Facilities or any part thereof under restricted or conditioned grants or donations, including, without limitation, monies received under the Public Health Service Act, 42 U.S.C. Section 291 et seq.

3.14 Tax Matters. Except as set forth in Section 3.14 of the Disclosure Schedule:

(a) Each Seller is exempt from federal income tax as an organization described in Section 501(c)(3) of the Code by virtue of the fact that it is classified as an organization described in Section 501(c)(3) of the Code and is classified as a public charity under Section 509(a) of the Code. No Seller knows of any basis for a challenge by the Internal Revenue Service to revoke or terminate any such exemption from federal income taxation;

(b) All Tax Returns for periods ended prior to the Effective Date required to be filed by any Seller (collectively, the "**Seller Tax Returns**") have been filed within the time and in the manner provided by law (including any valid extensions thereof);

(c) None of the Seller Tax Returns is currently the subject of an audit;

(d) The Seller Tax Returns were correct in all material respects;

(e) All Taxes that are shown as due on the Seller Tax Returns have been paid or adequate reserves therefor have been established; and

(f) (i) no Tax Lien or Encumbrance exists with respect to any of the Purchased Assets except for Permitted Encumbrances, (ii) no Litigation or Proceeding is pending, or, to Sellers' Knowledge, threatened, against any Seller with respect to any Taxes, (iii) there are no matters under discussion between any Seller and any Governmental Authority relating to any Taxes in an amount in excess of $250,000 and (iv) there are no claims against any Seller for additional Taxes in an amount in excess of $250,000 asserted by any Governmental Authority.

3.15 Environmental Matters. Except as set forth in Section 3.15 of the Disclosure Schedule:

(a) each Seller has obtained all applicable permits, licenses and other authorizations required for Seller's operations at the Purchased Assets under applicable Environmental Laws (the "**Environmental Permits**") and has made all necessary filings for issuance or renewal of the Environmental Permits, and no actions are pending, or to Sellers' Knowledge, threatened, to amend, challenge, terminate, cancel, limit, restrict or appeal any such Environmental Permits that would have a Material Adverse Effect;

(b) each Seller and the operations of each Seller at the Purchased Assets are in compliance with all terms and conditions of the Environmental Permits and with all applicable Environmental Laws;

(c) no Seller has any Knowledge of or any basis to expect, nor has any of them, received, any citation, directive, inquiry, notice, order, summons, warning or other communication that relates to any alleged, actual or potential violation or failure to comply with any Environmental Law with respect to the Purchased Assets or with respect to any property or facility to which Hazardous Substances generated, manufactured, refined, transferred, imported, used or processed by Seller have been transported, treated, stored, handled, transferred, disposed, recycled or received;

(d) there are no conditions at, in, on, under or related to the Real Property that pose a hazard to human health or the environment other than such conditions that are in compliance with applicable Environmental Laws;

(e) there is no (nor has there been any) production, use, treatment, storage, transportation, handling, discharge, disposal, arrangement for disposal or release or threatened release of any Hazardous Substance or Solid Waste in violation of applicable Environmental Law at, in, on, under, from, over or related to the Real Property, or into or upon or over soil, surface water or groundwater at, on, under or related to the Real Property;

(f) there are no underground tanks, collection sumps or pits, land disposal facilities or surface impoundments at, on or under the Real Property;

(g) the Owned Real Property and to Sellers' Knowledge the Leased Real Property does not have any (i) asbestos containing material that is damaged or friable in a form or condition which requires removal, abatement or repair as of the date hereof under applicable Environmental Laws, (ii) electrical transformers or other equipment or machinery that contain PCBs in regulated concentrations or (iii) radon in indoor air in excess of four picocuries per liter;

(h) each Seller and the Real Property is in compliance with all applicable Environmental Laws; and

(i) no Seller has received written notice from any Governmental Authority regarding any investigation or proceeding concerning the presence or alleged presence of any Hazardous Substances or Solid Waste on the Real Property or violation of any applicable Environmental Law.

3.16 Insurance. Section 3.16 of the Disclosure Schedule contains a true and correct list, as of the Effective Date, of all insurance policies or self-insurance funds of any nature

whatsoever in effect that insure the business, operations or employees of each Seller or affect or relate to the ownership, use or operation of any of the Purchased Assets and Business and that have been issued to any Seller or issued to an Affiliate of any Seller for the benefit of any Seller, which such Section 3.16 of the Disclosure Schedule reflects the policies' numbers, terms, identity of insurers, amounts and coverages. No written notice of cancellation or termination has been received by any Seller with respect to any policy listed in Section 3.16 of the Disclosure Schedule and all such policies are in full force and effect. There is not outstanding any requirement or recommendation by any insurance company that issued any such policy or by any Board of Fire Underwriters or other similar body exercising similar functions or by any Governmental Authority exercising similar functions which requires or recommends any repairs or other work to be done to any of the Purchased Assets. Each Seller has given to its insurer in a timely manner all notices required to be given under its insurance policies with respect to all claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions or reserved its rights in respect of or rejected any such claims.

3.17 Brokers. No broker, finder, investment banker or other Person is entitled to any brokerage, finder's or other fee or commission in connection with this Agreement or the transactions contemplated hereby based upon any agreements, arrangements or commitments made by or on behalf of any Seller.

3.18 Solvency. After giving effect to the transactions contemplated hereby, (a) each Seller will be Solvent, and, to the Knowledge of each such Seller, reasonably expects to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up Sellers' affairs, and (b) Sellers have not, and do not believe that they will have, incurred debts or liabilities beyond Sellers' ability to pay as such debts and liabilities mature; provided, however, that the foregoing shall cease to be a representation and warranty of Sellers pursuant to Article 3 hereunder if Sellers obtain the Sale Order and either of (x) the Sale Order has become a Final Order or (y) the Final Order Exception applies. Notwithstanding any of the foregoing, none of the Sellers is entering into the transactions contemplated by this Agreement for the purpose of hindering, delaying or defrauding any of its creditors or Buyer.

3.19 Financial Statements. Section 3.19 of the Disclosure Schedule sets forth the following financial statements (collectively, the "**Financial Statements**"): (a) an unaudited balance sheet for each of the Sellers as of the Balance Sheet Date and unaudited statement of operations for each of the Sellers for the six-month period ended on the Balance Sheet Date (collectively, the "**March 31, 2011 Financial Statements**"); and (b) audited balance sheets of each of the Sellers as of September 30, 2009 and September 30, 2010 and the related statements of operations for the 12-month period then ended. The Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto and normal year end adjustments. The balance sheets included in the Financial Statements fairly present, in all material respects, the financial condition of such Seller as of the dates indicated thereon, and the statements of operations included in the Financial Statements fairly present, in all material respects, the results of operations of such Seller for the periods indicated thereon, except, in the case of the March 31, 2011 Financial Statements, for the absence of notes thereto

and normal year end adjustments. Except as set forth in Section 3.19 of the Disclosure Schedule, since the Balance Sheet Date, there have occurred no material adverse changes in the financial condition, results of operations or business of such Seller as reflected in such Financial Statements, other than changes in the ordinary course of business.

3.20 Assets; Sufficiency of Assets.

(a) Except as set forth in Section 3.20 of the Disclosure Schedule, each Seller, as applicable, owns good and marketable title to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances and HSR Financing Agreements, and, at the Closing, will sell, transfer and assign to Buyer, good and marketable title in and to the Purchased Assets, free and clear of all Liens except for Permitted Encumbrances.

(b) Except as set forth in Section 3.20 of the Disclosure Schedule and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to Buyer that supplement or modify Section 3.20 of the Disclosure Schedule, all of the Purchased Assets are in good condition and repair except for ordinary wear and tear and are usable in the ordinary and normal course of business, consistent with past practices of Sellers, and the Purchased Assets include all assets necessary to conduct the Business in the ordinary and normal course of business, consistent with past practices of Sellers.

3.21 Equipment. Section 3.21 of the Disclosure Schedule sets forth a depreciation schedule as of March 31, 2011 that lists all the equipment associated with, or constituting any part of, the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, since March 31, 2011, no Seller has sold or otherwise disposed of any item of equipment having a replacement cost in excess of $250,000 constituting any part of the Purchased Assets. Except as set forth on Section 3.21 of the Disclosure Schedule, all of the Purchased Assets consisting of equipment, whether reflected in the Financial Statements or otherwise, are well maintained and in good operating condition, except for reasonable wear and tear. Except as set forth on Section 3.21 of the Disclosure Schedule, each Seller has good and marketable title to the equipment and all of such equipment is free and clear of any Lien or Encumbrance, except for Permitted Encumbrances. No person other than Sellers owns any equipment or other tangible assets situated on the Real Property.

3.22 Intellectual Property. Sellers have made available to Buyer complete and correct lists all of the patents, patent applications, names, trademark and trade name registrations and service mark registrations owned by any Seller (collectively, "**Intellectual Property Rights**"). Sellers own or have valid rights to use all such Intellectual Property Rights without conflict with the rights of others. The Intellectual Property Rights are not subject to any Liens or Encumbrances, except for Permitted Encumbrances. The Intellectual Property Rights are not subject to any restriction or limitation regarding use or disclosure other than pursuant to written license agreements. To Sellers' Knowledge, Sellers have not infringed upon or misappropriated any intellectual property or intellectual property rights of any other person. To Sellers' Knowledge, the conduct of the Business does not infringe upon any intellectual property owned or controlled by any other Person and no Person has made or, to Sellers' Knowledge, threatened to make, any claim that the operation of the Business or the use of the Intellectual Property

Rights is in violation of or infringes upon any patent, patent application, trademark, trade name, service mark or any other proprietary or trade rights of any third party.

3.23 Software. The operating and applications computer software programs and databases used by Sellers are listed and briefly described in Section 3.23 of the Disclosure Schedule (collectively, the "**Software**"). Sellers own outright or hold valid licenses to all copies of the Software used by Sellers. To Sellers' Knowledge, none of the Software, and no use thereof, infringes upon or violates any patent, copyright, trade secret or other proprietary right of any other Person, and no claim with respect to any such infringement or violation is threatened.

3.24 Absence of Default. Except as described on Section 3.24 of the Disclosure Schedule, no Seller is in default of any term or condition of any Indebtedness or liability, including any trade payable.

3.25 Charitable Funds. HSR and the Foundation have solicited, received, held, invested, expended and applied charitable funds donated to them, including the Charitable Funds (as defined below), in accordance with all restrictions placed thereon by donors, the terms of any applicable solicitation and Applicable Laws. No Seller has received written notice of any, whether actual or alleged, misuse of funds, failure to comply with any donor-imposed restriction, breach of duty related to the funds, or violation of any Applicable Laws, nor to Sellers' Knowledge, has any such misuse, failure, breach or violation occurred.

3.26 Bank Accounts. Section 3.26 of the Disclosure Schedule lists the name of each bank, savings and loan or other financial institution, in which an account, including cash contribution accounts, or a safe deposit box related the operations of any Seller is maintained and, to the extent practicable, the names of all persons authorized to draw thereon or to have access thereto.

3.27 No Undisclosed Liability. Except (a) as set forth on in Section 3.27 of the Disclosure Schedule, or as disclosed, set forth or reserved for in the Financial Statements (including the notes thereto), (b) for liabilities and/or obligations incurred in the ordinary course of business after the Balance Sheet Date or (c) for liabilities and/or obligations arising under any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which any Seller is a party that is entered into in the ordinary course of business (other than any such liabilities or obligations arising out of a breach by any Seller of any of the Material Contracts and Leases or any of the Real Property Leases or any other contract or agreement to which a Seller is a party), no Seller has any liability or obligation of any nature, whether or not accrued, contingent or otherwise.

3.28 No Untrue or Inaccurate Representations or Warranties. The representations and warranties of each Seller contained in this Agreement together with the Disclosure Schedule do not, and the statements of each Seller contained in the certificate delivered by Sellers to Buyer pursuant to Section 9.2(e) will not, contain any misstatement of a material fact or omit to state a material fact necessary in order to make the information contained therein not misleading.

ARTICLE 4. REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer represents and warrants to Sellers that the statements contained in this Article 4 are correct and complete as of the Effective Date and will be correct and complete as of the Closing Date (as though made then and as though the Closing Date were substituted for the Effective Date throughout this Article 4).

4.1 Organization; Authority. Buyer is a nonprofit corporation duly formed, validly existing and in good standing in the State of Connecticut and has the requisite power and authority to conduct its business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts. Except as set forth in Section 4.2 of the Disclosure Schedule, the execution, delivery and performance of this Agreement by Buyer and the consummation of the transactions contemplated hereby by Buyer: (a) are within its corporate powers, are not in contravention of the terms of the certificate of incorporation or bylaws (or comparable governing documents) of Buyer and have been duly authorized by all appropriate corporate action; (b) do not and will not require any approval or consent of, or filing with, any governmental agency or authority (other than the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda); (c) do not and will not violate any Applicable Law; (d) do not and will not conflict with, or result in a breach of or a default under (with or without notice or lapse of time, or both), any contract, agreement, indenture, mortgage, deed of trust, lease or other instrument to which Buyer is a party or by which Buyer is bound or subject; and (e) do not and will not violate any judgment, order or decree of any court or other governmental agency or authority to which Buyer may be subject. This Agreement has been duly executed and delivered by Buyer and constitutes a valid and binding obligation of Buyer, enforceable against it in accordance with its terms.

4.3 Brokers. No broker, finder or investment banker is entitled to any brokerage, finder's or other fee or commission in connection with the transaction contemplated by this Agreement based upon arrangements made by or on behalf of Buyer.

ARTICLE 5. CERTAIN COVENANTS OF SELLERS

5.1 Information. From the Effective Date to the Closing Date, each Seller shall continue to afford to those certain officers and representatives and agents of Buyer, designated by written notice to Sellers by Buyer, access upon reasonable notice and during normal business hours, to the Purchased Assets, including for purposes of conducting environmental and other property condition inspections, and, to the extent necessary, to Key Employees of Sellers, and all properties, books, contracts, commitments and records of each Seller relating to the Purchased Assets and the Business, the Retained Assets and the Retained Liabilities (regardless of where such information may be located), and promptly furnish Buyer with such additional available financial and operating data and other information relating to the same as Buyer may from time to time reasonably request, except to the extent any Seller is restricted from providing such information by Applicable Law or as a result of confidentiality agreements with third parties and except for Litigation or Proceedings where Buyer and Seller are both defendants. Buyer shall exercise its rights under this Section 5.1 in such a manner as not to interfere unreasonably with

the operation of Sellers. Any environmental and property condition inspections shall be limited to non-invasive testing unless Sellers have agreed to the scope of such invasive testing prior to commencement of the same; provided, however, that Buyer shall be permitted to perform Phase I Environmental Assessments and asbestos inspections of the Owned Real Property. If any Seller fails to fully, completely and promptly respond to Buyer's reasonable request for information and/or meetings with such Seller's officers to review the same, or any of such Seller's officers fail to fully, completely, honestly and promptly provide such requested information, the Agreement may be terminated as follows: Buyer's chief executive officer shall provide written notice to the chief executive officer of SRHS of Buyer's election to terminate this Agreement, and, upon the giving of such notice, Sellers shall be entitled to 15 business days after the receipt of such notice from Buyer to cure any such failure to respond to any request submitted by Buyer under this Section 5.1 so long as SRHS' chief executive officer provides Buyer's chief executive officer notice of such intention to cure within five business days of the receipt of Buyer's chief executive officer's election to terminate this Agreement. Seller's termination of employment of any non-compliant officer and the provision of the information requested if otherwise available to Seller shall constitute a cure. If (a) Sellers do not cure, within the aforementioned 15-day cure period (or such longer reasonable period permitted by Buyer's chief executive officer if such failure cannot be cured within 15 days and Sellers are diligently pursuing a cure within such 15-day period) any failure to respond to any request submitted by Buyer, or (b) Buyer, in the exercise of its reasonable judgment, determines that Sellers cannot cure such failure to respond, then Buyer may terminate this Agreement forthwith.

5.2 **Operations.** From the Effective Date through the Closing Date, except as otherwise contemplated by this Agreement, each Seller shall:

(a) carry on its business in substantially the same manner as such Seller has heretofore and not make any material change in personnel, operations, finance, accounting policies or real or Personal Property of the Business;

(b) maintain the Purchased Assets and all parts thereof in good working order and condition, ordinary wear and tear excepted, which shall include, without limitation, making capital expenditures in respect of the Facilities in the ordinary course of business consistent with past practices;

(c) perform all of its obligations under the Assumed Contracts, Assumed Leases and all agreements relating to or affecting the Purchased Assets or the Business, except where such failure would not reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect;

(d) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between any Seller and any of the foregoing;

(e) take all actions necessary and appropriate to render title to the Purchased Assets free and clear of all Liens and Encumbrances (except for the Permitted Encumbrances)

and to obtain appropriate releases, consents, estoppels and other instruments as Buyer may reasonably request;

(f) keep in full force and effect present insurance policies or other comparable insurance;

(g) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be promptly provided to Buyer;

(h) conduct and provide to Buyer a quarterly update of the Wind Down Plan (commencing December 31, 2011);

(i) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the draft annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year and the final audited financial statement will be delivered by Sellers to Buyer within five business days of Seller's receipt of such statement from their auditor;

(j) provide Buyer with notice, and a description thereof, of any entry into, assumption, amendment or termination of any Physician Contract; and

(k) provide Buyer with notice, and a description thereof, of any grant of any increase in merit-based compensation or market adjustments to compensation with respect to any non-management employee(s).

5.3 **Negative Covenants.** Without limiting the generality or effect of Section 5.2, from the Effective Date to the Closing Date, except as expressly provided in this Agreement or as set forth in Section 5.3 of the Disclosure Schedule, no Seller shall, without requesting, in writing from the chief executive officer of SRHS, and receiving the written consent of Buyer's chief executive officer, not to be unreasonably withheld or delayed (and any failure by Buyer's chief executive officer to respond to any such request for consent within five business days will be deemed to be such written consent):

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to enter into or carry out its obligations hereunder or to own the Purchased Assets or operate the Business;

(b) enter into, assume, amend or terminate any Material Contract (other than Physician Contracts and agreements with third party payors) or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease, in accordance with any limitations and procedures mutually agreed upon by the parties' legal counsel;

(c) grant any material waiver or give any material consent with respect to any Material Contract or Lease or any Real Property Lease that is to be any Assumed Contract or Assumed Lease except in the ordinary course of business and except to the extent doing so would not have a Material Adverse Effect;

(d) assign, abandon, cancel or terminate before the stipulated expiration of its term any Material Contract or Lease or any Real Property Lease that is to be an Assumed Contract or Assumed Lease;

(e) acquire, make any investment in, or make any capital contributions to, any Person, except for another Seller, for a price or with a value in excess of $250,000;

(f) acquire or lease any material assets or sell, lease or otherwise dispose of any material asset or property, or create, assume or permit to exist any Lien or Encumbrance on any material asset or property constituting a part of the Purchased Assets, (other than any Permitted Encumbrance) in an amount in excess of $250,000, individually or in the aggregate;

(g) sell, lease or otherwise dispose to a third party of any assets other than in the ordinary course of business that have a value in excess of $50,000, individually or in the aggregate, and except for the disposition of obsolete or worn out assets;

(h) (i) incur any Indebtedness or (ii) make any loans or advances to any Person other than inter-company advances in the ordinary course of business to another Seller;

(i) enter into any compromise or settlement of any Litigation or Proceeding (other than any Litigation or Proceeding to which both Buyer and one or more Sellers are party) involving a payment by any Seller exceeding the greater of (i) $50,000 or (ii) the amount reserved, if any, with respect to such Litigation or Proceeding in Sellers' financial statements;

(j) grant or agree to grant to any of its non-management employees any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish for any of its employees new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans, except to preserve the status of the Church Plan, or as required by Applicable Law or technical, administrative or design amendments that do not increase the cost of providing benefits; provided, however, that any grant of any increase in merit-based compensation or market adjustments to compensation, in each case as consistent with past practices and in the ordinary course of business, shall not require Buyer's consent as long as Sellers provide notice of the same to Buyer;

(k) grant or agree to grant to any of its management employees (i.e., assistant vice president or above), directors or officers any increase in wages or bonus, severance, profit sharing, retirement, deferred compensation, insurance or other compensation or benefits, or establish any new compensation or benefit plans or arrangements, or amend or agree to amend any existing plans;

(l) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(m) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables other than in the ordinary course of business;

(n) enter into any agreement that restrains, limits or impedes any Seller's ability to compete with or conduct any business or line of business;

(o) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates, except in the ordinary course of business or pursuant to a contract in existence on December 31, 2010 or to another Seller; or

(p) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 5.3.

Notwithstanding anything to the contrary contained in this Section 5.3, Sellers may, with the prior written consent of Buyer, liquidate the assets of the Foundation in accordance with the plan of liquidation set forth on Exhibit G.

5.4 Governmental Approvals. Without limiting the generality or effect of Section 5.7, each Seller shall use its reasonable best efforts to (a) obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities as are necessary for each Seller to consummate the transactions contemplated hereby, including, without limitation, the Hart-Scott-Rodino Act filing, the CON Filing and the Church Approvals and, in the case of the Caritas SPA, government approvals in the State of Vermont and, in the case of the Lukan SPA, government approvals in Bermuda, and (b) assist Buyer, to the extent reasonably requested by Buyer, and to the extent they are legally transferable, in the transfer of each Seller's licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities other than those set forth in Section 5.4 of the Disclosure Schedule.

5.5 Charitable Funds. Buyer acknowledges and agrees that certain of the Sellers, including HSR and the Foundation, have received grants and hold other funds (the "**Charitable Funds**") for the benefit of Sellers or the Facilities. Buyer and Sellers acknowledge and agree that such Charitable Funds shall be used by Sellers to satisfy the Retained Liabilities of Sellers that exist after Closing. Sellers acknowledge and agree that, to the extent any Charitable Funds are available for transfer after Closing, Sellers shall work with Buyer to identify the Charitable Funds that may be transferred to Buyer or Buyer's Affiliate as part of the Purchased Assets at Closing, which such transferred Charitable Funds shall be used at or for the benefit of the Facilities. With respect to such Charitable Funds, Sellers acknowledge and agree that, to the extent permitted under Applicable Law, any Charitable Funds that cannot be transferred to Buyer or Buyer's Affiliate at Closing as part of the Purchased Assets shall be used by Sellers at or for the benefit of the Facilities; provided, however, that if such Charitable Funds cannot be used at or for the benefit of the Facilities, such Charitable Funds shall be used by Sellers to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. At Buyer's request, Sellers shall seek approval from donors, Governmental Authorities and courts of competent jurisdiction to permit the transfer and use of Charitable Funds as contemplated by this Agreement. With respect to any Charitable Funds identified by Buyer and Sellers pursuant to this Section 5.5 for which the stated or intended use thereof, or any restriction thereon, becomes unlawful, impracticable, impossible to achieve or wasteful as a result of this Agreement or otherwise, Sellers shall request that a court of competent jurisdiction provide relief to the parties

by applying cy pres to modify or terminate the instrument pursuant to which such Charitable Funds were or are to be transferred to Sellers in a manner such that any such funds may be transferred to and used by Buyer in a manner acceptable to Buyer or used to fund activities mutually agreed upon by the parties that benefit the delivery of health care services consistent with the Directives in the greater New Haven, Connecticut area. After the Effective Time, no Seller shall solicit grants, donations or other charitable funds.

5.6 Church Approvals. Without limiting the generality or effect of Section 5.7, from the Effective Date until the Closing Date, each Seller shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders (collectively, the "**Church Approvals**") of the Archdiocese of Hartford and the Holy See (collectively, the "**Church**") as are necessary for each Seller to consummate the transactions contemplated hereby.

5.7 Closing Conditions. From the Effective Date until the Closing Date, each Seller shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Buyer in doing, all things necessary, proper, or advisable to consummate, in a timely manner, the transactions contemplated hereby, including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

5.8 Payment of Obligations. Without limiting any other provision of this Agreement, each Seller shall, in the ordinary course of business: (a) pay all liabilities and obligations incurred by any Seller in connection with the ownership of the Purchased Assets and the operation of the Business, including, but not limited to, any and all liabilities and obligations arising under the HSR Financing Agreements and the Retained Liabilities; (b) maintain the Purchased Assets in good order and repair, normal wear and tear excepted; and (c) file all Tax Returns and pay on a timely basis Taxes owed, if any, as set forth on such Tax Returns.

5.9 No-Shop Clause. From the Effective Date until Closing, no Seller shall, without the prior written consent of Buyer: (a) offer for sale, or receive or consider any offer to purchase, the Purchased Assets (or any portion thereof) or any ownership or control interest of or in any Seller, (b) solicit, receive or consider offers to buy all or any portion of the Purchased Assets or any ownership or control interest of or in any Seller, (c) hold discussions with any Person or organization (other than Buyer) looking toward such an offer or solicitation or looking toward a merger or consolidation of or in any Seller or (d) enter into any agreement with any Person or organization (other than Buyer) with respect to the sale, management, operation or other disposition of the Purchased Assets (or any portion thereof) or any ownership or control interest in any Seller, or with respect to any merger, consolidation or similar transaction involving any Seller.

5.10 Transfer of Assets. In the event that the parties determine before or after Closing that any asset owned by any Seller or Affiliate of any Seller is used primarily in, or relates primarily to, the operation of the conduct of the Business, such Seller shall, or shall cause such Affiliate to, transfer, convey and deliver to Buyer such Seller's or such Affiliate's right, title and interest in, to and under such asset, free and clear of any Liens or Encumbrances, other than Permitted Encumbrances, at or after Closing, as applicable.

5.11 Real Property. Within 30 days of the Effective Date, Sellers shall (a) deliver to Buyer a certified rent roll for each parcel of Owned Real Property under lease to tenants; (b) provide to Buyer the most current operating expense information with respect to the Leased Real Property; (c) deliver to Buyer copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed as of the Effective Date; and (d) use their best efforts to obtain estoppel certificates in the form attached hereto as Exhibit M confirming lease information from third party tenants and landlords of the Leased Real Property, such best efforts of Sellers to continue after said 30-day period.

5.12 Insurance Coverage. Except as otherwise set forth on Section 5.12 of the Disclosure Schedule, Sellers shall maintain assignable reinsurance coverage applicable for all years during which professional or hospital liability claims may arise and for which the applicable statute of limitations has not run. At all times, Sellers shall continue to satisfy all required conditions of such reinsurance coverage, including, without limitation, carrier notification and cooperation requirements. Seller agrees to use its best efforts to cooperate with any regulatory approval from any Governmental Authority necessary for Buyer to acquire any interest of Sellers or their Affiliates in Lukan Indemnity Company, Ltd. ("**Lukan**") and Caritas Insurance Company ("**Caritas**").

5.13 Bankruptcy. In the event that one or more of Sellers commences or has commenced against it a case under title 11 of the United States Code, (the "**Bankruptcy Code**"), the applicable Seller(s) agree that each of them will: (a)(i) file a motion on the date of the entry of the order for relief, in form and substance reasonably acceptable to Buyer, seeking to assume this Agreement and approve the transaction pursuant to 11 U.S.C. Sections 363 and 365 (the "**Sale Motion**"); (ii) obtain entry of an order approving the Sale Motion (the "**Sale Order**") in form and substance reasonably acceptable to Buyer approving the Sale Motion within 45 days after the date of filing the Sale Motion or such further time as may be ordered by the bankruptcy court for cause; and (iii) take or cause to be taken any and all actions necessary or appropriate to cause the Sale Order to become a Final Order (including, but not limited to, vigorously defending any appeal that may be taken from the Sale Order) unless subsections (a) or (b) of the Final Order Exception applies; and (b)(i) file a motion on the date of the entry of the order for relief, in form and substance reasonably acceptable to Buyer, that approves the Break-Up Fee and Expense Reimbursement on the terms and conditions set forth in Section 11.3, Section 11.4 and Section 11.5 (the "**Bid Protection Motion**"); (ii) obtain entry of an order (the "**Bid Protection Order**") in form and substance reasonably acceptable to Buyer approving the Bid Protection Motion within 30 days after the date of filing the Bid Protection Motion or such further time as may be ordered by the bankruptcy court for cause but in any event before the entry of the Sale Order; and (iii) take or cause to be taken any and all actions necessary or appropriate to cause the Bid Protection Order to become a Final Order (including, but not limited to, vigorously defending any appeal that may be taken from the Bid Protection Order). In the event that Sellers fail to obtain the Bid Protection Order or the Bid Protection Order does not become a Final Order, Buyer shall retain (and shall not be deemed to waive) any right or claim for breach of warranty or for indemnification under this Agreement; once the Bid Protection Order has become a Final Order, Buyer's sole remedies shall be those set forth in Sections 11.2, 11.3, 11.4 and 11.5 of this Agreement.

5.14 Pharmacy License. Sellers agree to use reasonable best efforts to sell the Pharmacy License, on or before the Closing Date, to a third party that is not an Affiliate of any Seller.

5.15 Disclosure Supplements. From time to time at least as often as quarterly after the Effective Date and immediately prior to Closing, Sellers shall supplement or amend the Disclosure Schedule with respect to any matter first existing or occurring after the Effective Date that (a) if existing or occurring at or prior to the Effective Date, would have been required to be set forth or described in the Disclosure Schedule, or (b) is required to correct any information contained in the Disclosure Schedule or any representation or warranty of any Seller; provided, however, that if any such matter could reasonably be expected to result in a Material Adverse Effect or significant Loss, Sellers shall deliver such supplement or amendment promptly following their becoming aware of any such matter. In the event prior to Closing, there is damage or destruction to all or any portion of the Owned Real Property and such damage or destruction is not repaired by Sellers and for which there is insufficient insurance available to fund such repair, Seller shall deliver to Buyer supplement(s) or amendment(s) to the Disclosure Schedule disclosing the Losses resulting therefrom and the provisions of this Section 5.15 shall apply. The Disclosure Schedule shall be deemed modified in accordance with any such supplement or amendment for all purposes of this Agreement, provided that if any supplement(s) or amendment(s) to the Disclosure Schedules to this Agreement that discloses any matter or matters that could reasonably be expected to result in Losses, individually or in the aggregate, in excess of $15,000,000, Buyer shall have the right to terminate this Agreement, by giving written notice to Sellers of its election to so terminate within seven days of Buyer's receipt of such supplement or amendment; provided, however, that in the event Buyer so gives Sellers written notice of its election to terminate this Agreement, Sellers shall be entitled to 40 days after the effective date of such notice from Buyer to cure any such matter so disclosed by such supplement or amendment so long as Sellers provide Buyer notice of such intention to cure within five business days of Sellers' receipt of Buyer's election to terminate this Agreement. If Buyer, in the exercise of its reasonable judgment and taking into account Sellers' diligence in their attempt to cure, determines that Sellers cannot cure such deficiency, then Buyer may terminate this Agreement by written notice to Sellers within 30 days of Buyer's receipt of such supplement or amendment. If such deficiency is susceptible of cure, following the expiration of the aforementioned 40-day cure period, Buyer shall send Sellers a notice informing Sellers whether Buyer accepts or rejects the adequacy of Sellers' cure efforts (any such notice of rejection being referred to herein as a "**Rejection Notice**"). If Buyer accepts such cure efforts or fails to timely send a Rejection Notice, such Disclosure Schedule shall be modified as contemplated by such supplement or amendment for all purposes of this Agreement. If Buyer rejects any supplement or amendment to such Disclosure Schedule, then this Agreement shall be deemed terminated by Buyer pursuant to Section 11.1(g) and Buyer shall have no further rights relating to such deficiency or arising from such termination. If such deficiency is susceptible of cure and Sellers cure such deficiency within such 40-day period, the Disclosure Schedule shall be deemed modified for all purposes of this Agreement.

5.16 Continuation of Group Health Plan Coverage and COBRA Continuation Coverage. During the term of the Transition Services Agreements, Seller will continue to provide group health plan coverage to the employees of Seller. With respect to each group health plan that is subject to Code Section 4980B, Seller has complied with the continuation

coverage requirements contained in Code Section 4980B and Part 6 of Title I of ERISA. As of and after the Effective Time, Seller will provide group health plan coverage to all COBRA Qualified Beneficiaries of Seller (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4). To the extent that Seller ceases to provide any group health plan benefits to any employee of Seller or any organization in any controlled group that includes Seller (within the meaning of Code Section 414(b) or (c)), Buyer will provide group health plan coverage to all persons who are COBRA Qualified Beneficiaries of Buyer (as defined in Treasury Regulation Section 1.4980B-9, Q&A 4).

5.17 Teamsters Plan. On or before the Closing Date, Seller shall cease making contributions to the Teamsters Plan and effect a total withdrawal from the Plan. As soon as reasonably possible after the Closing Date, Seller shall make all required total withdrawal liability contributions to the Teamsters Plan and secure a release form the Teamsters Plan that settles all withdrawal liability issues of Sellers with respect to the Teamsters Plan.

5.18 Notice of Breach. In the event that any Seller breaches, in any material respect, any of its covenants contained in this Article 5, such Seller shall immediately deliver written notice of such breach to Buyer in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by such party.

ARTICLE 6. CERTAIN COVENANTS OF BUYER

6.1 Governmental Approvals. Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall use its reasonable best efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any governmental agencies or authorities as are necessary for Buyer to consummate the transactions contemplated hereby and to operate the Business from and after the Closing Date, including, without limitation, the Hart-Scott-Rodino Act filing and filings relating to the approval of the Connecticut Department of Public Health, the Connecticut Office of Health Care Access and the Centers for Medicare and Medicaid Services for consolidation of the Facilities, other than Grimes Center, under Buyer's hospital license and Medicare, Medicaid, TRICARE and other provider agreements and identification numbers and, with respect to Grimes Center, for issuance of an approval letter to Buyer or Buyer's designee and certificate of need approval for a chronic and convalescent nursing home license to operate Grimes Center and for assignment of the Grimes Center Medicare and Medicaid provider agreements to Buyer or Buyer's designee, a filing with the appropriate Governmental Authority in the State of Vermont with respect to the Caritas SPA and a filing with the appropriate Governmental Authority in Bermuda with respect to the Lukan SPA.

6.2 Church Approvals. Without limiting the generality or effect of Section 6.3, from the Effective Date until the Closing Date, Buyer shall cooperate with Seller, as is commercially reasonable, to obtain all Church Approvals pursuant to Section 5.6.

6.3 Closing Conditions. From the Effective Date until the Closing Date, Buyer shall use its commercially reasonable efforts to take, or cause to be taken, all actions, and do, or cause to be done, and assist and cooperate with Sellers in doing, all things necessary, proper or

advisable to consummate, in a timely manner, the transactions contemplated hereby including, without limitation, the satisfaction of the conditions set forth in Article 7 and Article 8.

6.4 **Notice of Breach**. In the event that Buyer breaches, in any material respect, any of its covenants contained in this Article 6, Buyer shall immediately deliver written notice of such breach to Sellers in accordance with Section 13.4, and such notice shall provide a detailed description of such breach, the date that the breach first occurred, and the date that such breach was discovered by Buyer.

6.5 **Real Property Reports**. Upon Sellers' reasonable request, Buyer shall provide Seller with copies of any property condition and environmental reports of the Real Property, excluding any portion of such reports which contain financial data or financial analysis, in Buyer's possession or control to the extent not already disclosed, including, without limitation, any reports created by or at the direction of Buyer through and including Closing.

ARTICLE 7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer hereunder are subject to the satisfaction or written waiver, on or prior to the Closing Date, of the following conditions:

7.1 **Representations/Warranties**. The representations and warranties of each Seller contained in this Agreement (as supplemented or amended as provided in Section 5.15) that are qualified by materiality or reference to "Material Adverse Effect" shall be true in all respects, and those that are not so qualified shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

7.2 **Covenants**. Each covenant contained in this Agreement to be complied with or performed by each Seller on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects. Each Seller shall have duly performed and complied in all material respects with all agreements and conditions required by this Agreement to be performed or complied with by it prior to or on the Closing Date.

7.3 **Officers' Certificate**. Buyer shall have received from each Seller an officers' certificate, executed on behalf of each such party by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date and stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, as the case may be, that the conditions in Section 7.1 and Section 7.2 have been satisfied.

7.4 **Litigation or Proceedings**. No Litigation or Proceedings before a court or any other Governmental Authority or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions

contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

7.5 Governmental Approvals. All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, certificates of need, approvals, authorizations, clearances, qualifications or orders required to be obtained prior to Closing by Buyer or any Seller from, any Governmental Authority for the consummation of the transactions contemplated hereby, including, without limitation, such notices, reports, filings, licenses, permits, consents, certificates of need, approvals, authorizations, qualifications and orders set forth in Section 6.1, shall have been made or obtained.

7.6 Church Approvals. All notices, reports and other filings required to be made prior to Closing by any Seller with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by any Seller from, the Church for the consummation of the transactions contemplated hereby shall have been made or obtained.

7.7 Closing Deliveries. Each Seller shall have made the deliveries required to be made by it under Section 9.2.

7.8 Third Party Consents. Each Seller shall have obtained consents from third parties for the assignment of the Assumed Contracts and Assumed Leases listed in Section 7.8 of the Disclosure Schedule.

7.9 Satisfaction of Retained Liabilities. At Closing, Sellers shall have submitted to Buyer, in writing and in form and substance reasonably satisfactory to Buyer, a plan for the orderly and timely satisfaction of all Retained Liabilities of each Seller substantially in the form of Exhibit N (the "**Wind Down Plan**"). Any portion of the Purchase Price or any other amounts held by Sellers, including any interest or earnings on or attributable to the Purchase Price or such other amounts that are at any time determined to be in excess of the amount necessary to satisfy the Retained Liabilities, shall be promptly paid by Sellers to Buyer or returned to Buyer as soon as legally permissible after any such determination.

7.10 Charitable Funds. Between the Effective Date and the Closing Date, Seller and Buyer shall have identified the Charitable Funds, and Seller shall have developed, in writing and in a form and substance reasonably satisfactory to Buyer, and implemented to the reasonable satisfaction of Buyer, a plan for the disposition of such Charitable Funds.

7.11 Grimes Center Medical Rate. Sellers shall have obtained all necessary approvals and waivers from the Connecticut Office of Policy and Management and the Connecticut Department of Social Services, pursuant to Connecticut General Statutes Section 17b-340(a), to prevent the rescission and recovery for affected rate years of any interim Medicaid rate established for Grimes Center, including without limitation, the Grimes Center interim Medicaid rate established effective July 1, 2008; provided, however, that the satisfaction of the condition set forth in this Section 7.11 shall be a condition only to Buyer's obligation to (a) purchase from Grimes Center the Purchased Assets owned by Grimes Center and (b) assume the Assumed Liabilities of Grimes Center.

7.12 Solvency Upon Closing.

(a) After giving effect to the transactions contemplated hereby, each Seller is Solvent, and, to the Knowledge of each such Seller, reasonably expects to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up Sellers' affairs; provided, however, that the foregoing shall cease to be a condition precedent to the obligations of Buyer pursuant to Article 7 hereunder if the Sale Order is entered and either of (i) the Sale Order has become a Final Order or (ii) the Final Order Exception applies. If the Buyer consummates the transactions contemplated herein without the Sale Order having become a Final Order, no notice of such waiver of this or any other condition to the Closing need be given except to the Sellers, it being the intention of the parties hereto that Buyer shall be entitled to, and is not waiving, the protections of Section 363(m) of the Bankruptcy Code, the mootness doctrine and any similar statute or body of law if the Closing occurs in the absence of the Sale Order being a Final Order.

(b) Within 30 days of the receipt of all necessary Government Authority approvals and the expiration of all Government Authority-required waiting periods, Sellers shall provide Buyer in writing with a preliminary conclusion as to the Solvency of each Seller at Closing. If Buyer does not agree with Sellers' preliminary view of whether each Seller will be Solvent at Closing, then Buyers and Sellers shall mutually engage and equally share the cost of a financial advisor with recognized hospital industry financial expertise (the "Financial Advisor") to determine in a written report and in accordance with customary industry practices and procedures whether each Seller will be Solvent at Closing. If Sellers or the Financial Advisor determines that any Seller other than HSR, SRHSAP or the Foundation will not be Solvent at Closing, unless Buyer otherwise agrees in writing and expressly waives all Solvency requirements with respect to such Seller (including those contained in Sections 3.18 and 7.12(a)), that Seller will no longer be a party to this Agreement, and its assets and liabilities shall no longer be Purchased Assets and Assumed Liabilities as set forth in Article 2. The parties shall be entitled to rely on, and will be bound by, any determination of the Financial Advisor as to the Solvency of any Seller at Closing.

7.13 Captives' Assets. The aggregate Net Assets of Caritas, Lukan, and HSR as set forth on the certificate delivered pursuant to Section 9.2(u) shall be equal to or greater than $11,700,000 on the Closing Date.

ARTICLE 8. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS

The obligations of Sellers hereunder are subject to the satisfaction, on or prior to the Closing Date, of the following conditions:

8.1 Representations/Warranties. The representations and warranties of Buyer contained in this Agreement shall be true and correct in all material respects, on and as of the Closing Date as though such representations and warranties had been made on and as of the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date).

8.2 Covenants. Each covenant contained in this Agreement to be complied with or performed by Buyer on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects.

8.3 Officers' Certificate. Sellers shall have received from Buyer an officers' certificate, executed by Buyer by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date, stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, that the conditions in Section 8.1 and Section 8.2 have been satisfied.

8.4 Litigation or Proceedings. No Litigation or Proceedings before a court or any other governmental agency or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

8.5 Governmental Approvals. All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, any Governmental Authority in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

8.6 Closing Deliveries. Buyer shall have made the deliveries required to be made by it under Section 9.3.

8.7 Church Approvals. All notices, reports and other filings required to be made prior to Closing by Buyer with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by Buyer from, the Church in connection with the execution and delivery of this Agreement and the consummation of the transactions contemplated hereby shall have been made or obtained.

ARTICLE 9. CLOSING

9.1 Closing. Subject to the satisfaction or waiver of all the conditions set forth in Article 7 and Article 8, the consummation of the sale and purchase of the Purchased Assets contemplated by this Agreement ("**Closing**") shall take place at the offices of Wiggin and Dana LLP, One Century Tower, 265 Church Street, New Haven, Connecticut, at 10:00 a.m., local time, on or before the 60th day following the satisfaction or waiver of the conditions set forth in Article 7 and Article 8 (other than those conditions that are to be fulfilled at Closing) or at such other location and/or on such other date as the parties hereto may mutually designate in writing (the "**Closing Date**"). The Closing shall be effective as of 12:01 a.m., local time, on the day following the Closing Date (the "**Effective Time**").

9.2 Actions of Sellers at Closing. At Closing, each Seller, as applicable, shall deposit into escrow with the Title Company Escrow Agent the following:

(a) a copy of the Assignment and Assumption of Leases executed by each Seller, together with necessary consents to such assignments, as applicable;

(b) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by each Seller, as applicable;

(c) copies of the Deeds executed by each Seller, as applicable, together with a signed standard seller's affidavit sufficient for the Title Policies to delete exceptions for third parties in possession (other than the Assumed Leases with respect to the Owned Real Property) and mechanic's liens and a Real Estate Conveyance Tax for each Deed;

(d) copies of resolutions duly adopted by the members and boards of directors of each Seller, authorizing and approving its performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of each Seller;

(e) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that the conditions set forth in Article 7 have been satisfied;

(f) a FIRPTA certificate executed by each Seller, as applicable;

(g) certificates of incumbency for the respective officers or directors, as the case may be, of each Seller executing this Agreement or certificates delivered to Buyer pursuant to this Section 9.2;

(h) all such termination statements and releases as are necessary to remove from the Purchased Assets all Liens and Encumbrances, other than the Permitted Encumbrances;

(i) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that all approvals of each Seller and their Affiliates have been obtained that are necessary to consummate the transactions contemplated by this Agreement;

(j) a written good faith estimate of Sellers setting forth, in sufficient detail acceptable to Buyer, the aggregate amount of Indebtedness of Sellers as of the Closing Date as well as the Retained Liabilities as of the Closing Date (the "**Financial Certificate**");

(k) evidence that all closing conditions set forth in Article 8 of the Caritas SPA have been satisfied or waived in accordance with the terms therein;

(l) evidence that all closing conditions set forth in Article 8 of the Lukan SPA have been satisfied or waived in accordance with the terms therein;

(m) copies of the Transition Services Agreement and Wind Down Services Agreement executed by SRHS;

(n) a certificate of the president and/or chief executive officer of each Seller (solely in his/her capacity as such), dated as of the Closing Date, certifying that each such Seller has paid in full to the Continuing Employees any and all liabilities incurred and due to be paid to such Continuing Employees through the Closing Date;

(o) a certified rent roll for each parcel of Owned Real Property under lease to tenants specifying in addition to rent due and owing, any other outstanding amounts due between landlord and tenant, including, without limitation, amounts relating to tenant improvements;

(p) copies of all property condition reports and environmental reports in Sellers' possession or control to the extent not already disclosed;

(q) a letter to all tenants notifying them of the change of ownership of the Owned Real Property and directing such tenants to pay all future rentals to Buyer or Buyer's designee and further advising tenants that specific security deposits, advance rents and interest thereon, if any, have been transferred to Buyer (the "**Notice to Tenants**"), executed by Sellers;

(r) a certificate of the president and/or chief financial officer of SRHS and HSR, respectively, certifying that to their Knowledge, after giving effect to the consummation of the transactions contemplated hereby, each Seller is Solvent and reasonably expects to remain Solvent through the winding up of its affairs, and will be able to timely satisfy its Retained Liabilities in full, as such Retained Liabilities become due and payable, based upon information then available and reasonable expectations and assumptions concerning competitive and regulatory conditions affecting the Business including the length of time it may take to wind up such Seller's affairs; provided, however, that this Section 9.2(r) shall cease to be a delivery required by (i) such Sellers if the Sale Order is entered and either of (A) the Sale Order has become a Final Order or (B) the Final Order Exception applies or (ii) any Seller that ceases to be a Seller, or as to which Seller Buyer has waived the Solvency requirement, pursuant to Buyer's election under Section 7.12(b);

(s) the Wind Down Plan;

(t) copies of the Caritas SPA and Lukan SPA executed by SRHS;

(u) A certificate of the president or chief financial officer of Caritas, Lukan and HSR (solely in his or her capacity as such), dated as of the Closing Date, setting forth the Net Assets as of the Closing Date, presented in substantially the form attached hereto as Exhibit O;

(v) A release from each Seller of all claims and causes of action that any of them may hold against Caritas and Lukan, in such form and substance as SRHS and Buyer shall mutually determine; and

(w) such other certificates, instruments, and documents as Buyer may reasonably request.

9.3 Actions of Buyer at Closing. At Closing, Buyer shall deposit into escrow with the Title Company Escrow Agent the following:

(a) (i) an amount equal to the amount required to be paid at Closing in accordance with Section 2.3, (ii) conveyance taxes due in connection with the Deeds, (iii) prorations pursuant to Section 9.4(c), (iv) the cost of the Owner's Title Policy and any endorsements thereto, (v) the cost of recording the Deeds to the Owned Real Property, (vi) Title Company Escrow Agent's fee, and (vii) survey costs;

(b) a copy of the Assignment and Assumption of Leases executed by Buyer;

(c) a copy of the Bill of Sale, Assignment and Assumption Agreement executed by Buyer;

(d) copies of resolutions duly adopted by the governing board of Buyer, authorizing and approving Buyer's performance of the transactions contemplated hereby and the execution and delivery of this Agreement, certified as true and in full force as of the Closing Date by the Secretary or an Assistant Secretary of Buyer;

(e) a certificate of Buyer, dated as of the Closing Date and signed by an authorized officer of Buyer, certifying that the conditions set forth in Article 8 have been satisfied;

(f) certificates of incumbency for the respective officers of Buyer executing this Agreement or any certificates delivered to Sellers pursuant to this Section 9.3;

(g) copies of the Transition Services Agreement and Wind Down Services Agreement executed by Buyer;

(h) a Notice to Tenants executed by Buyer;

(i) copies of the Caritas SPA and Lukan SPA executed by Buyer; and

(j) such other certificates, instruments and documents as Sellers may reasonably request.

9.4 Close of Title Company Escrow.

(a) The Title Company Escrow Agent will close escrow (the "**Close of Escrow**") on the Closing Date if all conditions specified in this Agreement have been satisfied or waived by (i) delivering the Deeds for recording, with instructions to deliver the Deeds to Buyer after recording, (ii) paying to each appropriate Seller the portion of the Title Company Escrow Funds due to such Seller, by wire transfer of immediately available funds to an account designated by SRHS, (iii) delivering to Sellers the deliveries required to be made by Buyer under Section 9.3 and (iv) delivering to Buyer the deliveries required to be made by Sellers under Section 9.2 (other than the Deed) and a copy of the Deed.

(b) Simultaneously with the Close of Escrow, Seller will deliver to Buyer, outside of the closing escrow, originals or, if originals are not in Sellers' possession, copies of (i) all service contracts assigned to Buyer, (ii) only to the extent in Sellers' possession, certificates of occupancy for the Owned Real Property, and documents evidencing other permits,

licenses, approvals, utility rights, development rights and similar rights related to the Owned Real Property, if any, transferred to Buyer that are in the possession of Sellers, (iii) all Leases and all Guarantees of Leases, if any, (iv) all assignable warranties and Guarantees covering all or any part of the Owned Real Property that are transferred to Buyer, if any, and (v) keys and security codes for all security devices necessary to the operation and maintenance of the Owned Real Property.

(c) Sellers and Buyer shall prorate between them as of the Closing Date all income and expense related to the normal operation, maintenance and repair of the Owned Real Property and, as applicable, the Leased Real Property, with the following clarifications and Encumbrances:

(i) The following are to be apportioned as of 12:01 a.m., local time, on the Closing Date:

(A) Real property and personal property taxes upon the Owned Real Property and Personal Property for the current calendar or fiscal year shall be prorated as of the Closing Date, Sellers' pro rata portion of such taxes shall be based upon taxes actually assessed for the current calendar or fiscal year. If, for any reason, such taxes for the current calendar year have not been assessed on the Owned Real Property, such proration shall be estimated based upon such taxes for the immediately preceding calendar or fiscal year, and thereafter adjusted when actual amounts become available;

(B) With respect to the Owned Real Property, water charges, storm water charges and sewer charges on the basis of the calendar year for which assessed;

(C) With respect to the Owned Real Property, fuel, including steam, oil and coal, if any, at the price charged therefor by Sellers' supplier;

(D) Amounts paid or payable under service contracts and similar agreements affecting the Owned Real Property;

(E) With respect to the Owned Real Property, rents, not in arrears, and any prepaid rent under the Assumed Leases; and

(F) With respect to the Leased Real Property, rents, any prepaid rent, any additional rent, escalations, taxes, utility payments and other payments made under the Real Property Leases.

(ii) Buyer shall be credited at Closing with an amount equal to the security deposits, if any, in connection with the Assumed Leases relating to the Owned Real Property, or Sellers shall turn such security deposits over to Buyer at Closing.

(iii) Sellers shall be credited at Closing with an amount equal to the security deposits, if any, and any utility deposits in connection with the Real Property Leases.

(iv) All charges for electric and gas service supplied to the Owned Real Property prior to the Closing Date shall be the obligation of Sellers, and Sellers agree to pay the invoices rendered in connection with such services promptly upon receipt thereof, whether such receipt is received before or after the Closing.

(v) If there is a water meter on the Owned Real Property, Sellers shall furnish a reading or readings to a date not more than three days before the Closing Date and the unfixed meter charge and sewer rent, if any, shall be apportioned on the basis of such last reading.

(vi) Sellers shall have the option to credit Buyer as an adjustment of the cash portion of the Purchase Price with the amount of any unpaid water charges and sewer rents, together with any interest and penalties thereon.

(vii) Real estate tax refunds and credits received after the Closing Date which are attributable to the fiscal or calendar year during which the Closing occurs shall be apportioned between Sellers and Buyer, after deducting reasonable expenses of collection thereof; provided, that Buyer shall not be obligated to pay Sellers their share of the same to the extent that Buyer determines, in the exercise of its reasonable judgment, that tenants under the Assumed Leases are entitled to the same and Buyer pays the same to such tenants.

(viii) Any errors or omissions in computing apportionments at the Closing shall be corrected as soon after discovery as possible. The provisions of this Section 9.4(c) shall survive the Closing for a period of 12 months.

(ix) Sellers shall forthwith turn over to Buyer any rental, additional rental and any other amounts received by Sellers in respect of the Owned Real Property at any time after the Closing and properly allocable to the period after the Closing. Buyer shall forthwith turn over to the Sellers any rental, additional rental and other amounts received by Buyer in respect of the Owned Real Property and properly allocable to the period prior to the Closing. Buyer shall use reasonable efforts after the Closing for a period of one year to collect delinquent rents for the period up to the Closing Date. If any tenant of Owned Real Property is in arrears in the payment of rent on the Closing Date, rents received from such tenant after the Closing shall be applied in the following order of priority: (A) first to the month preceding the month in which the Closing occurred; (B) then to the month in which the Closing occurred; (C) then to any month or months following the month in which the Closing occurred; and (D) then to the period prior to the month preceding the month in which the Closing occurred. If rents or any portion thereof received by Sellers or Buyer after the Closing are payable to the other party by reason of this allocation, the appropriate sum, less the proportionate share of any reasonable attorneys' fees, costs and expenses of collection thereof,

shall be promptly paid to the other party, which obligation shall survive the Closing. Buyer shall provide to Sellers an accounting of such collection activities 60 days thereafter for a period of one year from the Closing Date. Sellers shall have the right to pursue any delinquent rents for the period up to the Closing Date provided Sellers shall not have the right to commence any dispossess actions against such tenants.

(x) Brokerage commissions and tenant costs shall be apportioned and such obligations shall be assumed by Buyer as set forth on the rent roll for each Owned Real Property, as updated for Closing.

(xi) All prorations and payments to be made under the foregoing provisions shall be made on the basis of a written statement or statements delivered to Buyer by Sellers and approved by Buyer. In the event any prorations, apportionments or computation shall prove to be incorrect for any reason, then either party shall be entitled to an adjustment to correct the same, provided that it makes written demand on the one from who it is entitled to such adjustment within one year after Closing. The provisions of this Section 9.4(c) shall survive the Closing.

ARTICLE 10. CERTAIN ADDITIONAL COVENANTS

10.1 Operations Transition.

(a) YNHH Board. Upon the Effective Time, Buyer shall continue to be governed by a local Board of Trustees, to which three lay individuals and one member of SOC, mutually determined by Sellers and Buyer, shall be appointed to serve in accordance with the rights and responsibilities set forth in the bylaws of Buyer and established by Connecticut law, until his or her removal, resignation or retirement.

(b) Medical Staff and Medical Staff Bylaws. The medical staff of HSR at Closing shall continue their service as of the Effective Time and will become members of and combined with and become a part of the medical staff of Buyer (the "**Combined Medical Staff**"). The Combined Medical Staff will operate in accordance with the Bylaws, Rules and Regulations and Fair Hearing Plan, each as adopted by Buyer at Closing (collectively, the "**Combined Medical Staff Bylaws**"). Buyer shall ensure that the Combined Medical Staff Bylaws provide that the resources of Buyer will be available to all members of the Combined Medical Staff, without regard to whether they are university-based physicians or community-based physicians.

(c) Medical Staff Leadership.

(i) Medical Board. As of the Effective Time, Buyer will include on the Medical Board of the Combined Medical Staff certain individuals from the Medical Staff of HSR, including, at a minimum, the President and President Elect as of the Closing Date, such individuals to serve as two of the 12 community physician members of the Medical Board, filling vacancies in such membership. Each such individual shall, in accordance with the Combined Medical Staff

Bylaws and subject to removal or re-election in accordance with the terms thereof, serve for a term of three years or until the first election of community physician members to the Medical Staff thereafter.

(ii) Medical Staff Committees. Buyer will include representation of the Medical Staff of HSR as of the Closing Date on each of the following committees of the Combined Medical Staff, each such member to be identified by HSR and approved by Buyer in its reasonable discretion and to serve for a term of one year from the Effective Time:

(A) Credentials Committee;

(B) Perioperative Executive Leadership Committee;

(C) Institutional Practice Quality and Peer Review Committee;

(D) Bioethics Committee;

(E) Medical Record and Clinical Information Committee;

(F) Pharmacy and Therapeutics Committee;

(G) Pathology and Tissue Committee; and

(H) Utilization Review and Discharge Planning Committee.

(d) Medical Directorships. Buyer shall, effective as of the Effective Time, appoint a member of the Medical Staff of HSR as of the Closing Date to serve as Medical Director of each of the following services performed at the Facilities (each, a "**Medical Director**"), each such member to be identified by HSR and approved by Buyer in its reasonable discretion:

(i) Cardiology;

(ii) General Surgery;

(iii) Internal Medicine;

(iv) Obstetrics and Gynecology;

(v) Orthopedic Surgery; and

(vi) Psychiatry.

Each Medical Director shall provide oversight of the identified clinical services at the Facilities for a period of five years after the Effective Time, in accordance with and subject to the terms and conditions as established by Buyer prior to Closing.

(e) **Employed Physicians.** At Closing, Buyer or its designee will offer job opportunities, pursuant to terms and conditions of employment to be established by Buyer or its designee, to the employed physicians of HSR who are in good standing with HSR as of the Closing Date and who agree to become employed under Buyer's, or its designee's, terms and conditions of employment (the "**Continuing Physicians**"). Such offers of employment will be subject to the following objective eligibility criteria: (i) the U.S. Department of Health and Human Services OIG "excluded persons list" and (ii) the validation of licensure and other necessary qualifications where applicable. With respect to the Continuing Physicians, Buyer or its designee will provide compensation and benefits that is the same as what is provided by Buyer or its designee to its physicians in similar roles at the Closing Date. The Continuing Physicians' length of service at HSR shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise will be structured commensurate with those benefits offered to any newly-hired physician by Buyer or its designee at that time. Buyer or its designee will not assume any liability for any accrued vacation, severance or sick leave expenses of the Continuing Physicians who become employed by Buyer or its designee, and in connection therewith, HSR will be solely responsible for ensuring that any such amounts owing to the Continuing Physicians are paid upon the closing.

(f) **Site Directorships**. Buyer shall, effective as of the Effective Time, appoint a member of the Medical Staff of HSR as of the Closing Date to serve as Site Director of each of the following services performed at the Facilities (each, a "**Site Director**"), each such member to be identified by HSR and approved by Buyer in its reasonable discretion:

(i) Perioperative Services;

(ii) Diagnostic Radiology;

(iii) Anesthesia;

(iv) Emergency Department;

(v) Pathology; and

(vi) Radiology Oncology.

Each Site Director shall provide oversight of the identified clinical services at the Facilities for a period of five years after the Effective Time, in accordance with and subject to the terms and conditions as established by Buyer prior to Closing.

(g) **Hospital Services.** HSR is a party to various agreements (the "**Hospital Based Service Agreements**") pursuant to which community Physician groups provide hospital-based services, including anesthesia, radiology, radiation therapy and clinical and anatomic pathology services (the "**Hospital Based Services**"), to HSR patients. On or before the Closing Date, HSR shall cause each Hospital Based Service Agreement to be terminated or amended as of the Effective Time, in a manner directed by Buyer, in order to do one of the following, as determined by Buyer in its sole discretion: (i) terminate the Hospital Based Service Agreement without penalty to HSR, on the condition that the physicians providing services thereunder (the "**Hospital Based Physicians**") satisfy the requirements of and become full-time faculty members

of the Yale School of Medicine in order that services may be provided on and after the Effective Time as integrated services under the direction of the Yale School of Medicine; (ii) terminate or amend the Hospital Based Service Agreement without penalty to HSR, on the condition that the Hospital Based Physicians agree to the terms of a subcontract arrangement with the Yale School of Medicine in order that services may be provided on and after the Effective Time as services under subcontract with the Yale School of Medicine; or (iii) terminate the Hospital Based Service Agreement without penalty to HSR, on the condition that the Hospital Based Physicians become employed by Northeast Medical Group, Inc. in order that services may be provided on and after the Effective Time as services under subcontract between Northeast Medical Group, Inc. and the Yale School of Medicine. Any such amendment or termination shall be in form and substance satisfactory to Buyer, and may contain terms that require Hospital Based Physicians or any additional Physicians engaged on or after the Effective Time to provide Hospital Based Services to be or become full-time faculty members of the Yale School of Medicine.

(h) **Graduate Medical Education.** Buyer intends to integrate Seller's "entire program" into its graduate medical education programs as described in applicable federal regulations. In furtherance thereof:

(i) HSR shall assist Buyer in transferring the following residency and/or fellowship programs to Buyer (including the obtaining of any approvals required by any Residency Review Committee of the Accreditation Council for Graduate Medical Education), in order for such residency and/or fellowship programs to be integrated with the existing residency and/or fellowship programs operated by Buyer:

(A) Surgery;

(B) Diagnostic Radiology;

(C) Geriatrics;

(D) Nephrology;

(E) Cardiology;

(F) Oral and Maxillofacial Surgery; and

(ii) On or after the Effective Date, Buyer shall integrate is Primary Care residency program with the Internal Medicine residency program operated by HSR, and HSR shall obtain any required approvals (including any approvals required by the applicable Residency Review Committee of the Accreditation Council for Graduate Medical Education for HSR's Internal Medicine residency program to be integrated with Buyer's Primary Care residency program.

10.2 Preservation of Catholic Heritage. In light of the parties' understanding of and respect for the commitment of Sellers to the principle that care for the sick, the poor and the dying has deep roots in its Catholic ministry, Buyer will continue to provide patient care at the

Facilities in a manner that respects its Catholic heritage and this ethical principle as described herein. Buyer agrees that it will, after the Effective Time:

(a) cause the appointment of a Catholic Heritage Committee. The Catholic Heritage Committee shall be formed to ensure that the clinical services provided at the Facilities are consistent with the Directives, as adapted to the conditions of modern science and medicine and as deemed appropriate by SOC from time to time. The Catholic Heritage Committee will engage in self-evaluation, education and policy review, and may collaborate with other community organizations around mutually held goals. The Catholic Heritage Committee shall meet no less than twice annually and shall review clinical services provided at the Facilities, including, if applicable, any inquiry made by an employee, physician, patient or other regarding such clinical services. The Catholic Heritage Committee shall be composed of five staff members, including three staff members nominated by SOC. The Yale-New Haven Hospital Executive for Catholic Heritage and Pastoral Care shall serve on the Catholic Heritage Committee as one of the five staff members;

(b) modify the existing Community Advisory Committee in order to continue to support the parties' shared mission to provide services to improve access to health care services by including members nominated by SOC. Such members shall compose not less than 25% of the membership of the Community Advisory Committee;

(c) engage an individual selected by Buyer in consultation with SOC as the Executive for Catholic Heritage and Pastoral Care at the Facilities, whose duties will include mission and values. The Executive shall also have responsibility for Catholic heritage and pastoral care activities at the Facilities and shall be a member of Buyer senior team;

(d) amend the medical staff bylaws, employee code of conduct and other documents, as appropriate and as agreed to by the parties, to state the requirement to adhere to the Directives at the Facilities;

(e) provide annual education for medical staff members and other personnel at the Facilities concerning the Directives;

(f) maintain the Chapel at the Facilities as a place for Catholic, ecumenical and interreligious services as needed and appropriate for the benefit of staff, patients and families, and maintain appropriate signage and other symbols of Catholic identity at the Facilities, including, but not limited to, the name "The Hospital of Saint Raphael in the tradition of the Sisters of Charity of Saint Elizabeth" to the fullest extent permitted by 42 CFR Section 413.65 and other applicable state or federal law. Such Chapel, signage and religious symbols as SOC wishes to remain both within and on the external walls of the Facilities will so remain; provided, however, that in the event such signage and religious symbols cease to be used for any reason, they shall be transferred to SOC; and

(g) host a celebration of Founder's Day at the Facilities on an annual basis in order to honor SOC.

The commitments set forth in this Section 10.2 shall continue except as may be modified in accordance with this paragraph. If, as a result of changes in clinical services or programs,

practices or locations, or as a result of changes in the interpretation of the Directives, Buyer finds, acting reasonably and in good faith, that continued compliance with certain Directives will create a significant operational or patient care burden on Buyer, then Buyer shall work in good faith with the Catholic Heritage Committee to mitigate the burden while preserving the other commitments described in this Section 10.2. If, after working together for a period of at least 90 days, Buyer and the Catholic Heritage Committee have not found a practical way to reconcile mitigation of the burden with compliance with the Directives at issue, then the matter will be presented to Buyer's board of trustees for consideration and resolution. The decision by Buyer's board of trustees with respect to such matter shall be final. SOC may, at any time, terminate the mutual commitments set forth in this Section 10.2 by providing 90 days prior written notice to Buyer's board of trustees. Upon the effect of such termination, SOC may reclaim any religious symbols utilized at the Facilities.

10.3 Preservation and Access to Records After Closing.

(a) With regard to patient records relating to the Business, from and after the Effective Time, Buyer shall maintain the patient records held at the Facilities as of the Effective Time relating to periods prior to Closing in accordance with Applicable Law, and in a manner consistent with the policies and procedures of Buyer governing maintenance of patient records generated at the Facilities after the Effective Time.

(b) Each party acknowledges that, as a result of operating the Facilities, it will gain access to patient and other information that is subject to statutes, laws, rules and regulations regarding confidentiality, and agrees to abide by such statutes, laws, rules and regulations with regard to such confidential information.

(c) Each party hereto acknowledges that subsequent to Closing, the other parties may need access to information or documents in the control or possession of such party for the purposes of concluding the transactions contemplated hereby, audits, compliance with governmental requirements and regulations and the prosecution or defense of third party claims. Accordingly, each Seller, on one hand, and Buyer, on the other hand, agree that after Closing each shall make reasonably available to the other's representatives or agents, independent auditors and/or governmental agencies or authorities, upon written request, consistent with Applicable Law, and at the expense of the requesting party, such documents and information as may be available relating to the Business for periods prior and subsequent to Closing to the extent necessary to facilitate concluding the transaction herein contemplated, audits, compliance with governmental requirements and regulations and the prosecution or defense of claims.

10.4 Employee Matters.

(a) As of Closing, Buyer or its designee will offer job opportunities to substantially all of the Non-Bargaining Unit Employees of Seller(s) (other than those covered by Section 10.4(b) and Section 10.4(c) below) who (i) are in Good Standing with their respective Seller-employer(s) as of the Closing Date, (ii) agree to become employed under Buyer's, or its designee's, terms and conditions of employment and (iii) agree to waive and release their rights to payment for any accrued vacation, sick leave or other paid time off to which they would have otherwise been entitled from Seller(s) at their termination with such employer (the "**Continuing**

Non-Bargaining Unit Employees"). Such offers of employment will further be subject to the following objective eligibility criteria: (x) the U.S. Department of Health and Human Services OIG "excluded persons list" and (y) the validation of licensure and other necessary qualifications where applicable. With respect to the Continuing Non-Bargaining Unit Employees, Buyer or its designee will provide compensation and benefits that are consistent with what is provided by Buyer or its designee to employees in similar roles with Buyer, or its designee, at the Effective Time. The Continuing Non-Bargaining Unit Employees' length of service with their respective employer as of the Effective Time shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise be structured commensurate with those benefits offered to any newly-hired employee by Buyer or its designee at the Effective Time. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Non-Bargaining Unit Employees accrued as of the Effective Time, and in connection therewith, HSR or Grimes Center, as applicable, will be solely responsible for ensuring that any such amounts owed are paid upon Closing; provided, however, that the Continuing Non-Bargaining Unit Employees shall be afforded credit for accrued vacation days in accordance with Buyer's paid time off personnel policies.

(b) At Closing, Buyer or its designee will offer job opportunities to substantially all of the Bargaining Unit Employees who are in Good Standing with their respective Seller-employer(s) as of the Closing Date and who agree to become employed under Buyer's, or its designee's, terms and conditions of employment (the "**Continuing Bargaining Unit Employees**"). Such offers of employment will be subject to the following objective eligibility criteria: (i) the U.S. Department of Health and Human Services OIG "excluded persons list" and (ii) the validation of licensure and other necessary qualifications where applicable. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Bargaining Unit Employees accrued as of the Effective Time, and in connection therewith, HSR or Grimes Center, as applicable, will be solely responsible for ensuring that any such amounts owed are paid upon Closing. Neither Buyer nor its designee will assume any of the existing collective bargaining agreements in effect between any of the Sellers and the Teamsters. If Continuing Bargaining Unit Employees constitute a majority of the employees in an appropriate bargaining unit or units at the Facilities at the time that Buyer or its designee has hired the majority of the workforce in such unit(s), Buyer or its designee will recognize the Teamsters as the collective bargaining agent for such unit(s) and will enter into good faith negotiations with the Teamsters regarding a new collective bargaining agreement for such unit(s).

(c) At Closing, Buyer or its designee will offer job opportunities, to substantially all of the employees of Sellers (other than HSR and Grimes Center) (the "**Additional Employees**") who (i) are in Good Standing with their respective Seller-employer as of the Closing Date, (ii) agree to become employed under Buyer's, or its designee's, terms and conditions of employment and (iii) agree to waive and release their rights to any accrued vacation, sick leave or other paid time off to which they would have otherwise been entitled from Seller(s) at their termination with such employer (the "**Additional Continuing Employees**"). Such offers of employment will be subject to the following objective eligibility criteria: (x) the U.S. Department of Health and Human Services OIG "excluded persons list" and (y) the validation of licensure and other necessary qualifications where applicable. With respect to the Additional Continuing Employees, Buyer or its designee will provide compensation and benefits

that are consistent with what is provided by Buyer or its designee to its employees in similar roles with Buyer, or its designee, at the Effective Time. The Additional Continuing Employees' length of service with Sellers as of the Effective Time shall be recognized for purposes of benefits eligibility and vesting, and such benefits eligibility and vesting shall otherwise will be structured commensurate with those benefits offered to any newly-hired employee by Buyer or its designee at the Effective Time. Neither Buyer nor its designee will assume any liability for any vacation, severance or sick leave expenses of the Additional Employees accrued as of the Effective Time, and in connection therewith, each Seller will be solely responsible for ensuring that any such amounts owed are paid upon Closing; provided, however, that the Additional Continuing Employees shall be afforded credit for accrued vacation days in accordance with Buyer's paid time off personnel policies.

(d) The employment offers to the Continuing Employees shall provide for commencement of employment at the Effective Time. Nothing in this Section 10.4 is intended to or shall obligate Buyer or its designee(s) to employ or cause any person to employ any Continuing Employee(s) for any particular period of time.

(e) The provisions of this Section 10.4 are for the sole benefit of the parties to this Agreement and nothing herein, expressed or implied, is intended or shall be construed to confer upon or give to any Person (for the avoidance of doubt, including, but not limited to, any current or former directors, officers, employees, managers or independent contractors of any Seller, any of their Affiliates or any labor organization representing any of the Sellers' employees) any legal, equitable or other rights or remedies as third-party beneficiaries of this Agreement or any of the terms contained herein, or to expand the rights or terms of employment of such employees under any existing contracts, agreements or understandings, if any, with Buyer or its designee or Affiliates.

(f) At Buyer's reasonable discretion, after consultation with Sellers, it may in writing prior to the closing, receive and obtain control over all of the assets held as funds for "estimated workers' compensation liabilities." Further, Buyer has the right to assume all such funds or to choose to assume only those funds set forth in the "trust fund" or the workers' compensation funds held by a bank or financial institution as cash collateral for the "performance bond." If Buyer chooses to exercise this right it will notify Seller at least five days before Closing and also assume all liabilities and obligations under any agreement related to these funds as well as for all outstanding and future workers' compensation liabilities of any present or former Seller employee, regardless if said employee is employed in the future by Buyer.

(g) Sellers acknowledge and agree that they shall use their best efforts to cause any renewal or extension of (i) the Prefunding Deductible Reimbursement and Security Agreement, effective effective April 17, 2011, by and among SRHS and Pennsylvania Manufacturers' Association Insurance Company, Manufacturers Alliance Insurance Company, and/or Pennsylvania Manufacturers Indemnity Company (the "**Security Agreement**") and/or (ii) the Agreement for Third Party Claims Handling Services, dated March 30, 2011, by and among HSR and PMA Management Corp. of New England, Inc. and Pennsylvania Manufacturers Indemnity Company (the "**TPC Agreement**") (collectively, the Security Agreement and TPC Agreement are referred to herein as the "**PMA Agreement**"), to expire or terminate as of Closing. Notwithstanding the foregoing or any provision of this Agreement, including the

Disclosure Schedule, to the contrary, under no circumstances shall the PMA Agreement constitute an Assumed Contract if, at Closing, the then-existing term of the PMA Agreement is for a period of greater than two years.

10.5 Tax Matters.

(a) From and after Closing, in connection with the preparation of Tax Returns, audit examinations and any administrative or judicial proceedings relating to any Tax liabilities imposed on any Seller or Buyer for Pre-Closing Tax Periods, Buyer shall cooperate with Sellers, and Sellers shall cooperate with Buyer, including, without limitation, furnishing or making available during normal business hours records, personnel (as reasonably required and at no cost to the other party), books of account, powers of attorney or other materials necessary or helpful for the preparation of such Tax Returns, the conduct of audit examinations, or the defense of claims by Tax authorities as to the imposition of Taxes. From and after Closing, Sellers shall retain all Tax Returns, schedules and work papers and all material records or other documents relating to all Taxes of Sellers for the Pre-Closing Tax Periods until the later of (i) the expiration of the statute of limitations of the taxable periods to which such Tax Returns and other documents relate, without regard to extension, except to the extent notified by another party in writing of such extensions for the respective taxable periods, or (ii) seven years following the due date (without extension) for such Tax Returns, and Sellers shall maintain such Tax Returns, schedules, work papers, records and documents in the same manner and with the same care it currently uses in maintaining its Tax Returns, schedules, work papers, records and documents. Sellers shall give Buyer reasonable written notice prior to destroying or discarding any such books or records and, if the notified party so requests, the notified party shall be permitted to take possession of such books and records. Any information obtained under this Section 10.5(a) shall be kept confidential, except as may be otherwise necessary in connection with the filing of Tax Returns or claims for refund or in conducting an audit or other proceeding.

(b) Buyer shall pay, and indemnify Sellers from and against, to the extent paid by Sellers, any sales, use, transfer, value added, stamp, registration, real property transfer or gains, recording or other similar Taxes, together with any conveyance fees, recording charges and other charges, payable as a result of the transactions provided for by this Agreement. Sellers shall cooperate with Buyer to the extent reasonably requested to reduce or eliminate such Taxes, fees or charges. Buyer and Sellers, as applicable, at Buyer's own expense, shall file or cause to be filed all necessary Tax Returns and other documentation with respect to all such Taxes.

10.6 Sellers' Cost Reports. Sellers shall be solely responsible for and shall prepare and timely file all cost reports and all other filings which are required to be filed with any Governmental Authority under the Medicare, Medicaid or TRICARE programs with respect to the operation of the Business preceding the Effective Time. Sellers shall be solely responsible for any pending or potential audit or examination, and any and all payments, interest, fines and penalties related to any such cost reports and filings.

10.7 Allocation of Purchase Price. The payments made by Buyer pursuant to Section 2.3 shall be allocated among the Purchased Assets as mutually agreed between the Parties prior to Closing (the "**Section 1060 Allocation**"). The parties agree that any Tax Returns shall be prepared and filed consistently with such agreed upon Section 1060 Allocation. In this

regard, the parties agree that, to the extent required, they will each properly prepare and timely file Form 8594 in accordance with the agreed upon Section 1060 Allocation.

10.8 Patient Receivables.

(a) Sellers hereby authorize Buyer or Buyer's designee, and Buyer agrees to perform or cause its designee to perform, the services specified herein with respect to the Patient Receivables relating to the rendering of services and provision of medicine, drugs and supplies by Sellers after the Effective Date and prior to the Effective Time to patients admitted to the Facilities on or before the Effective Time but from whom payment has not been received as of the Effective Time. In connection therewith, on or before Closing, Buyer and Sellers shall establish an account of Sellers at a financial institution in New Haven, Connecticut selected by Sellers and reasonably acceptable to Buyer. After Closing, the Patient Receivables shall be received in Sellers' name and on Sellers' behalf, and Buyer or its designee shall deposit in such account cash, checks, drafts or other similar items of payment allocable to Sellers' Patient Receivables.

(b) Sellers shall be the owner of the account and shall have control over that account. However, Sellers shall execute a standing transfer order causing amounts on deposit in the account to be swept on a periodic basis (designated by Buyer) to an account owned and controlled solely by Buyer. Amounts deposited into the account are to be swept to Buyer's designated account.

(c) Sellers shall cooperate with Buyer in the execution of such documents, instruments, authorizations and consents as Buyer reasonably may request from time to time to carry out the purposes and intent of this Section 10.8. Neither Buyer nor its designee shall have any duty with respect to the Patient Receivables other than as specifically set forth herein.

10.9 Return of Payments. If Sellers or Buyer receives any amount from patients or third-party payors which under the terms of this Agreement, belongs to the other party, the party receiving such amount shall , upon confirmation of ownership of the amount, remit within 10 business days said full amount to the other party.

10.10 Title.

(a) Sellers shall be obligated to remove or bond over all liens and monetary encumbrances to title (meaning mortgages and deeds of trust, mechanics liens and judgments) other than non-delinquent real property taxes prior to the Closing and to remove any encumbrances to title created by Sellers between the Effective Date and the Closing Date unless approved by Buyer in writing. Sellers may utilize the closing proceeds to secure release of any such lien or monetary encumbrance.

(b) The title herein required to be furnished by the Seller shall be marketable, subject only to the items set forth in Schedule A of Disclosure Schedule 3.9(a) Part A and the Permitted Encumbrances, and the marketability thereof shall be determined in accordance with those provisions of the Connecticut General Statutes addressing marketability of title and the Standards of Title of the Connecticut Bar Association. Any and all defects in or encumbrances against the title which come within the scope of such provisions of the General Statutes and/or

the Standards of Title shall not constitute valid objections on the part of the Buyer, if such Statutes or Standards do not so provide, and provided the Seller furnishes any affidavits or other instruments which may be required by the applicable Statutes or Standards, and further provided title will be insurable at standard premiums by the Title Company or such other title insurance company licensed in the State of Connecticut reasonably satisfactory to Buyer.

10.11 Property Planning Review.

(a) Buyer shall have the right to conduct, at its sole expense, a property planning review of the Owned Real Property after the Effective Date. Such review may include environmental inspections and site assessments, a survey of the Owned Real Property, a review of the status of compliance of the Owned Real Property with applicable laws, ordinances, codes and regulations, architectural and engineering inspections and tests, soils, building condition, zoning status, real estate tax bills, review of leases, and any and all other matters relating to the Owned Real Property and its condition, legal status and operations and such other tests and inspections as Buyer determines in consultation with Buyer's consultants, subject to the provisions of clause (b) of this Section.

(b) Upon reasonable advance notice to Sellers, Sellers shall grant Buyer, or Buyer's agent, the right to enter upon the Owned Real Property during normal business hours at times mutually acceptable to Buyer and Sellers for the purposes of the performance of any of the inspections, tests or evaluations set forth above. No invasive testing or boring shall be done without prior notification to Sellers of the scope of the invasive testing and Sellers' written permission of the same, which permission shall not be unreasonably conditioned, withheld or delayed. Buyer will not interfere unreasonably with the activity of tenants or any persons occupying or providing service at the Owned Real Property. Buyer shall be liable for any damages resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents during the period of Buyer's inspection, testing of, and access to, the Owned Real Property. Within 30 days following the completion of any such inspections, tests or evaluations or such earlier date in the event this Agreement is terminated, Buyer shall make such repairs and perform such restoration with respect to portions of the Owned Real Property affected by the activities or inspections of Buyer to the same condition as existed prior to such activities or inspections performed by or on behalf of Buyer.

(c) Prior to commencement of any investigative activities on the Owned Real Property, Buyer shall obtain at Buyer's sole cost and expense a policy of commercial general liability insurance with limits of not less than $1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage liability, containing the insurer's standard provision regarding waiver of subrogation and shall name Sellers as an additional insureds. Buyer shall provide a certificate of insurance reasonably approved by Sellers, which such approval shall not be unreasonably withheld. Sellers approve GEI as Buyer's enviornmental consultant. Any consultants retained by Buyer shall be reasonably satisfactory to Sellers. If Buyer retains consultants to perform investigative activities on the Owned Real Property, Buyer shall cause consultant(s) to provide certificates of insurance from each consultant prior to entering the Owned Real Property. Consultant(s) certificates of insurance shall provide limits of insurance not less than $1,000,000 combined single limit for bodily injury and property damage

and, if appropriate, professional liability with limits of not less than $1,000,000 and shall name Buyer and Sellers as additional insureds. Certificates of insurance and the insurance carrier providing those certificates shall be reasonably satisfactory to Sellers. Buyer shall also cause such consultants to provide evidence of workmens' compensation insurance and to enter into indemnification agreements in form and substance reasonably acceptable to Sellers.

(d) Buyer shall protect, indemnify, defend and hold the Owned Real Property, Sellers and Sellers' officers, directors, shareholders, participants, affiliates, employees, representatives, invitees, agents and contractors free and harmless from and against any and all claims, damages, liens, stop notices, liabilities, losses, costs and expenses, including reasonable attorney's fees and court costs for personal injury or property damage resulting from Buyer's inspection, testing of, and access to, the Owned Real Property or from the conduct of Buyer or its employees, invitees or agents (collectively, the "**Claims**") including, without limitation, repairing any and all damages to any portion of the Owned Real Property arising out of or related (directly or indirectly) to Buyer's conducting such inspections, surveys, tests, and evaluations, but Buyer shall not be liable for any diminution in Owned Real Property value resulting from Buyer's discovery of any matters by such inspection and testing nor shall Buyer be liable for any existing conditions or for any personal injury or property damage attributable to the negligence or misconduct of Sellers or its representatives. Buyer shall keep the Owned Real Property free and clear of any mechanic's liens or materialmen's liens related to Buyer's right of inspection and the activities contemplated by this Section. Notwithstanding anything to the contrary contained in this Agreement, the Buyer's indemnification obligations set forth herein shall survive the Closing or termination of this Agreement prior to the Closing for a period of two years.

10.12 Confidentiality. It is understood by the parties hereto that this Agreement, the information, documents and instruments exchanged by the parties or the parties' agents in connection with the transactions contemplated hereby, and the information, documents and instruments delivered in connection with the transactions contemplated hereby (collectively, the "**Confidential Information**") are of a confidential and proprietary nature. Each of the parties hereto agrees that, to the extent permitted by Applicable Law, both prior and subsequent to Closing, they shall maintain the confidentiality of the Confidential Information and, without the prior written consent of the other party, shall disclose the Confidential Information only to their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them and applicable Governmental Authorities), exercising the same care in handling such Confidential Information as would be exercised by such party in connection with similar information of its own. Each of the parties hereto further agrees that if the transactions contemplated hereby are not consummated or if this Agreement is terminated in accordance with its terms, it shall return any and all written Confidential Information and all copies thereof in the possession of their duly authorized officers, directors, representatives and agents (including attorneys and accountants engaged by them) to the other party to this Agreement at such other party's request. Each of the parties hereto recognizes that any breach of this Section 10.12 would result in irreparable harm to the other parties to this Agreement and their Affiliates and that therefore either 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 their other legal and equitable remedies. Prior to Closing, except as otherwise required by law or legal process, any release to the public of information respecting the matters set forth herein (including, without limitation, press releases and other media

contacts), will be made only in the form and manner approved by the parties and their respective counsel (which approval may be withheld only for good reason or cause). If Closing fails to occur for any reason or if this Agreement is terminated in accordance with its terms, the parties hereto agree to keep confidential and not disclose the Confidential Information for a period of five years from the Effective Date.

10.13 Tail Insurance.

(a) At Buyer's expense, Sellers shall arrange or shall cause its Affiliates to arrange for Buyer to either (i) purchase tail insurance policies for the insurance policies listed in Section 10.13(a) of the Disclosure Schedule providing continued coverage for a period of three years following the Closing (the "**Tail Insurance Policies**"), or (ii) be named as an additional insured on the Tail Insurance Policies. Buyer shall be entitled to file claims and receive payment pursuant to the terms of the Tail Insurance Policies after Closing.

(b) Except as otherwise agreed to by Buyer, HSR shall cause Lukan to offer a Tail Insurance Policy to each Physician (other than Physicians employed by Sellers) on commercially reasonable terms and conditions.

10.14 Press Releases. Buyer and Sellers shall jointly determine and agree upon the form, timing and content of all public announcements, press releases or other public statements concerning the transactions described in this Agreement, and neither Buyer nor Sellers shall independently make such statements without the prior consent of the other.

10.15 Compliance with the Transfer Act. Buyer and Sellers acknowledge that the property located at 1450 Chapel Street, New Haven is an "establishment" as that term is defined in the Transfer Act. Buyer agrees to be solely responsible for compliance with the Transfer Act and the performance of all obligations under the Transfer Act and specifically covenants to perform the following acts:

(a) determine the applicability of the Transfer Act;

(b) sign and file any appropriate Transfer Act form with the Connecticut Department of Environmental Protection as a "Certifying Party" and make all required submissions in connection with the Transfer Act;

(c) pay any Transfer Act form filing fee and all other related fees and costs; and

(d) conduct any additional environmental assessment, remediation and/or monitoring that may be required pursuant to the Transfer Act.

10.16 Post Effective Time Operations. From the Effective Time through the winding down of the affairs of each Seller, each such Seller shall:

(a) wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) conduct and provide to Buyer a quarterly update of the Wind Down Plan;

(c) provide Buyer with (i) notice and a complete oral description of any discussions with any of Sellers' creditors, bondholders, bond trustees, bond insurers, credit enhancers, swap counterparties or any other lenders and (ii) copies of any written correspondence, documents, agreements or other materials between and Seller and any of the foregoing;

(d) provide to Buyer copies of any and all draft and final annual audited financial statements of Sellers for fiscal years 2011 and 2012, respectively; the final annual audited financial statements will be delivered by Sellers to Buyer no later than December 1 of the subject year; and

(e) conduct end of quarter stub period audits upon Buyer's request and at Buyer's expense, the results and any work product of which shall be immediately provided to Buyer.

10.17 Post Effective Time Negative Covenants. Without limiting the generality or effect of Section 10.16, from the Effective Time through the winding down of the affairs of each Seller, no such Seller shall, except in accordance with the Wind Down Plan or with the written consent of Buyer:

(a) amend its governance documents in any manner which would impair in any material respect its authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(b) acquire, make any investment in, or make any capital contributions to any Person;

(c) acquire or lease any material assets;

(d) sell, lease or otherwise dispose to a third party of any assets;

(e) (i) incur any Indebtedness or (ii) make any loans or advances to any Person;

(f) enter into any compromise or settlement of any Litigation or Proceeding involving a payment by any Seller exceeding $50,000;

(g) make any material change in any method of accounting or accounting practice or policy, except as required by any changes in GAAP or Applicable Law;

(h) compromise, settle, reduce or offer any discount or other inducement for the early payment of accounts receivables;

(i) enter into any agreement that restrains, limits or impedes any Seller's authority or ability to wind down its affairs and satisfy all of its Retained Liabilities in accordance with the Wind Down Plan;

(j) make any distributions to its members or make any payment of cash or transfer any property to any Person, including any Affiliates; or

(k) authorize any of, or commit or agree to take any of, the foregoing actions in respect of which it is restricted by the provisions of this Section 10.17.

10.18 Restrictive Covenants.

(a) Sellers recognize and acknowledge that: (i) Buyer's entering into this Agreement is induced because of the covenants and assurances made by Sellers hereunder; (ii) the covenant not to compete of Sellers and their Affiliates is necessary to insure the continuation of the business of Buyer in respect of the Purchased Assets subsequent to Closing; and (iii) irreparable harm and damage will be done to Buyer in the event that any Seller or any of their Affiliates compete with Buyer within the area or areas specified in this Section 10.18. Therefore, in consideration of the premises and as a necessary inducement for Buyer to enter into this Agreement and consummate the transactions set forth herein, Sellers, on their own behalf and on behalf of their Affiliates (collectively, the "**Restricted Entities**"), agree that for a period of five years from and after the Closing Date (the "**Noncompete Period**"), the Restricted Entities shall not, directly or indirectly, in any capacity own, manage, operate, control, participate in the management or control of, be employed by, extend credit to, provide consulting services for or maintain or continue any interest whatsoever in any enterprise that is located within 35 miles of any of the Facilities and which is engaged in any health care services other than community outreach services provided without reimbursement as part of a charitable, educational or religious mission.

(b) Sellers agree and acknowledge that the restrictions contained in this Section 10.18 are reasonable in scope and duration, and are necessary to protect Buyer. If any Seller breaches or violates any provision of this Section 10.18, the Noncompete Period shall be extended by the amount of time that such breach or violation continues, as determined by Buyer in its reasonable discretion. Sellers agree and acknowledge that any breach of this Section 10.18 will cause irreparable injury to Buyer and upon any breach or threatened breach of any provision of this Section 10.18, Buyer shall be entitled to injunctive relief, specific performance or other equitable relief, without the necessity of posting bond; provided, however, that this shall in no way limit any other remedies which Buyer may have as a result of such breach, including the right to seek monetary damages. Sellers further acknowledge and agree that the payment of the Purchase Price shall constitute, among other things, full consideration for the restrictive covenants contained in this Section 10.18. The parties agree that Buyer may assign, without limitation, the foregoing restrictive covenants to any successor of Buyer. The provisions of this Section 10.18 shall be construed as an agreement on the part of Sellers independent of any other part of this Agreement or any other agreement, and the existence of any claim or cause of action of any Seller against Buyer, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement by Buyer of the provisions of this Section 10.18.

ARTICLE 11. TERMINATION

11.1 Termination. This Agreement shall have a term commencing on the Effective Date and continuing through the winding up of the affairs of the Sellers. This Agreement may be terminated as follows:

(a) by the mutual written consent of Sellers and Buyer;

(b) by Sellers or Buyer, if Closing shall not have occurred on or before March 1, 2013, other than as a result of any breach of any provision of this Agreement by the party seeking to terminate this Agreement; provided, however, that, if an appeal is taken of the Sale Order, this date shall be extended until 30 days following the final resolution or disposition of all such appeals;

(c) by Buyer prior to Closing, upon an injunction issued by a court of competent jurisdiction preventing the consummation of the transactions contemplated by the Agreement;

(d) by Sellers prior to Closing, by written notice to Buyer, if Buyer shall have (i) breached any of its representations or warranties contained in this Agreement that are qualified by reference to "Buyer Effect", (ii) breached in any respect any of its representations or warranties that are not so qualified if such breach could reasonably be expected to have a Buyer Effect or (iii) breached in any material respect any of its covenants contained in this Agreement, in each case which breach cannot be or has not been cured within 30 calendar days after the giving of written notice to Buyer;

(e) by Buyer prior to Closing, by written notice to Sellers, if any Seller shall have (i) breached any of its representations or warranties contained in this Agreement that are qualified by reference to "Material Adverse Effect", (ii) breached in any respect any of its representations or warranties that are not so qualified if such breach could reasonably be expected to have a Material Adverse Effect or (iii) breached in any material respect any of its covenants contained in this Agreement, in each case which breach cannot be or has not been cured within 30 calendar days after the giving of written notice to such party;

(f) by Buyer, prior to Closing, pursuant to Section 5.1;

(g) by Buyer prior to Closing, pursuant to Section 5.15;

(h) by Buyer if an Alternative Transaction is consummated or any Seller or court of competent jurisdiction enters into or approves, as applicable, any agreement for an Alternative Transaction; or

(i) notwithstanding anything to the contrary in this Section 11.1, by Buyer prior to Closing by written notice to Sellers, if (i) after giving effect to the transactions contemplated hereby, (A) Sellers or the Financial Advisor have determined that HSR, SRHSAP or the Foundation will not be Solvent at Closing, and (B) to any Seller's Knowledge, HSR, SRHSAP or the Foundation does not reasonably expect to remain Solvent through the winding up of its affairs based upon information then available and reasonable expectations and

assumption concerning competitive and regulatory conditions affecting the Business of such Seller including the length of time it may take to wind up such Seller's affairs; or (ii) any Seller fails to commence a bankruptcy case under title 11 of the United States Code, as contemplated by the terms of Section 3.18, Section 5.13 and Section 7.12, within 45 days following Sellers' or the Financial Advisor's determination that such Seller is no longer Solvent.

11.2 Effect of Termination. In the event of the termination of this Agreement and the abandonment of the transactions contemplated hereby pursuant to Section 11.1, this Agreement shall forthwith become void and have no effect, without any liability on the part of any party hereto, and all rights and obligations of all parties under this Agreement shall cease; provided, however, that (a) Section 10.12, this Section 11.2, Section 11.3, Section 11.4, Section 11.5 and Article 13 shall survive any such termination and abandonment and (b) nothing contained in this Section 11.2 shall relieve any party from liability for fraud or any breach of any covenant in this Agreement.

11.3 Break-Up Fee and Expense Reimbursement. In consideration of Buyer's due diligence, good faith negotiations of and entering into this Agreement and as reimbursement of Buyer's expenses incurred in connection with the transactions contemplated hereunder, the Sellers shall pay to Buyer in accordance with Section 11.4 and Section 11.5 the following:

(a) a break-up fee in the amount equal to three and one-half percent of the Purchase Price (the "**Break-Up Fee**"); and

(b) notwithstanding anything contained to the contrary in Section 13.3, Buyer's expenses incurred in connection with this Agreement (including any other agreements, exhibits and schedules contemplated hereunder) and the transactions contemplated herein and therein, including, but not limited to, Buyer's legal and accounting expenses, due diligence (including travel expenses), all work performed by Buyer to prepare the Purchased Assets and the related servicing for transition to Buyer upon or soon after Closing and the prosecution and filing of the Hart-Scott-Rodino Act filing (the "**Expense Reimbursement**").

11.4 Conditions for and Payment of Break-Up Fee and Expense Reimbursement. Buyer shall earn (a) the Break-Up Fee and the Expense Reimbursement upon one or more Sellers (or any Affiliate thereof) accepting a bid or offer for an Alternative Transaction, and (b) the Expense Reimbursement upon the failure of the condition in Section 7.12 due to (i) any Seller's failing to commence a bankruptcy case under title 11 of the United States Code, as contemplated by the terms of Section 3.18, Section 5.13 and Section 7.12, within 45 days following Sellers' or the Financial Advisor's determination that such Seller is no longer Solvent or (ii) any Seller's failure to comply with the covenants in Section 5.13. The Break-Up Fee shall be paid by wire transfer of immediately available funds to an account designated in writing by Buyer on the date that an Alternative Transaction is consummated. The Expense Reimbursement shall be paid by wire transfer of immediately available funds to an account designated in writing by Buyer within five business days of the Sellers' receiving from Buyer evidence of such expenses; provided, however, that, if an appeal is taken of the Sale Order, the Expense Reimbursement shall not be payable until (and Buyer shall receive payment of any Expense Reimbursement upon) any final resolution or disposition of such appeal. Notwithstanding anything to the contrary set forth in this Agreement, unless the Bid Protection Order is entered and has become a Final Order, this

Section 11.4 shall not be deemed or construed to limit any rights or remedies, at law or in equity, Buyer may have against the Sellers and/or any of their Affiliates, principals, shareholders or members in connection with any violation or breach of (whether actual or anticipatory), or default under, this Agreement; once the Bid Protection Order has become a Final Order, Buyer's sole remedies shall be those set forth in Sections 11.2, 11.3, 11.4 and 11.5 of this Agreement. In no event shall Buyer be entitled to receive or retain the Break-Up Fee or the Expense Reimbursement if the transactions contemplated by this Agreement are consummated, whether or not pursuant to a Sale Order.

11.5 Joint and Several Liability of Sellers for Break-Up Fee and Expense Reimbursement. The Sellers' obligation to pay the Break-Up Fee and the Expense Reimbursement pursuant to Section 11.4(a) and Section 11.4(b) shall be joint and several. To the extent (a) consummation of any Alternative Transaction is made pursuant to a sale authorized pursuant to title 11 of the United States Code, a plan of reorganization, plan of liquidation or other plan of arrangement under applicable law, or (b) the Expense Reimbursement is earned pursuant to Section 11.4(b)(ii), the Sellers shall undertake reasonable best efforts to seek approval from a court of competent jurisdiction to have the Break-Up Fee and the Expense Reimbursement owed to Buyer pursuant to Section 11.4(a) and Section 11.4(b)(ii), respectively, deemed to be (w) an allowed administrative expense claim, (x) paid out of and constitute a first priority secured claim, to the extent applicable, against (i) any deposit paid by the purchaser in such Alternative Transaction or (ii) any deposit paid by any competing purchaser in any Alternative Transaction and retained by an escrow agent in compliance with the applicable court-approved bidding procedures, (y) an additional carve-out that attaches to and is prior in ranking to the priority Liens of the Sellers' lenders on the assets and (z) be paid prior to any distributions to any party.

ARTICLE 12. INDEMNIFICATION

12.1 Indemnification by Sellers. Subject to the other provisions of this Article 12, from and after the Closing Date, Sellers, jointly and severally, shall defend and indemnify Buyer and its Affiliates (the "**Buyer Indemnified Parties**") and hold the Buyer Indemnified Parties wholly harmless from and against any and all Losses that a Buyer Indemnified Party incurs as a result of (i) any breach of any representation and warranty of any Seller contained in this Agreement; (ii) any breach of any covenant of any Seller contained in this Agreement; (iii) any failure of any Seller to pay, perform or otherwise satisfy or discharge any of the Retained Liabilities; (iv) the ownership of the Purchased Assets, the operation of the Facilities and the conduct of the Business prior to the Effective Time; and (v) any breach of any representation, warranty or covenant of HSR contained in (A) the Lukan SPA or (B) the Caritas SPA.

12.2 Indemnification by Buyer. Subject to the other provisions of this Article 12, from and after the Closing Date, Buyer shall defend and indemnify Sellers and its Affiliates (the "**Seller Indemnified Parties**") and hold the Seller Indemnified Parties wholly harmless from and against any and all Losses that a Seller Indemnified Party incurs as a result of or with respect to (a) any breach of any representation and warranty of Buyer contained in this Agreement, (b) any breach of any covenant of Buyer contained in this Agreement, (c) any failure of Buyer to pay, perform or otherwise discharge any of the Assumed Liabilities, except to the extent that such

Losses arise from events that entitle a Buyer Indemnified Party to indemnification by Sellers pursuant to Section 12.1.

12.3 Time and Amount Limitations.

(a) The representations and warranties made by the parties in or pursuant to this Agreement (except Section 3.1, Section 3.2, Section 3.6, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a)) or in any document delivered pursuant hereto shall survive the Closing until, and will expire upon, the second anniversary of the Closing Date; provided, however, that the representations and warranties made in Section 3.6 shall survive the Closing until, and will expire upon, the fourth anniversary of the Closing Date; provided, further, that the representations and warranties made in Section 3.1, Section 3.2, Section 3.14, Section 3.15, Section 3.18, Section 3.20(a) shall survive until the expiration of the applicable statute of limitations with respect to the subject matter relating thereto. All covenants and agreements made or created herein shall, unless otherwise specifically provided herein, survive the Closing.

(b) Except as specified in Section 12.3(f), the aggregate liability of any Seller for indemnification pursuant to Section 12.1(i) or Section 12.1(iv) shall not exceed the Purchase Price (the "**Maximum Liability Amount**"), and the aggregate liability of Buyer for indemnification pursuant to Section 12.2 shall not exceed the Maximum Liability Amount.

(c) Except as specified in Section 12.3(f), no claim for indemnification pursuant to this Article 12 shall be made unless the Losses incurred by Sellers or Buyer (as applicable) as a result of a single breach (or, multiple breaches arising from the same facts or circumstances) exceed $50,000 (the "**De Minimis Threshold**"). Notwithstanding the foregoing, no Seller will have any liability to any one or more of the Buyer Indemnified Parties until the aggregate amount payable by Sellers to the Buyer Indemnified Parties in respect of all such Losses sustained by such Buyer Indemnified Parties exceeds $1,600,000 (the "**Basket Amount**"), in which case the Sellers will be obligated to indemnify the Buyer Indemnified Parties for the aggregate amount of all such Losses, regardless of the De Minimis Threshold.

(d) Neither Sellers nor Buyer shall have any obligation or liability under Section 12.1 or Section 12.2, respectively, with respect to any Losses that are caused, contributed to or exacerbated by the actions of Buyer Indemnified Parties (in the case of Sellers' indemnification obligations and liabilities) or Seller Indemnified Parties (in the case of Buyer's indemnification obligations and liabilities). Any exclusion, recovery or offset contemplated by the immediately preceding sentence shall reduce the amount of Losses incurred by any Indemnified Party for all purposes of this Agreement, including Section 12.3(c).

(e) After Closing, except for any nonmonetary, equitable relief to which either of the parties hereto may be entitled and except for the rights and remedies to which either of the parties hereto may be entitled based on a claim against the other for fraud in connection with the execution and delivery of this Agreement or the consummation of the transactions contemplated hereby, the rights and remedies set forth in this Article 12 shall constitute the sole and exclusive rights and remedies of the parties hereto under or with respect to the subject matter of this Agreement.

(f) Notwithstanding anything contained in this Agreement to the contrary, the limitations on recovery of Losses set forth in this Section 12.3 shall not apply to reduce the obligation of Sellers to (i) make payments or deliver checks or funds under Section 10.8, or (ii) indemnify the Buyer Indemnified Parties under Section 12.1(ii), Section 12.1(iii) or 12.1(v). It is the intent of the parties that any payment required to be made pursuant to such sections shall not be limited by this Section 12.3.

12.4 Notice and Control of Litigation.

(a) Notice of Asserted Liability. As soon as is reasonably practicable after a Seller Indemnified Party or a Buyer Indemnified Party becomes aware of any direct or third party claim that such party has under this Article 12 that may result in Losses for which such party is entitled to indemnification hereunder (a "**Liability Claim**"), such party (the "**Indemnified Party**") shall give notice of such Liability Claim (a "**Claims Notice**") to the other party (the "**Indemnifying Party**"). A Claims Notice must describe the Liability Claim in reasonable detail and must indicate the amount, calculated in good faith and to the extent feasible, of the Losses that have been or may be suffered by the Indemnified Party. No delay in or failure to give a Claims Notice by the Indemnified Party to the Indemnifying Party pursuant to this Section 12.4(a) will adversely affect any of the other rights or remedies that the Indemnified Party has under this Agreement or alter or relieve the Indemnifying Party of its obligation to indemnify the Indemnified Party to the extent that such delay or failure has not materially prejudiced the Indemnifying Party.

(b) Opportunity to Defend. The Indemnifying Party has the right, exercisable by written notice to the Indemnified Party within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12, to assume and conduct the defense of such Liability Claim in accordance with the limits set forth in this Agreement with counsel selected by the Indemnifying Party and reasonably acceptable to the Indemnified Party, provided that the (i) defense of such Liability Claim by the Indemnifying Party will not, in the reasonable judgment of the Indemnified Party, have a material adverse effect on the Indemnified Party; (ii) the Liability Claim solely seeks (and continues to seek) monetary damages; (iii) the Liability Claim does not include criminal charges; and (iv) the Indemnifying Party expressly acknowledges in writing its responsibility for all Losses relating to such Liability Claim (the conditions set forth in clauses (i) through (iv) are, collectively, the "**Litigation Conditions**"). If the Indemnifying Party does not assume the defense of a Liability Claim in accordance with this Section 12.4(b) within 10 days after receipt of a Claims Notice from the Indemnified Party of the commencement or assertion of any Liability Claim in respect of which indemnity may be sought under this Article 12 the Indemnified Party may continue to defend the Liability Claim. The Indemnifying Party or the Indemnified Party, as the case may be, has the right to participate in (but not control), at its own expense, the defense of any Liability Claim that the other is defending as provided in this Agreement. The Indemnifying Party, if it has assumed the defense of any Liability Claim as provided in this Agreement, may, with the prior written consent of the Indemnified Party, not to be unreasonably withheld, consent to a settlement of, or the entry of any judgment arising from, any such Liability Claim; provided, however, that the Indemnifying Party may not consent to any such settlement or judgment to the extent that any such settlement or judgment (I) does not include as an unconditional term thereof the giving by the claimant or

the plaintiff to the Indemnified Party of a complete and irrevocable release from all liability in respect of such Liability Claim, (II) grants any injunctive or equitable relief or (III) may reasonably be expected to have an adverse effect on the affected business of the Indemnified Party. The Indemnified Party has the right to settle any Liability Claim, the defense of which has not been assumed by the Indemnifying Party.

(c) Jurisdiction; Process. Each party consents to the non-exclusive jurisdiction of any court in which a Proceeding is brought by another Person not party to this Agreement against any Indemnified Party for purposes of any claim that such Indemnified Party may have under this Agreement with respect to the Proceeding or the matters alleged therein. Each party consents and agrees that process may be served on it with respect to such a claim anywhere in the United States of America.

ARTICLE 13. GENERAL

13.1 Choice of Law. THE PARTIES AGREE THAT THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF CONNECTICUT, REGARDLESS OF LAWS THAT MIGHT OTHERWISE GOVERN UNDER APPLICABLE PRINCIPLES OF CONFLICTS OF LAWS THEREOF.

13.2 Assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and assigns. No party may assign, delegate or otherwise transfer its rights and obligations under this Agreement; provided, however, Buyer has the right to assign, delegate or otherwise transfer, in whole or in part, its rights and obligations under this Agreement to any of its Affiliates. Notwithstanding the foregoing, to the extent that Buyer assigns, delegates or otherwise transfer any of its rights and obligations to any of its Affiliates, Buyer shall remain liable for the performance of all such rights and obligations in accordance with the terms of this Agreement.

13.3 Cost of Transaction. Except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, whether or not the transactions contemplated hereby shall be consummated and except as otherwise provided herein, the parties agree as follows: (a) Sellers shall pay the fees, expenses and disbursements of Sellers and their agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing the consummation of such transaction; and (b) Buyer shall pay: (i) the fees, expenses and disbursements of Buyer and its agents, representatives, accountants and counsel incurred in connection with preparing this Agreement and otherwise pursuing consummation of such transaction; (ii) conveyance taxes due in connection with the Deeds; (iii) prorations pursuant to Section 9.4(c); (iv) the cost of the Owner's Title Policy and any endorsements thereto; (v) the cost of recording the Deeds to the Owned Real Property; (vi) Title Company Escrow Agent's fee; (vii) survey costs; and (viii) all other costs and expenses associated with the transactions contemplated by this Agreement not otherwise expressly set forth in this Section 13.3. Each party shall be responsible for their respective filing fees associated with the Hart-Scott-Rodino Act. Notwithstanding the foregoing and except as otherwise provided in Section 11.3, Section 11.4 and Section 11.5, Buyer and Sellers have agreed to bear the fees and expenses of jointly retained consultants as set forth on Exhibit K.

13.4 **Notice.** Any notice, demand or communication required, permitted or desired to be given hereunder shall be in writing and deemed effectively given when personally delivered in hand, or when received if sent by a nationally recognized overnight delivery service, addressed as follows:

Buyer or YNHHS:

Marna P. Borgstrom
President and Chief Executive Officer
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

cc (which shall not constitute notice):

William J. Aseltyne
Senior Vice President and General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Any Seller:

Christopher M. O'Connor
President and Chief Executive Officer
Saint Raphael Healthcare System, Inc./Hospital of Saint Raphael
1450 Chapel Street
New Haven, CT 06511

cc (which shall not constitute notice):

Janeanne C. Lubin-Szafranski, Esq.
Vice President/General Counsel
Saint Raphael Healthcare System, Inc.
659 George Street
New Haven, CT 06511-4405

Jeffrey L. Heidt, Esq.
Verrill Dana, LLP
One Boston Place, Suite 2330
Boston, MA 02108

or to such other address, and to the attention of such other person or officer, as any party may designate. Receipt of a courtesy copy shall not be necessary in order for the notice, demand or communication to be deemed to have been effectively given.

13.5 **Severability.** In the event any term or other provision of this Agreement is held by any court or other tribunal of competent jurisdiction to be invalid, illegal or unenforceable for any reason and 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, and enforceable in accordance with its terms so long as the

economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adversely to any party.

13.6 Gender, Number and Inferences. 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. 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, any party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such party.

13.7 Divisions and Headings. The division of this Agreement into articles and sections 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.

13.8 No Third-Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of the parties hereto and their respective permitted successors or 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, including but not limited to a Sponsoring Organization, any current or former employee of the Sellers, or any labor organization representing any of the Sellers' current or former employees.

13.9 Entire Agreement. Unless the context clearly otherwise requires, as used herein, the term "Agreement" means this Agreement, the Exhibits hereto and the Disclosure Schedules, as supplemented in accordance with Section 5.15. This Agreement and the agreements referenced as Exhibits to this Agreement supersede and constitute the entire agreement existing between the parties with respect the subject matter hereof and thereof, and no party shall be entitled to benefits other than those specified herein or therein. As between the parties, no oral statement or prior written material not specifically incorporated herein shall be of any force and effect. The parties specifically acknowledge that in entering into this Agreement and the agreements referenced as Exhibits to this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and the agreements referenced as Exhibits to this Agreement and no others. This Agreement may be amended, supplemented or modified only by an agreement in writing signed by each of the parties hereto. All Exhibits attached to or delivered in connection with this Agreement are integral parts of this Agreement as if fully set forth herein.

13.10 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.

13.11 Amendment. This Agreement may not be amended or modified except with the written consent of all of the parties hereto and compliance herewith may not be waived except in writing by the party waiving compliance.

13.12 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 other provision hereof. No waiver of any provision or

condition of this Agreement shall be valid unless in writing signed by such party or operational by the terms of this Agreement.

13.13 Other Interpretative Matters. In this Agreement, unless the context otherwise requires: (a) words such as "herein" and "hereof" refer to the entire Agreement and not to a particular article or section of this Agreement; (b) references to articles and sections are references to articles and sections of this Agreement; and (c) references to any party to this Agreement shall include references to its successors and permitted assigns. ALL RELEASES, DISCLAIMERS, LIMITATIONS ON LIABILITY AND INDEMNITIES SET FORTH IN THIS AGREEMENT SHALL APPLY AND OPERATE IN ACCORDANCE WITH THEIR RESPECTIVE TERMS NOTWITHSTANDING ANY SOLE, JOINT AND/OR CONCURRENT NEGLIGENCE, STRICT LIABILITY OR OTHER FAULT OR BASIS FOR LIABILITY OF THE PARTY WHOSE LIABILITY IS RELEASED, DISCLAIMED, LIMITED OR INDEMNIFIED. The Disclosure Schedule referred to herein is hereby incorporated in and made a part of this Agreement as if set forth in full herein.

13.14 Reproduction of Documents. This Agreement and all documents relating thereto, including, without limitation, (a) consents, waivers, amendments and modifications that may hereafter by executed, (b) the documents delivered at Closing and (c) other written information previously or hereafter furnished to any party, may be reproduced by such party by any photographic, photostatic, microfilm, micro-card, miniature photographic or other similar process and the parties may destroy any original documents so reproduced. The parties agree and stipulate that any such reproduction shall be admissible in evidence as the original itself in any Litigation or Proceeding (whether or not the original is in existence and whether or not such reproduction was made by any party in the regular course of business) and that any enlargement, facsimile or further reproduction of such reproduction shall likewise be admissible in evidence.

13.15 Waiver of Jury Trial. Each of the parties hereto hereby knowingly, voluntarily and intentionally, after opportunity for consultation with independent counsel, waives its right to trial by jury in any action or proceeding to enforce or defend any rights or obligations under this Agreement. No party hereto will seek to consolidate any such action in which a jury trial has been waived with any other action in which a jury trial has not been or cannot be waived. The provisions of this Section 13.15 have been fully negotiated by the parties hereto, and these provisions shall be subject to no exceptions. No party hereto has in any way agreed with or represented to any other party that the provisions of this Section 13.15 will not be fully enforced in all instances; and this Section 13.15 is a material inducement for the Buyer to enter into this Agreement.

13.16 Time of the Essence. The parties agree that time is of the essence in the execution and performance of this Agreement.

[*Remainder of page intentionally left blank. Signature pages follow.*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers or directors, as the case may be, all as of the Effective Date.

SAINT RAPHAEL HEALTHCARE SYSTEM, INC.

By: _____
Name: _____
Title: _____

SAINT REGIS HEALTH CENTER, INC. D/B/A SISTER ANNE VIRGINIE GRIMES HEALTH CENTER

By: _____
Name: _____
Title: _____

HOSPITAL OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

SAINT RAPHAEL HEALTHCARE SYSTEM AFFILIATED PHYSICIANS, INC. D/B/A AFFILIATED PHYSICIANS OF SAINT RAPHAEL

By: _____
Name: _____
Title: _____

DEPAUL HEALTH SERVICES CORPORATION, INC.

By: _____
Name: _____
Title: _____

SAINT RAPHAEL FOUNDATION, INC.

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HEALTH SERVICES CORPORATION D/B/A YALE NEW HAVEN HEALTH SYSTEM

By: _____
Name: _____
Title: _____

YALE-NEW HAVEN HOSPITAL, INC.

By: _____
Name: _____
Title: _____

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 3, 2013

Ms. Gayle Capozzalo
Executive Vice President
Strategy & System Development
Yale-New Haven Hospital
20 York Street
New Haven CT 06504

RE: Compliance Filing for the Certificate of Need issued under Docket Number 12-31747-CON Yale-New Haven Hospital's Acquisition of the Hospital of Saint Raphael Healthcare System, Inc., including The Hospital of Saint Raphael

Dear Ms. Capozzalo:

This is to acknowledge receipt of the signed unredacted Asset Purchase Agreement by and among Yale-New Haven Hospital, Inc. ("Yale") and Yale-New Haven Health Services Corporation and the various corporate members of the Saint Raphael Healthcare System, Inc., including The Hospital of Saint Raphael. The unredacted signed Asset Purchase Agreement was received by the Office of Health Care Access ("OHCA") by electronic mail on November 7, 2012 and by mail on November 13, 2012, in accordance with Stipulation Number 2 of the Certificate of Need Agreed Settlement under Docket Number 12-31747-CON. Please be informed that OHCA reserves it right to request that Yale submit a copy of any or all of the Exhibits listed on page vi of the Asset Purchase Agreement (Exhibits A through O).

Please contact Karen Roberts, Principal Health Care Analyst or Paolo Fiducia, Associate Health Care Analyst at 860-418-7001 if you have any questions regarding this letter.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:kr

Greer, Leslie

From: Roberts, Karen
Sent: Thursday, January 03, 2013 3:26 PM
To: 'Gayle.Capozzalo@ynhh.org'
Cc: Greer, Leslie; Fiducia, Paolo
Subject: Compliance with CON DN 12-31747-CON
Attachments: 31747.pdf

To: Gayle Capozzalo
Executive Vice President
Strategy & System Development
Yale-New Haven Hospital

Hi Ms. Capozzalo:

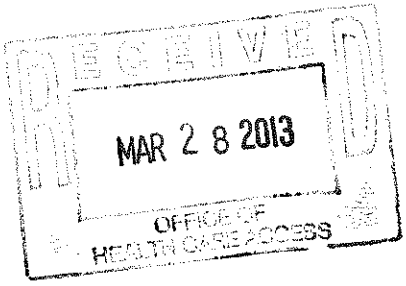
Attached please find a letter from the Office of Health Care Access regarding the Hospital's compliance with the Certificate of Need issued under Docket Number 12-31747-CON. This letter will be maintained in the record for that docket number. Please let me know if you have any questions regarding the attached.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Department of Public Health
Division of Office of Health Care Access
Phone: 860-418-7041
Fax: 860-418-7053
Email: karen.roberts@ct.gov

Office of the President

YALE-NEW HAVEN HOSPITAL



March 28, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

Pursuant to Condition Number 3 of the Agreed Settlement signed on June 27, 2012 and subsequently modified by the Office of Health Care Access (OHCA) on October 9, 2012, I have enclosed Yale-New Haven Hospital's three-year plan for the integration of YNHH and the Hospital of Saint Raphael. The plan consists of a detailed narrative organized into the following sections:

A. Acquisition Vision and Anticipated Benefits
B. Organization of the Three-Year Integration Plan
   B1. Completed Integration Activities
C. Three-Year Integration Workplan: Description
D. Summary of Beds & Services by Campus
E. Cost Savings and Revenue Enhancements
F. Ongoing Reporting

Accompanying the narrative is Gantt chart which displays the integration activities and target time frames for the next three fiscal years. These activities are described in more detail in Section C of the narrative report.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Richard D'Aquila
President & Chief Operating Officer

Enclosures

Copy to: Kimberly Martone, Director of Operations

20 York Street
New Haven, CT 06510-3202
203-688-2606
Fax 203-688-3774

Yale New-Haven Hospital's Acquisition
of the Saint Raphael Healthcare System, Inc.
Docket No: 12-31747-CON

Three Year Integration Plan
Narrative
March 31, 2013

INTRODUCTION

The Office of Healthcare Access (OHCA) approved the Certificate of Need (CON) application (DN: 12-31747-CON) for Yale-New Haven Hospital's (YNHH) acquisition of the Saint Raphael Healthcare System (SRHS) including the Hospital of Saint Raphael (HSR) via Agreed Settlement dated June 27, 2012. Condition 3 of the Agreed Settlement was modified on October 9, 2012 via DN: 12-31747-MDF due to the postponement of the final acquisition closing date. As required in Condition 3 of DN: 12-31747-MDF, YNHH will submit a three-year plan to integrate the operations of both hospitals and attain the cost savings stated within the CON application. At a minimum the plan will contain the following elements: (a) planned location of services and beds; (b) anticipated cost savings; (c) staffing and quality improvements; and (d) merger-related revenue enhancements.

Since the closing on September 12, 2012, YNHH senior administrators and clinicians have been assessing the state of operations and the Saint Raphael campus. Although some of this activity occurred before the closing, it was not until after the closing the YNHH management was able to fully access the facilities and obtain all of the necessary information to assess the situation. Much work has been done to date, although this process is not yet complete and will continue for the remainder of this fiscal year.

This report is structured into the following sections:

A. ACQUISITION VISION AND ANTICIPATED BENEFITS

B. ORGANIZATION OF THE THREE-YEAR INTEGRATION PLAN
   B1. Completed Integration Activities

C. THREE-YEAR INTEGRATION WORKPLAN: DESCRIPTION

D. SUMMARY OF BEDS & SERVICES BY CAMPUS

E. COST SAVINGS AND REVENUE ENHANCEMENTS

F. ONGOING REPORTING

A. ACQUISITION VISION AND ANTICIPATED BENEFITS

The integration of the HSR into YNHH operations provides the opportunity to develop a two-campus hospital providing integrated care, thereby enhancing healthcare quality, access and efficiency for greater New Haven and the broader region. The close proximity of the two hospitals permits YNHH to combine appropriate service lines at one campus and to integrate other services across the two campuses to rationalize the provision of care and to improve the utilization of expensive facilities and equipment. Integration of service lines also will permit YNHH to meet projected increasing demand for its services in future years without incurring the substantial cost of constructing an additional bed tower.

The acquisition provided YNHH with an opportunity to obtain immediate capacity relief. YNHH is now focused on developing one standard of care for the community, ensuring appropriate healthcare reform readiness and improving the overall financial performance of the organization. It will provide the required capacity for the organization to continue its destination hospital trajectory, grow marquis clinical programs at the York street campus and develop new programs at the Saint Raphael campus. The integration of the hospitals officially took place on September 12, 2012, and Yale-New Haven is now the fourth largest hospital in the United States with 1,541 beds.

B. ORGANIZATION OF THREE-YEAR INTEGRATION PLAN

This document summarizes the three-year plan which begins with FY 2013 and extends to FY 2015. YNHH identified three phases of the integration of operations over the next three years which include:

1. Developing "one standard of care" – September 12, 2012 – December 31, 2012
   This phase focused on employee onboarding, immediate bed strategy and policy normalization and has already been completed. Summary of activities pertaining to this phase can be found in the "Completed Integration Activities" section of this document.

2. Developing "one system of care" – January 1, 2013 – September 30, 2014
   Integration activities are occurring collaboratively with physician leaders on both campuses and focus on aligning systems and processes across both campuses to ensure consistency in care delivery. Allocation of campus clinical services will maintain the following basic principles; maintain core medical/surgical programs including corresponding ancillary services at both campuses; select anchor destination programs for each campus (e.g. Musculoskeletal at Saint Raphael campus and transplant/Children's/Smilow at York Street campus); cohort select patient populations with less resource intensive support services at the Saint Raphael campus and centralize tertiary/quaternary care services at York Street campus. More specifically, one system of care will be accomplished through a common care management structure, common information system (Epic), common performance improvement committees (e.g. throughput) and the definition and implementation of the first phase of the clinical integration plan. Additional information regarding specific activities can be found in the Integration Workplan included as Attachment I.

3. Developing "one destination of care" – October 1, 2014 – September 30, 2015
   Integration activities during this time period will focus on completing the final components of the clinical integration vision. Additional information regarding specific activities can be found in the Integration Workplan included as Attachment I.

The last two phases guide the specific activities that must occur over the next three years to ensure a fully unified organization.

B1. Completed Integration Activities

In the six months since the acquisition occurred, YNHH has completed a number of integration activities namely:

1. Successful onboarding and training of 3,497 employees into the YNHH and Yale New Haven Health System.
2. Conducted a comprehensive compensation review at the Saint Raphael campus and increased the base salary for 500 employees, to ensure alignment across both campuses.
3. Transitioned 361 physician contracts from the HSR to Yale New Haven Health System, and preserved care continuity at the Saint Raphael campus.
4. Integrated 133 medical trainees from HSR residency and fellowship programs into Yale School of Medicine programs (Internal Medicine, General Surgery, Oral and Maxillofacial Surgery, Diagnostic Radiology, Nephrology, Cardiology and Geriatrics).
5. Established a campus leadership team for the Saint Raphael campus, including the appointment of a Senior Vice President Operations and Chief Implementation Officer to oversee the successful implementation of the integration plan outlined in this document.
6. Established a bi-campus morning safety report and extension of the "Great Catch" program to the Saint Raphael campus. Over 80 safety" near misses" were prevented by staff in the last six months and recognized through the "Great Catch" program. This program reflects our commitment to creating a culture of safety throughout the institution and empowering employees at all levels of the organization to act as patient advocates.
7. Created a Community and Emergency Care Assessment Committee to better understand the greater New Haven population healthcare needs and service gaps, as well as develop strategies to enhance access to timely and appropriate care. The Committee will deliver its final report in the spring and will offer a guide to investments to improve the health of our community.
8. Aligned all care policies and establishment of a common regulatory readiness infrastructure. This allows YNHH to ensure consistent delivery and fulfillment of regulatory commitments across all of our practice sites.
9. Successfully completed the Joint Commission extension survey for the Saint Raphael campus. Developed and implemented a Manager regulatory readiness training program including lunch and learns and reference manuals.
10. Established a common infrastructure for patient satisfaction spanning both campuses and ambulatory areas to ensure a common patient experience throughout the continuum of care. Manager training on patient experience expectations and tools has been completed.
11. Achieved inpatient volume growth on the Saint Raphael campus attributed to the transfer of Medicine patients from the York Street campus and Shoreline Emergency Department. Average daily census (FYTD 2013 – February) has increased by an average of 62 patients per day since the closing in September 2012.

12. Renovated Sister Louise Anthony 3 inpatient unit and associated opening of 24 additional general medicine beds on the Saint Raphael campus.
13. Integrated Hospitalist operations across both campuses.
14. Consolidated major trauma activities at the York Street campus.
15. Consolidated all inpatient pediatric activities (excluding Child Psychiatry and Newborn Special Care) at the York Street campus.
16. Established telestroke at the Saint Raphael campus to ensure timely care for stroke patients presenting to the Saint Raphael campus.
17. Created dedicated inpatient psychiatric units for Child and Adolescent Psychiatry. Patients 12 years of age and under are directed to the York Street Campus (Winchester Chest 1), patients from 13-15 years of age are directed to the Saint Raphael Campus (Celentano 5) and patients aged 16 and 17 years of age are directed to the York Street campus (Liberty Village 2). The creation of dedicated units allows for an enhanced experience for patients and families.
18. Consolidated care management activities under a common leader.
19. Consolidated corporate functions including Planning, Legal, Community and Government Affairs, Supply Chain and Marketing and Communications.
20. Established a cultural integration oversight committee with leaders from both campuses.
21. Developed common communication strategy across both campuses, including redesigned website, redesigned employee newsletter, monthly bi-campus management meetings and employee integration email updates.

C. INTEGRATION WORKPLAN: DESCRIPTION

Attachment I contains the detailed Integration Workplan for FY 2013 through FY 2015 which is organized into five major sections including: (1) Major Strategic Initiatives; (2) Service Lines; (3) Clinical Areas; (4) Non-Clinical Areas; and (5) Corporate Services. The Integration Workplan includes specific activities for each of these five areas and the estimated time frame by fiscal year for completion.

Section 1. Major Strategic Initiatives:

Major strategic initiatives pertain to activities with a broad impact throughout the organization. Ten initiatives were defined and are described below.

1. *Physician Integration*
   YNHH assumed 361 physician contracts from the HSR on September 12, 2012. The organization will review each contract to understand contract terms and services provided, and assess against clinical needs. Additionally, per the asset purchase agreement, strategies to integrate hospital-based services (Anesthesiology, Diagnostic Radiology, Emergency Medicine and Laboratory/Pathology) into Yale School of Medicine full-time faculty by September 12, 2013 are being developed. Although all residency and fellowship programs were integrated immediately following the transaction close date, bi-campus rotation schedules will be developed to solidify the medical trainee experience (level of integration in rotation schedules is department specific).

2. *Epic Implementation*
   As was referenced in the CON application, the implementation of Epic provides access to an integrated inpatient and outpatient medical record and will allow for greater care coordination among the care continuum. The Epic electronic medical records system is expected to improve patient care by reducing variation in treatment and reducing the cost of wasteful duplicative tests and procedures. Epic will permit participating doctors to access patients' medical records in real time from any location. As a result, it will permit seamless integration of the provision of medical care across all doctor's offices, outpatient clinics and hospitals that have implemented Epic.

   On February 1, 2013, YNHH successfully implemented the Epic system at the York Street campus. Epic will be implemented at the Saint Raphael campus on June 1, 2013. By end of fiscal year 2013, all Yale New Haven Health System hospital and physician practices will be utilizing Epic, further enhancing care continuity among the health system.

3. *Patient Experience Forum*
   YNHH has a clearly defined philosophy of patient care with corresponding policies and procedures which address staff behavior and patient service. Patient and family advisory Councils currently in place at the York Street campus were rolled out to the Saint Raphael campus beginning in March 2013. Other integration activities to be completed beginning in April 2013 include patient experience forums, where patient comments and improvement opportunities are discussed in a systematic manner by site leadership and staff representatives.

4. *Regulatory*
   Although YNHH recently obtained Joint Commission accreditation for the Saint Raphael campus, two additional hospital-wide regulatory surveys are expected to take place in 2013, namely the Department of Public Health licensure survey and the Joint Commission triennial accreditation survey. Feedback from Joint Commission surveyors will be incorporated in the regulatory action plan. To ensure appropriate readiness, ongoing mock audits will be conducted, and management and staff education plans will be developed and implemented. Additionally, the proactive environment of care regulatory readiness rounds (Clean and Safe rounds) currently in place at the York Street campus will be implemented at the Saint Raphael campus later this spring.

5. *Transforming Patient Care*
   Transforming Patient Care refers to a review of nursing workflows and supporting systems/processes. By removing non-value added activities from nursing workflows, additional time at the bedside can be given to nursing staff, simultaneously improving patient outcomes such as fall rates, productivity, patient satisfaction as well as employee satisfaction. Transforming patient care was implemented at the York Street campus in 2010 and has resulted in additional 90 minutes per 12-.hour shift of bedside care for nurses and 48 minutes per 8-hour shift for patient care associates. Additionally, the implementation of Epic will allow for medication barcoding, which will also improve nursing productivity (on both campuses).

6. *Safe Patient Flow*
   Safe Patient Flow refers to throughput improvement activities. Safe Patient Flow was implemented at the York Street campus in 2008 and has resulted in a 11% improvement in throughput (as measured by 11am discharge rate and median discharge time), and was instrumental in helping the organization reduce length of stay to accommodate census pressures pre-acquisition. Targets and improvement plans will be developed for the Saint Raphael campus.

7. *Cultural Integration*
   To ensure that the Catholic heritage of the Sisters of Charity of Saint Elizabeth remains reflected in Saint Raphael campus operations, a Catholic Heritage Committee has been formed and will be overseeing development and implementation of staff education on the Ethical and Religious Directives. Additionally, the auxiliaries for the two campuses will be integrated.

8. *Bed Management/Capacity*
   An additional adult inpatient unit (Verdi 4 North) is being renovated and will be operational in early FY 2014. The new 24-bed unit will have telemetry capabilities. The opening of these additional general medicine beds will improve access to YNHH and its services, particularly for patients being transferred to YNHH via Y-Access. Y-Access remains an important source of growth for the organization and additional capacity at the Saint Raphael campus has already permitted YNHH to transfer a record number of 475 transfers in December 2012. Bed allocation by service is not yet finalized but the current status and time lines for remaining decisions are outlined in a subsequent section of this report entitled "Summary of Services and Beds by Campus".

9. *Infrastructure*
   A few years ago, the York Street campus implemented the Off Shift Executive model to provide executive level coverage during off-shifts (evenings, nights and weekends). The off-shift leaders engage in employee recognition, service recovery and other required general hospital operations. The model will be implemented on the Saint Raphael campus in early summer of 2013 and will allow for a common structure to address any emergent situation.

10. *Care Management Across the Continuum*
    Care Management activities (Care Coordination, Utilization Review and Social Work) were centralized under a single physician leader in early March 2013. In the coming months, the incumbent will work to implement multidisciplinary transitional care rounds at the York Street campus. Transitional Care Rounds have been in place on all inpatient units at the Saint Raphael campus for a number of years, and will be phased in at the York Street campus over several months beginning in March 2013. The new leadership structure and increased multidisciplinary collaboration will help the organization decrease readmissions, optimize flow and coordination, as well as enhance the patient experience along the care continuum in a cost effective manner.

Section 2. Service Lines

Vision, facility investments and integration activities for major clinical service lines comprise the second section of the Integration Workplan. It is important to note that the information provided below predominantly addresses inpatient services as ambulatory activities are currently being reviewed as part of a comprehensive ambulatory strategic planning exercise, identified in Section 3.

The following service lines are included:

1. *Children's*
   The vision is to establish the Yale-New Haven Children's Hospital as the destination of choice for pediatric needs. Planned facility investments include a new newborn intensive care unit at the York Street campus pending philanthropic contributions. Activities include the integration of neonatology services across all practice sites (York Street campus, Saint Raphael campus and Bridgeport Hospital).

2. *Heart and Vascular*
   The vision is to establish the Yale-New Haven Heart and Vascular Center as a regional leader for cardiac care, with complex valve and transplant procedures concentrated at the York Street campus. Facility investments include renovation of interventional laboratories at the Saint Raphael campus into modern rooms with both Cardiac Catheterization and Interventional Radiology capabilities. Activities include the development of a vascular access center and development of an aortic institute.

3. *Musculoskeletal*
   The vision is to establish a leading regional Musculoskeletal Center at the Saint Raphael campus supported by a series of ambulatory satellites throughout the state of Connecticut. The Center will include joint replacement, metabolic bone disease, rehabilitation, neurological sciences, rheumatology, bone lengthening, pain management, advanced minimally invasive surgery and clinical trials, among others. The Musculoskeletal Center will be distinguished by a multidisciplinary collaboration between YNHH clinicians and scientists, modeled after what currently exists between the Smilow Cancer Hospital and the Yale Cancer Center. A business model will be developed, required facilities investments and program offering of the Musculoskeletal Center, and recommendations are planned for June 2013. The Center is expected to be operational in FY 2015.

4. *Neurosciences*
   The vision is to establish an integrated Neurosciences service line with complex Neurology and Neurosurgery cases (e.g. intracranial procedures) centralized at the York Street campus. As was mentioned earlier, telestroke has already been implemented at the Saint Raphael campus and allows for real time evaluation and treatment of stroke patients. Facilities investments include the allocation of increased Neurology beds at the York Street campus.

5. *Oncology*
The vision is to establish an integrated Oncology service line across both campuses, supported by satellite operations in surrounding communities. The majority of Oncology services will be centralized at the Smilow Cancer Hospital at the York Street campus, and chemotherapy and radiation therapy will continue to be offered at the Chapel Street campus to support inpatient services.

6. *Transplant*
The vision is to be the leader of solid organ transplantation services in Connecticut and the broader region. Currently, transplantation services are solely offered at the York Street campus and this will continue to be the future practice. The Saint Raphael campus had an organ donation registry which will be consolidated in 2013.

Section 3. Clinical Areas

Additional clinical integration beyond the service lines described in Section 2 must occur in other clinical areas which are described and listed below:

1. *Diagnostic Radiology*
Diagnostic Radiology is an essential clinical support service for inpatient care. A comprehensive assessment of diagnostic radiology equipment and facilities master plan for both campuses is currently being developed to ensure optimal resource utilization. Integration activities include common scheduling across all diagnostic radiology sites, which will be possible once the Epic implementation is completed across both campuses (summer 2013). Additionally, a CON for the change in ownership of the Saint Raphael Magnetic Resonance Center Joint Venture to YNHH was submitted to OHCA on January 25, 2013 and is under OHCA review.

2. *Emergency Department*
Emergency Departments will remain at both campuses, and provide an opportunity to develop an integrated model and common staffing pool of nurses and clinicians to float between YNHH's three Emergency Departments (York Street, Saint Raphael campus and Shoreline). Additionally, equipment across all Emergency Departments will be reviewed to ensure consistency and opportunities to review ambulance operations will also be evaluated. Moreover, the sponsor hospital program (i.e. training provided to ambulance companies) will also be reviewed to ensure that program offerings and structure meet hospital and community needs.

3. *Laboratory/Pathology*
Components of Laboratory and Pathology will remain at the Saint Raphael campus to support inpatient operations. These services will be identified in coming months, and will also be evaluated in conjunction with laboratory consolidation opportunities across the health system. During the summer of 2013, the existing laboratory information system (SOFT) will be implemented at the Saint Raphael campus, in

conjunction with Epic. Common information systems will facilitate the ordering, processing and test reporting for laboratory tests.

4. *Medicine*

The activities described for Medicine refer predominantly to General Medicine (Hospitalist service), the Medical critical care unit and Geriatrics. Although the Hospitalist service was consolidated upon the closing of the acquisition, opportunities to further align admission criteria to the Hospitalist service and coverage schedules will be completed in FY 2013. A business case to implement electronic ICU (eICU) coverage capabilities at the Saint Raphael campus is currently being developed and would reduce off-shift physician coverage requirements in the medical intensive care unit and could be implemented in other inpatient units. The business case for eICU is expected to be completed in late summer 2013, with implementation to be completed in fiscal 2014. In terms of geriatrics, beginning in April 2013, an evaluation will be done regarding the creation of a leading geriatric service line. Activities will focus on a programmatic review of geriatric services and identification of potential consolidation opportunities as well as required investments. Results of this process are expected in summer 2013.

5. *Nursing*

A Nursing Magnet gap analysis was completed and remediation plans will be implemented to ensure that both campuses meet the standards to obtain Magnet recertification in FY 2015. Committees such as Transforming Patient Care described in an earlier section will be instrumental in achieving targeted productivity, patient satisfaction and employee satisfaction improvements. Pilot units at the Saint Raphael campus will be selected Spring of 2013 for initial process improvement changes and a roll-out plan will be developed to ensure practice consistency hospital-wide. Standard monitoring dashboards and metrics will be developed to monitor progress.

6. *Pharmacy*

Pre-acquisition, the HSR contracted for pharmacy leadership services with Cardinal Health. Since the closing, leadership positions have been in-sourced and the employees have become YNHH employees. Required investments include the purchase and standardization of Pyxis machines. Integration activities include the creation of a unified drug formulary across both sites and across the health system.

7. *Psychiatry*

As was referenced earlier, a standard model of care for inpatient children/adolescent psychiatric services has been implemented. Other integration activities include the implementation of the Behavioral Intervention Teams, currently in place across inpatient medicine services at the York Street campus, to the Saint Raphael campus. The Behavioral Interventional Teams provide proactive consultations to Medicine patients with psychiatric conditions and have played an important role in decreasing length of stay for patients with psychiatric co-morbidities on Medicine units. The organization has faced an increase in psychiatric patients presenting to the Emergency Department and triage and treatment mechanisms are being reviewed to ensure patient care needs are met in a timely and appropriate manner.

Additionally, YNHH was approved to join a consortium with 5 other providers to organize primary and psychiatric care services for the severe, persistent mentally ill populations in Southern CT. Involvement in this collaborative will place the organization at the forefront of psychiatric care in the region. A comprehensive review of inpatient psychiatric activities was conducted during the winter of 2012/2013 and outlined areas requiring facilities investments. A supporting plan is being developed and will be implemented this spring of 2013.

8. *Surgical Services*

With the acquisition of the HSR, YNHH now has 86 operating rooms, distributed over four main practice sites (York Street campus, Saint Raphael campus, Shoreline and Temple). To ensure optimal and efficient resource utilization, a comprehensive assessment of existing sites and equipment will be conducted and a three-year strategic plan for perioperative services will be developed (including efficiency improvements, practice standardization governance structure, roles and responsibilities, among others). The assessment and plan are expected to be complete in early fall 2013, with implementation beginning in early FY 2014.

With the recruitment of a new clinical leader for digestive diseases, a business case is being developed to create a multidisciplinary digestive diseases center. The plan is expected to be completed by summer 2013. Additionally, planning for a bariatric center of excellence will begin in summer 2013, and implementation will begin in FY 2014.

9. *Women's Services*

The Vidone Center at the Saint Raphael campus provides an ideal setting to grow low-risk deliveries. The campus will serve as the practice location for the Yale University midwifery program. To support increased obstetric volume at the Saint Raphael campus, a requisition will be placed to increase the size of the Obstetrics residency to help cover the campus. A final determination regarding growing the OB residency program is expected by late calendar 2013.

10. *Ambulatory Services*

Nearly a year ago, YNHH began the process of developing a strategic plan for its ambulatory operations. With the recent integration of the HSR, a comprehensive inventory of all ambulatory locations must be developed (including size and status of facility, lease payments, etc.). The inventory will serve as the basis to identify ambulatory consolidation opportunities as well as growth opportunities to ensure that the needs of patients in greater New Haven and surrounding areas are met. The inventory is expected to be completed in April of 2013 with programmatic recommendations by end of FY 2013. Preliminary consolidation opportunities include outpatient psychiatric services, dental services, and primary care operations, among others.

Section 4. Non-Clinical Support Services

As it pertains to non-clinical support services, vendor consolidation opportunities were identified for Environmental Services, Food and Nutrition, Linen Services and Protective Services. Estimated savings can be found in Section E – Cost Savings and Revenue Enhancement (Other Operating and Contractual Labor categories).

Section 5. Corporate Services

Corporate services include seven key areas and integration activities for each are described below.

1. *Accounting & Finance*
   Integrated budgeting processes covering both campuses were developed, and cost accounting and decision support systems were consolidated. The finance functional area includes the following specific business units that will be integrated into the existing YNHHS financial function: Accounting and Finance; Decision Support, Budgeting and Financial Planning; Finance and Accounting; Revenue Cycle/Access; Revenue Cycle/H.I.M.; Revenue Cycle/Billing & Collecting; and Reimbursement.

2. *Compliance*
   Existing Yale New Haven Health System policies (including conflict of interest process) and mandatory staff training were implemented at the Saint Raphael campus. Annual training via Healthstream is required for all employees (consistent with what is done at other health system hospitals).

3. *Human Resources*
   As was referenced earlier, a comprehensive compensation review was conducted and compensation for Saint Raphael employees was aligned with that of the York Street campus. To provide an opportunity for staff to participate in programs to further their skills and advance to higher positions within the organization, common employee career ladders and criteria are being developed and will be launched in summer 2013. Employees at the Saint Raphael campus meeting the required number of hours (1,000) will be eligible for the performance incentive program (PIP), which offers up to 3% to employees as a one-time bonus based on the organization achieving required goals.

   The performance management system (annual review) has been standardized and employees will be eligible for annual merit increases and special achievement awards based on performance. Education programs for Managers are currently being developed to ensure that they have the required tools to effectively manage their employees.

   The employee engagement survey will be standardized across both campuses and the first survey is expected to take place September/October of 2013.

4. *Information Technology & Information Systems*
   YNHH has consolidated the information technology departments of Saint Raphael's into the existing IT department at YNHHS and will focus on establishing a common technology platform across the two campuses. Although the immediate focus is on the successful implementation of the Epic system at the Saint Raphael campus, the conversion to Epic will provide the organization with an opportunity to standardize platforms and reduce the number of required information technology applications across both campuses for Laboratory, Anatomical Pathology, Cardiology, Radiation Oncology, Neurosciences, Gastroenterology, Food and Nutrition and Sleep Study.

   Moreover, Help Desk Center operations and Telecom services will be standardized across both campuses.

5. *Legal and Planning*
   As it pertains to Legal and Planning, vendor consolidation opportunities have been identified. Integration work with a medical malpractice insurance company (MCIC) remains ongoing.

6. *Marketing, Communications, Image & Community Wellness*
   Yale-New Haven will be working with municipal leaders to develop a comprehensive community revitalization strategy, including continued commitment to Habitat for Humanity. Additionally, employee and manager communication strategies employing new media will be developed to ensure more efficient communication with employees. The organization will remain a strong advocate with State and Federal governments for continued access to high quality healthcare services for Connecticut residents.

7. *Supply Chain*
   Integration activities pertaining to Supply Chain are focused in three main areas: 1) contract renegotiations, 2) inventory management and 3) service response center consolidation.

   Contract renegotiations are described in more detail in Section E – Cost Savings and Revenue Enhancement.

   Inventory management opportunities pertain to the implementation of new inventory management systems (ParX; currently in place at the York Street campus) and standardizing the layout of inpatient units to facilitate access to supplies and decrease the need for more frequent ordering of supplies. Mailrooms will also be consolidated to allow for greater oversight of package delivery.

   The Service Response Center is a call center that triages calls pertaining to janitorial, maintenance and other similar requests. It also provides a tracking mechanism to ensure that requests are addressed in a timely manner. It has been in place for over 9 years at the York Street campus and will include the Saint Raphael campus in FY 2014.

D. SUMMARY OF SERVICES AND BEDS BY CAMPUS

As described in Section C above, planning the integration of clinical services is still underway and specific campus locations and allocated beds have not yet been fully finalized. The two tables below summarize tentative plans for the services and beds by location. This information is subject to change and any changes will be provided to OHCA in subsequent semi-annual reports.

Planned Services by Campus for 2015 (as of March 2013):

Services	YNHH Campus	SR Campus
Service Lines		
Children's	**X**	
Heart & Vascular	**X** (Tertiary/Quaternary)	**X**
Musculoskeletal		**X**
Neurosciences	**X** (Tertiary/Quaternary)	**X**
Oncology	**X** (Tertiary/Quaternary)	**X**
Transplant	**X**	
Clinical Areas		
Anesthesia	**X**	**X**
Diagnostic Radiology	**X**	**X**
Emergency Department	**X**	**X**
Laboratory/Pathology	**X**	**X**
Medicine	**X**	**X** **Geriatrics**
Psychiatry	Older Adolescents/Adult	Children's/ Younger Adolescents/Adult
Surgery	**X**	**X**
Women's	Low & High Risk Maternity	Low Risk Maternity/ Midwifery Program

FY 2013:

Beds:	**YNHH Campus**			**SR Campus**		
	General Care	***ICU***	***Total***	***General Care***	***ICU***	***Total***
Medicine	334	50	384	237	18	225
Surgery	211	53	264	112	31	143
Rehabilitation	0		0	18		18
Maternity	48		48	19		19
Pediatric*	88	17	105			
Pediatric Psych Only				20		20
Psych	73		73	25		25
Future Use				31		31
Total Beds	**754**	**120**	**874**	**462**	**49**	**511**
Bassinets	40	52	92	13	9	22

Note: Included in YNHH license is **another 22 pediatric beds and 20 bassinets** located at Bridgeport Hospital campus.

E. COST SAVINGS AND REVENUE ENHANCEMENT

Cost Savings

As stated in the CON Application, with the acquisition of the HSR, YNHH projected a total of $300 million in operational cost savings over five years. These savings result from the integration of both clinical and non-clinical services.

Projected costs savings have been provided according to the categories outlined by OHCA and Report 175. Based on the Three-Year Integration Workplan and the timeframes for completion, projected cost savings for FY 2013-FY 2015 have been identified and categorized in the table below. A total operational cost savings of $189.3 million is projected to be attained in the first three years which represents 63% of the $300 million of operational cost savings over five years as identified in the CON application.

Projected Cost Savings	**FY 2013**	**FY 2014**	**FY 2015**
Salaries & Wages	$24.0m	$27.0m	$27.9m
Fringe Benefits	$6.7m	$7.5m	$7.7m
Contractual Labor Fees	$3.0m	$3.2m	$3.3m
Medical Supplies & Pharmaceuticals	$8.1m	$10.8m	$13.2m
Utilities	$1.3m	$1.3m	$1.4m
Business Expenses	$12.2m	$14.9m	$15.8m
Other Operating Expenses			
TOTAL	**$55.3m**	**$64.7m**	**$69.3m**

The components of projected cost savings identified for each area above are briefly explained below.

- Salaries & Wages / Fringe Benefits: The main source of FY 2013 savings during the initial integration process came from salary, and fringe benefits. The health system was able to consolidate responsibilities for various administrative and business functions into existing structures and positions. Notable areas of change include elimination of dual campus Financial/Accounting, Legal, Marketing/Public Relations, Information Technology System (ITS), and human resource functions. The expansion of executive administration roles between the campuses also resulted in savings for various clinical & non-clinical areas throughout the Saint Raphael's campus.

  An ongoing process will involve standardizing and benchmarking salary expense per unit of service. This information will guide the organization to pursue additional opportunities for consolidation. By utilizing economies of scale that exist on both sites additional savings can be realized through clinical integration.

- Contractual Labor Fees: Contractual Labor Fee savings will be realized through a number of initiatives.

  1. Contractual Management Services: Utilizing the Administrative and IT infrastructure of the Yale New Haven Health System, the elimination of certain contractual management services into in-house functions has become a viable financial option. Contractual

premiums previously paid by HSR for these types of services can be eliminated as certain contracts are renegotiated. Some examples of contractual management services that can be eliminated include Care Coordination, Laboratory, Pharmacy and Environmental Services.

2. Professional Service Agreements: There are a number of physician services at the Saint Raphael Campus that are currently provided for through professional service arrangements with community physician practices. A number of these services can now be combined with the programmatic physician resources that have been developed on the York Street campus, and new physician programs can be created to respond to the increase in volume. These types of services can result in financial savings for the combined YNHH. An example of savings in this area would be laboratory medicine physician coverage being provided by Yale School of Medicine, as opposed to an outside community practice.
3. Outside Legal Counsel: In addition to the Labor savings in the area of Legal and Risk Management services it is expected that the use of outside legal counsel related to the Saint Raphael's campus will be decreased. The work previously performed by outside legal counsel will be incorporated into the current legal department of YNHH

- Medical/Surgical (Med/Surg) Supplies & Pharmaceuticals: A number of contractual benefits related to supply items will now apply to both the York Street and the Saint Raphael Campus. Contracts for the following areas will be addressed.
  1. Medical/Surgical Supply Best Pricing: The first step in achieving savings for Med/Surg supplies is to compare the existing contracts between the campuses and determine where best pricing exists. During this process, savings due to the integration of the hospitals will be realized on both campuses depending on the cost of each individual supply item. In areas where there is a large differential on similar items, discussions will take place with the vendors in order to gain the lowest possible price. All Med/Surg supplies that are used on both campuses are being reviewed in this manner.
  2. Standardization of Supply Utilization: As clinical functions within the health system continue to be integrated, standard practice related to supply items will be developed. This will decrease the variability between vendors and lower the quantity of supplies that are campus specific. As utilization for certain supplies/vendors increase (and other decrease) contractual savings through both tiered pricing and renegotiated vendor contracts will occur. Although standardization is being evaluated for all services within the hospital, the area that is expected to achieve the largest savings is the Operating Room.
  3. System Contracting: Subsequent to the review of best pricing by campus, the combined entity will initiate system-wide contracts to ensure the lowest price (for both supply items and contractual services) throughout the Yale New Haven Health System. Savings have already been achieved in this manner for blood products and minor surgical supplies.
  4. Pharmaceuticals: As a result of YNHH's acquisition of HSR, pharmaceuticals for outpatients treated on the Saint Raphael Campus will now be purchased at 340B costs, which produce cost savings. The various outpatient services throughout the institution will achieve savings through this initiative. Additionally, tiered pricing and contract negotiation for specific high cost pharmaceuticals are expected to result in savings for the combined YNHH.

- Utilities: Aligning utility prices throughout the hospital is another area of opportunity where savings are expected to be realized. Although the heating sources vary between the campuses lower electricity pricing has already been obtained through the extension of York Street contracted rates. Telecommunications is another area evaluated for savings. Converting outside vendor contracted services into internal resources will result in lower costs. Consolidating in-house telecommunication/operator services is another area being evaluated related to savings.

- Business Expenses – This category represents a variety of different savings initiatives on the Saint Raphael's campus. The primary areas of focus related to business expenses are information technology integration, the consolidation of financial fees, decreased contracted costs for construction projects, duplicate memberships and fees, and various other contractual services.

    1. ITS integration: The two campuses utilize a wide array of various IT systems. These systems require license fees and maintenance contracts. In many cases different systems are used in order to accomplish the same task. One of the goals of the EPIC integration is to align these various systems. In addition to organizational consistency, this will allow for lower pricing related to the fees mentioned above. An effort is also underway to standardize the physical IT infrastructure at YNHH. This initiative will result in decreases to the standard maintenance fees related to these systems.
    2. Financial Fees: Audit, banking fees and other financial service fees will be reduced as a result of the integration.
    3. Construction Cost: Over the past several years various renovation and construction projects have been delayed at the Saint Raphael Campus due to HSR's financial situation. One of the primary goals in the integration process with Saint Raphael Campus is to invest in necessary upgrades to the physical plant that have been needed for some time. YNHH has traditionally received preferential pricing related to its various construction and renovation efforts. This decreased construction expense for these vital projects, and future projects will help in maintaining lower costs on an ongoing basis.
    4. Duplicative Memberships and Fees: Traditionally fees related to strategic planning database services, hospital professional organizations, and programmatic licensing has been paid by both hospitals. One of the benefits of integration is that YNHH can now significantly reduce, if not eliminate, the duplicate fees. Payments for the combined YNHH will be lower for membership fees such as the Advisory Board, Connecticut Hospital Association, and Sg2. In addition, duplicate fees for certifications for centers of excellence will be eliminated.
    5. Other Contractual Services: There are a variety of other contractual services being reviewed at both campuses related to several different services. As integration activities continue and clinical functions and locations are finalized, the necessity of maintaining any related contracts will be determined. Wherever possible, services are being consolidated or internalized wherever the current infrastructure can support. An example of this is the Cancer Registry contractual services previously in place at Saint Raphael's. By adding employees into the current Cancer Registry department on the York Street Campus and utilizing the systems in place, services were able to continue undisturbed at a lower cost.

Revenue Enhancement

As part of YNHH's integration plan, the Hospital is in the process of reviewing all revenue cycle management (RCM) functions, while integrating current YNHH York Street practices at the Saint Raphael campus. Additionally, implementation of Epic at the Saint Raphael campus which is currently scheduled for the second half of fiscal year 2013, will significantly facilitate improvements in the RCM process and revenue enhancement.

Specific RCM topics assessed in the first 100 days at the Saint Raphael campus included:

- System Interfaces - Yale-New Haven Hospital's transition to the Epic system integrating the electronic medical records and claims processing in February 2013 which will be rolled out to the Saint Raphael campus in June 2013.

- The Clinical Documentation Management Program (CDMP) initiatives are being expanded to ensure the full and appropriate capture of clinical documentation is reflected in the claims processing data for the claim to be reimbursed at the accurate level.

- A review of the billing processes indicated not all services performed and items provided are billed. Key indicators included self-administered drugs, drug waste, ancillary services such as infusions, injections, and blood transfusions for patients in observation status, full capture of laboratory/pathology services, and the volume of procedure codes did not appear fully captured in the outpatient setting.

- The percentage of claim denials was noted to be above the benchmark. Opportunities are being assessed related to the pre-service financial clearance process, improved communications and understanding of payor documentation requirements, and the case management processes.

- Wage Index: The Medicare rates for each hospital are adjusted based on the geographical wage index assignment of the hospital. As a result of the integration, Medicare rates for care provided on the Saint Raphael campus will be paid at the higher Fairfield County Medicare Wage Index rates thus resulting in higher Medicare reimbursement.

- Medicare Disproportionate Share (DSH): The other significant component of revenue enhancement is expected through an increase in the Medicare DSH reimbursement. The increase will result from blending the payor mix of HSR and YNHH which is expected to result in higher DSH payments.

F. ONGOING REPORTING

Beginning November 30, 2013 and in conjunction with semi-annual filings also required in Condition 3, OHCA will be provided with Reports 175, 100 and 150, along with a narrative which details achievements to date in each of the five sections of the three-year integration plan, updates to beds and services by campus, cost savings and revenue enhancements.

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

Key Activities	COMPLETE	FY 2013	FY 2014	FY 2015
1. Major Strategic Initiatives				
1a. Physician & Midlevel Integration				
A1. Transition HSR physician contracts to YNHHS				
A2. Integrate medical trainees from HSR residency/fellowships in YSM				
A3. Physician Contract Review Process				
A4. Consolidate Hospital Based Services, Each in a Cost Neutral Manner				
1. Anesthesiology				
2. Diagnostic Radiology				
3. Emergency Medicine				
4. Laboratory/Pathology				
A5. Integrated ACGME Residency and Fellowship Programs				
1b. EPIC Implementation				
A1. EPIC Go-Live at York Street Campus				
A2. EPIC Go-Live at Chapel Street Campus				
1c. Patient Experience				
A1. Establish common infrastructure for patient satisfaction				
A2. Implement Patient Experience Workplan and Supporting Infrastructure at SRC				
1. Patient and Family Advisor Program				
2. Reward and Recognition Structure				
3. Service Recovery Training/On-line Certificates				
A3. Implementation of the "Quiet Plan" Across Both Campuses				
1. Implement Leader Rounding				
2. Managers Train Staff				
A4. Launch Patient Experience Forum				
1d. Regulatory/Safety/Quality				
A1. Establish bi-campus morning safety report/extend "Great Catch" Program to SRC				
A2. Align care policies & establish common regulatory readiness infrastructure				
A3. Complete Joint Commission extension survey for SRC				
A4. Preparation for Department of Public Health and Joint Commission surveys				
1. Environmental of Care (EOC)				
2. Life Safety				
3. Provision of Care/Record of Care				
4. Adherence to Licensure				
5. Infection Prevention				
A5. Consistent Regulatory Compliance and Practices				
1. Audit of Polices and Procedures to Ensure Adherence				
A6. Ongoing Regulatory Education and Improvements				
1. Self-Review and Integrated Audits				
2. Structure Implemented for Twice Monthly CMS/DPH Audits & Twice Yearly TJC Audits at SRC				
A7. Clean and Safe Rounds				
1e. Transforming Patient Care				
A1. Implement Bedside Nursing Transformation at SRC to Ensure Consistent Staffing Models/Caregiver Hours Across Both Campuses				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

	COMPLETE	FY 2013	FY 2014	FY 2015
Key Activities				
A2. Medication Barcoding Process Implemented				
1f. Safe Patient Flow				
A1. Implement Common Safe Patient Flow Throughput Improvement				
A2. Identify Process Changes (Ongoing)				
1g. Cultural Integration				
A1. Establish cultural integration oversigh committee				
A2. Formation of Catholic Heritage Committee				
A3. Ethical and Religious Directive Educational Program and Materials Created				
A4. Common Value System Defined				
A5. Auxiliaries of Two Campuses Integrated in Operations				
A6. Medical Staff "Healthier Together" Open Forums				
A7. Employee Open Forums and Management Meetings				
1h. Bed Management/Capacity				
A1. Increase Average Daily Census on SRC				
A2. Renovate Sister Louise Anthony 3 unit/open 24 medicine beds on SRC				
A3. Open 24 General Medicine Beds on Verdi 4 North				
A4. Implement Y-Access Growth Plan				
A5. Develop Strategies to Optimize Inpatient Bed Utilization Across Both Campuses				
1i. 24/7 Infrastructure				
A1. Establish campus leadership team for SRC				
A2. Common Administrator on Call and Off-Shift Executive Model Implemented				
A3. Off-shift Department Management				
1j. Care Management to Integrate Services Across the Continuum				
A1. Consolidate care management activities under common leader				
A2. Common Care Management Structure Implemented				
2. Service Lines				
2a. Children				
A1. Vision				
1. YNHCH is a destination of choice for pediatric care.				
A2. Facilities & Capital				
1. Develop and Implement the Plan for NNICU Expansion and Fundraising				
A3. Integration Activities				
1. Consolidate inpatient pediatrics (excl. child psych and newborn SC) to York St. campus				
2. Integrate Pediatrics Services Across Both Campuses				
3. Align Child and Adolescent Psychiatry Across Campuses				
4. Combine Hospitalist Programs at YNHCH Campuses				
5. Conduct search for new Chief of Neonatology				
2b. Heart & Vascular				
A1. Vision				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

	COMPLETE	FY 2013	FY 2014	FY 2015
Key Activities				
1. Integrate Heart and Vascular Operations Across Both Campuses and Outpatient Centers				
A2. Facilities & Capital				
1. Renovate Catheterization Laboratories				
A3. Integration Activities				
1. Development of Vascular Access Center				
2. Development of Aortic Institute				
3. Expansion of the Interventional Radiology Program at SRC				
2c. Musculoskeletal				
A1. Vision				
1. Musculoskeletal Service Line Established and Recognized as leading program				
A2. Facilities & Capital				
1. Operational and Capital Plan in Place				
A3. Integration Activities				
1. Business plan implementation				
2d. Neurosciences				
A1. Vision				
Leading Neurosciences program in CT				
A2. Facilities & Capital				
1. Allocated appropriate number of beds to Neurosciences				
A3. Integration Activities				
Telestroke at Saint Raphael Campus				
2e. Oncology				
A1. Vision				
1. Integrated Oncology Operations Across Both Campuses				
A2. Integration Activities				
1. Chemotherapy on both campuses				
2f. Transplant				
A1. Vision				
1. Provide leading solid organ transplantation services in CT (ongoing)				
A2. Integration Activities				
1. Organ Donation Registry				
3. Clinical Areas				
3a. Diagnostic Radiology				
A1. Staffing/Coverage				
1. Enterprise-wide Scheduling (Consolidation of Scheduling/Registration Functions)				
A2. Facilities & Equipment				
1.CON for YNHH to acquire SRMRC Joint Venture				
2. Facilities Plan Completed				
A3. Integration Activities				
1. Assessment of all radiology services and equipment and implementation				
3b. Emergency Department				
A1. Staffing/Coverage				
1. Realign ED Structure to Create an Integrated Model				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

Key Activities	COMPLETE	FY 2013	FY 2014	FY 2015
A2. Facilities & Equipment				
1. Review AMR ED Ambulance Operations				
2. Standardized Equipment (As Replacements Are Needed)				
A3. Integration Activities				
1. Consolidation of Major Trauma at York Street				
2. Review Sponsor Hospital Program Offering, Infrastructure, Costs and Opportunities				
A4. Other				
1. Create Community & Emergency Care Assessment Committee				
3c. Laboratory and Pathology				
A1. Integration Activities				
1. Evaluate consolidation of Laboratory Services System-Wide (Integrated Lab and Shared LIS)				
2. Install and Operate SOFTLaboratory IS system on Both Campuses				
3d. Medicine				
A1. Integrate Hospitalists operations across both campuses				
A2. Review Hospitalist Staffing Model and Admission Criteria to Hospitalist Service				
A3. Develop Business Case for eICU				
A4. Evaluate creation of Geriatrics service line				
* See section 1h for new medical bed reference				
3e. Nursing				
A1. Quality				
1. Implement Magnet Remediation Plans				
A2. Inregration Activities				
1. Consistent Metrics and Standards and Creation of Unit/Service Line Dashboard				
2. Achieve Reduction in Caregiver Hours (see Transforming Patient Care)				
3f. Pharmacy				
A1. Staffing/Coverage				
1. Establish staffing with YNHH employees (eliminate Cardinal Health contract)				
A2. Facilities & Equipment				
1. Purchase and standardize Pyxis machines				
A3. Integration Activities				
1. Pharmacy Strategy Executed with Single Unified Product Formulary Cross Campuses				
3h. Psychiatry				
A1. Staffing/Coverage				
1. Develop a Standard Model of Care for Psychiatric Services at Both Campuses				
a. 12 Years Old and Under on Winchester One, YSC				
b. 13-15 Year Olds on Celatano 5, SRC				
c. 16-17 Year Olds on LV2, YSC				
2. One Standard Model of Care with One Psych ED and BIT Team Implementation at SRC				
A2. Quality & Regulatory				
1. Participate in State Collaborative Regional Plan- Integrating Behav.Health Service Payment and Delivery				
A3. Integration Activities				
1. Conduct Crisis Intervention Unit Assessment & Develop/Implement an Improvement Plan (w/ED)				
2. Develop Strategies to Reduce Long LOS for Psychiatry Patients				

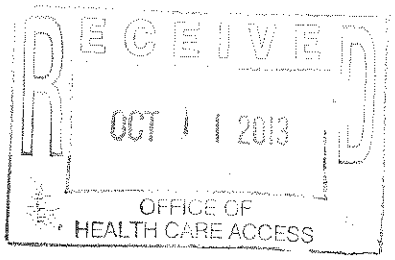
Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

Key Activities	COMPLETE	FY 2013	FY 2014	FY 2015
3l. Surgical Services				
A1. Facilities & Equipment				
1. Conduct an Assessment of Operating Room and Clinical Support Services				
A2. Consistent Operations				
1. Integrate OR Operations Across Both Campuses, Temple and Shoreline				
2. Optimize Utilization Across All Sites				
3. GI Procedure Integration (YSC, SRC, and Temple)				
4. Develop a Dedicated Bariatric Program (location TBD) & Obtain Center of Excellence Certification				
5. Establish Common Set of Metrics				
3m. Women				
A1. Integration Activites				
1. Integrate OB-GYN Services Across Both Campuses				
2. Expand OB Residency to Cover SRC				
3. Establish low risk delivery service at SR Campus utilizing midwifery program.				
3n. Ambulatory Services				
A1. Complete Ambulatory Strategic Plan				
1. Develop inventory of all ambulatory locations and services				
2. Develop and implement programmatic recommendations				
4. Non-Clinical Areas				
A1. Consolidation of Vendors for Environmental Svcs, Food/Nutrition, Linen and Protective Services				
5. Corporate Services				
5a. Accounting & Finance				
A1. Consolidate Finance & Accounting				
A2. Integrate Capital Budgeting Process Covering Both Campuses				
A3. Integrate Operating Budgeting Process Covering Both Campuses				
A4. Consolidation of Cost Accounting and Decision Support Systems				
A5. Maintain individual Accounts Receivable systems until Epic Go-Live				
5b. Compliance				
A1. Consolidate Compliance				
A2. Ensure All Staff Receive Compliance Education Annually (Ongoing Communications and In-services)				
A3. Billing, Coding, and Documentation Audits of Both Hospital and Physician Activities				
A4. SRC Incorporated into YNHHS Conflict of Interest Process				
5c. Human Resources				
A1. Consolidate Human Resources				
A2. Onboard and train HSR employees				
A3. Conduct compensation review at SRC/adjust base salaries where appropriate				
A4. Standardize Career Ladders				
A5. Standardize Performance Management System and Process				
A6. Standardize Rewards, Recognition, and leveraging Performance Based Pay				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of March 2013

Key Activities	COMPLETE	FY 2013	FY 2014	FY 2015
A7. Employee Engagement Survey				
A8. Develop and Implement Saint Raphael Campus Manager Education Programs				
5d. Information Technology and Information Systems				
A1. Consolidate Information Technology				
A2. Consolidate Approved Applications				
1. Reduce Application Portfolio for EPIC Implementation				
2. Application Consolidation for The Following Areas: Laboratory – Anatomic Pathology, Cardiology, Radiation Oncology & Neurosciences				
3. Application Consolidation for The Following Areas: Gastroenterology, Dietary Services, POS & Sleep Center				
A3. Service Desk Standardized				
A4. Consolidate Telecom Operator Services				
A5. Review Service Contracts for Systems Used Prior to EPIC Integration				
5e. Legal & Planning				
A1. Consolidate Legal & Planning				
A2. Identify vendor consolidation opportunities				
A3. Continue Integration Work with MCIC				
5f. Marketing, Communications, Image, and Community Wellness				
A1. Consolidate Marketing, Communications, Image & Comm. Wellness				
A2. Develop common communication strategy for both campuses				
A3. Develop and Implement Community Revitalization Strategy				
A4. Implement Communication Strategies for Managers and Employees				
A5. Consolidate Advocacy Groups				
5g. Revenue Cycle				
A1. Identical Billing Systems and Vendors to Support Revenue Cycle Functions				
A2. Revenue Cycle Functions Centralized Organizationally and Physically, Where Possible				
A3. Implement consistent charge master				
A4. Implement Revenue Cycle Opportunities				
5g. Reimbursement and Managed Care				
A1. Negotiate consistent contracts for all payors				
5h. Supply Chain				
A1. Consolidate Supply Chain				
A2. Contract renegotiations				
A3. Inventory management				
A4. Service Response Center consolidation				

YALE-NEW HAVEN HOSPITAL



October 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

I have enclosed a CON Modification request for the above referenced CON application. YNHH requests that the November 30 due date included in Condition #3 be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Nancy Rosenthal
Senior Vice President – Health Systems Development

Enclosures

Copy to: Kimberly Martone, Director of Operations

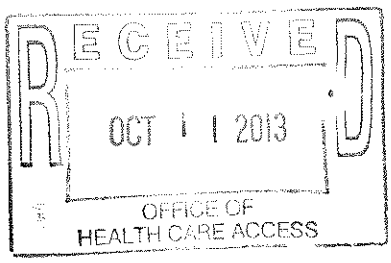
20 York Street
New Haven, CT 06504

Yale-New Haven Hospital's

Docket Number: 12-31747-CON and 12-31747-MDF:

Yale-New Haven Hospital's Acquisition

of the Saint Raphael Healthcare System, Inc



Certificate of Need Modification

October 11, 2013

YALE-NEW HAVEN HOSPITAL

October 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

I have enclosed a CON Modification request for the above referenced CON application. YNHH requests that the November 30 due date included in Condition #3 be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Nancy Rosenthal
Senior Vice President – Health Systems Development

Enclosures

Copy to: Kimberly Martone, Director of Operations

20 York Street
New Haven, CT 06504

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	Yale-New Haven Hospital	
Doing Business As		
Name of Parent Corporation	Yale New Haven Health System	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	20 York Street New Haven, CT 06510	
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	
Name of Contact person, including title	Nancy Rosenthal, Sr. Vice President, Health Systems Development	
Contact person's street mailing address	20 York Street New Haven, CT 06510	
Contact person's phone, fax and e-mail address	(203) 863-3908 (PH) (203) 863-4736 (Fax) nancy.rosenthal@greenwichhospital.org	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):
Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. DN: 12-31747-CON as subsequently modified as DN: 12-31747-MDF

b. Location of proposal (Town including street address):
20 York Street, New Haven, CT 05610

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☒ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

N/A

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE: N/A

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

Condition #3_

b. Provide the rationale for such requested change:

Condition #3 identifies semi-annual reporting periods and due dates. YNHH requests that the November 30 due date be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record. No change is needed for the May 31 semi-annual reporting due date. YNHH will provide a report on May 31st which will summarize financial data for the time period of October 1 – March 31.

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

A completed CON Modification Affidavit has been included as Attachment I.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

Not applicable

c. Identify what has been accomplished to date in terms of full project implementation.

Integration activities are progressing consistent with the Three-Year Integration Plan submitted to OHCA on March 31, 2013. An updated narrative of all progress completed through fiscal year 2013 will be provided along with the financial reporting in accordance with Condition #3.

ATTACHMENT I
AFFIDAVIT

CON MODIFICATION AFFIDAVIT

Applicant: Yale-New Haven Hospital

Project Title: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

I, Richard D'Aquila, (Name) President and Chief Operating Officer (Position – CEO or CFO)

of Yale-New Haven Hospital being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

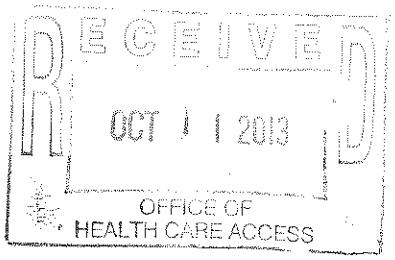
Signature 10/10/13 Date

Subscribed and sworn to before me on October 11, 2013

Nancy T. LaPierre
Notary Public/Commissioner of Superior Court

My commission expires: September 30, 2016

YALE-NEW HAVEN HOSPITAL



October 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

I have enclosed a CON Modification request for the above referenced CON application. YNHH requests that the November 30 due date included in Condition #3 be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Nancy Rosenthal
Senior Vice President – Health Systems Development

Enclosures

Copy to: Kimberly Martone, Director of Operations

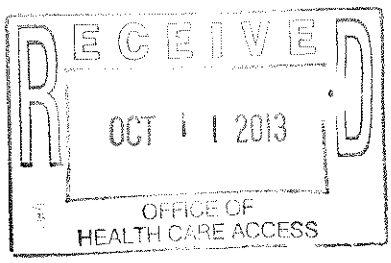
20 York Street
New Haven, CT 06504

Yale-New Haven Hospital's

Docket Number: 12-31747-CON and 12-31747-MDF:

Yale-New Haven Hospital's Acquisition

of the Saint Raphael Healthcare System, Inc



Certificate of Need Modification

October 11, 2013

YALE-NEW HAVEN HOSPITAL

October 11, 2013

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

I have enclosed a CON Modification request for the above referenced CON application. YNHH requests that the November 30 due date included in Condition #3 be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Nancy Rosenthal
Senior Vice President – Health Systems Development

Enclosures

Copy to: Kimberly Martone, Director of Operations

20 York Street
New Haven, CT 06504

State of Connecticut
Office of Health Care Access
Form for Modification of a Previously Authorized Certificate of Need

All persons who are requesting a modification to a previously authorized Certificate of Need must complete this form. Completed forms should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner	Petitioner
Full legal name	Yale-New Haven Hospital	
Doing Business As		
Name of Parent Corporation	Yale New Haven Health System	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	20 York Street New Haven, CT 06510	
Petitioner type (e.g., P for profit and NP for Not for Profit)	NP	
Name of Contact person, including title	Nancy Rosenthal, Sr. Vice President, Health Systems Development	
Contact person's street mailing address	20 York Street New Haven, CT 06510	
Contact person's phone, fax and e-mail address	(203) 863-3908 (PH) (203) 863-4736 (Fax) nancy.rosenthal@greenwichhospital.org	

SECTION II. GENERAL PROPOSAL INFORMATION

a. Title of Previously Authorized Project and Associated Docket Number(s):
Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. DN: 12-31747-CON as subsequently modified as DN: 12-31747-MDF

b. Location of proposal (Town including street address):
20 York Street, New Haven, CT 05610

c. Type of Modification Request:

☐ Change in the Scope of the Authorized Certificate of Need Project

☐ Extension of CON Expiration Date

☒ Change in a CON Order Condition *(other than to extend expiration date)*

☐ Other – Describe: _____

SECTION III. IF REQUESTING A CHANGE IN THE SCOPE OF AUTHORIZED PROJECT:

a. Provide a one page description of the requested change in the scope of a previously authorized Certificate of Need project and provide a detailed rationale for such change:

N/A

SECTION IV. IF REQUESTING AN EXTENSION OF THE CON EXPIRATION DATE: N/A

a. Certificate of Need expiration date per CON Final Decision: _____

b. Requested revised CON expiration date: _____

c. Rationale for increased time to fully complete and implement the authorized project:

_____

_____

_____

_____

_____

SECTION V. IF REQUESTING A CHANGE IN A CON FINAL DECISION CONDITION *(other than extension of the CON expiration date)*

a. Identify the CON Condition that you are requesting to be revised or vacated.

Condition #3_

b. Provide the rationale for such requested change:

Condition #3 identifies semi-annual reporting periods and due dates. YNHH requests that the November 30 due date be changed to December 20 in order to allow for completion of the year-end audit and reporting to the Board of Trustees. In addition, in lieu of reporting semi-annual financial data, YNHH is proposing that the December 20th report will include twelve months of financial data for the recently completed fiscal year. This request is being made in order to provide OHCA with complete and accurate data and to ensure year-end results have been audited and provided to the Board of Trustees before such data is available on the public record. No change is needed for the May 31 semi-annual reporting due date. YNHH will provide a report on May 31st which will summarize financial data for the time period of October 1 – March 31.

SECTION VI. OTHER

a. Submit a completed CON Modification Affidavit.

A completed CON Modification Affidavit has been included as Attachment I.

b. Identify any other pertinent changes to the findings of facts upon which the original CON authorization was based as a result of this requested modification.

Not applicable

c. Identify what has been accomplished to date in terms of full project implementation.

Integration activities are progressing consistent with the Three-Year Integration Plan submitted to OHCA on March 31, 2013. An updated narrative of all progress completed through fiscal year 2013 will be provided along with the financial reporting in accordance with Condition #3.

ATTACHMENT I
AFFIDAVIT

CON MODIFICATION AFFIDAVIT

Applicant: Yale-New Haven Hospital

Project Title: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

I, Richard D'Aquila, (Name) President and Chief Operating Officer (Position – CEO or CFO)

of Yale-New Haven Hospital being duly sworn, depose and state that the information provided in this CON Modification form is true and accurate to the best of my knowledge.

Signature 10/10/13 Date

Subscribed and sworn to before me on October 11, 2013

Nancy T. LaPierre
Notary Public/Commissioner of Superior Court

My commission expires: September 30, 2016

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

October 31, 2013

Nancy Rosenthal
Senior Vice President-Health Systems Development
Yale-New Haven Hospital
20 York Street
New Haven, CT 06504

Re: Docket Number 13-31747-MDF: A Request to Modify Docket Number 12-31747-CON and 12-31747-MDF

Dear Ms. Rosenthal:

The Office of Health Care Access ("OHCA") received your request on behalf of Yale-New Haven Hospital ("Applicant") to modify the Certificate of Need ("CON") decision rendered in Docket Number 12-31747-CON, as modified by Docket Number 12-31747-MDF, which authorized the Applicant to acquire certain assets of the Saint Raphael Healthcare System, Inc.

The Applicant requested a modification of Condition Number 3 of the Order under the Agreed Settlement, as modified, in order to change the November 30th due date for the filing of certain financial documents to December 20th and modify the content of the financial filing to include twelve months of financial data for the recently completed fiscal year. The reason given for this request is to allow time for the completion of the year-end audit and reporting to the board of trustees before such data is available on the public record.

The Applicant's request to modify the CON does not show changed conditions, as required by Connecticut General Statutes § 4-181a(b). Therefore, the Applicant's request to modify Docket Number 12-31747-CON, as modified by Docket Number 12-31747-MDF, is denied. The Agreed Settlement under Docket Number 12-31747-CON, as modified by Docket Number 12-31747-MDF, stands as previously ordered by OHCA.

Sincerely,

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3802
RECIPIENT ADDRESS	912038634736
DESTINATION ID	
ST. TIME	11/01 09:46
TIME USE	00'23
PAGES SENT	2
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: NANCY ROSENTHAL

FAX: 203 863-4736

AGENCY: YALE-NEW HAVEN HOSPITAL

FROM: OHCA

DATE: 11/1/13 Time:

NUMBER OF PAGES: 2
(including transmittal sheet

Comments:

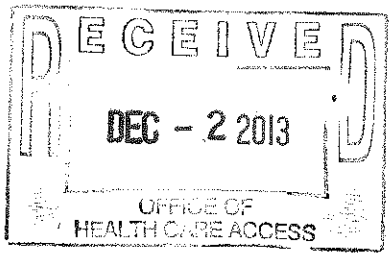
Please see attached regarding modification request regarding DN: 13-31747

PLEASE PHONE Barbara K. Oleiarz IF THERE ARE ANY TRANSMISSION

Office of the President

YALE-NEW HAVEN HOSPITAL

November 29, 2013



Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

Pursuant to Condition Number 3 of the Agreed Settlement signed on June 27, 2012 and subsequently modified by the Office of Health Care Access (OHCA) on October 9, 2012, I have enclosed Yale-New Haven Hospital's (YNHH) narrative update on the progress of implementation of the three year integration plan. Accompanying the narrative is a Gantt chart which displays the integration activities and time frames for the three year integration plan. These activities are described in more detail in Section A of the narrative report. The narrative update includes cost saving totals per operating expense categories as identified by OHCA. In addition, completed OHCA Reports 100, 150 and 175 for the consolidated YNHH are also attached.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Richard D'Aquila
President & Chief Operating Officer

Enclosures

Copy to: Kimberly Martone, Director of Operations

20 York Street
New Haven, CT 06510-3202
203-688-2606
Fax 203-688-3774

YALE-NEW HAVEN
HOSPITAL

Yale New-Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. Docket No: 12-31747-CON

Three Year Integration Plan Narrative Update

November 30, 2013

Yale New-Haven Hospital's Acquisition
of the Saint Raphael Healthcare System, Inc.
Docket No: 12-31747-CON

Three Year Integration Plan
Narrative

INTRODUCTION

This narrative report has been prepared as part of the reporting requirements for Yale-New Haven Hospital (YNHH) in accordance with the Agreed Settlement for Docket Number: (DN) 12-31747-CON, subsequently modified as DN: 12-31757-MDF for the acquisition of the Saint Raphael Healthcare System, including the Hospital of Saint Raphael (HSR).

This report is structured into the following sections:

A. PROGRESS AGAINST THREE-YEAR INTEGRATION PLAN

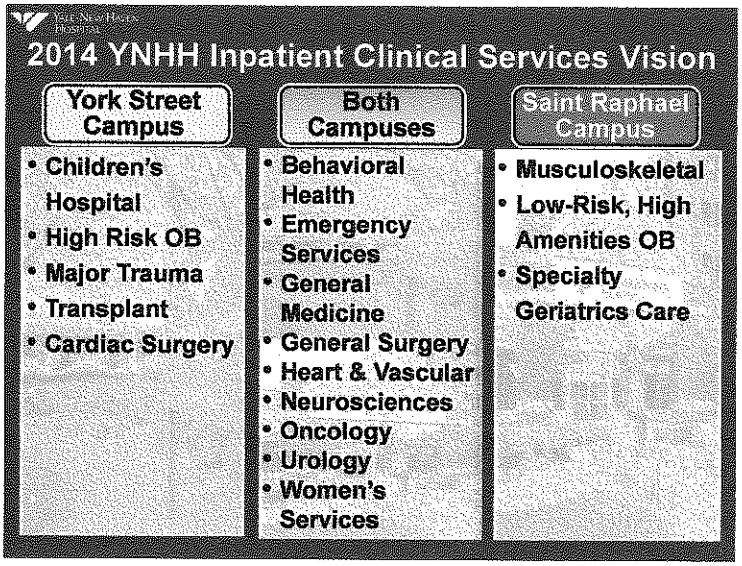
B. SUMMARY OF BEDS & SERVICES BY CAMPUS

C. COST SAVINGS AND REVENUE ENHANCEMENTS

D. ONGOING REPORTING

A. PROGRESS AGAINST THREE-YEAR INTEGRATION PLAN

Consistent with the three-year integration plan submitted on March 31, 2013, the focus of the last fiscal year has been on developing one standard of care across all inpatient campuses and ambulatory operations. YNHH has defined its clinical vision for its inpatient campuses and a summary can be found below.



As such, many of the activities described in this report were developed to support the successful implementation of the clinical vision.

Attachment I contains the updated Integration Workplan for FY 2013 through FY 2015 in Gantt chart format which is organized into five major sections including: (1) Major Strategic Initiatives; (2) Service Lines; (3) Clinical Areas; (4) Non-Clinical Areas; and (5) Corporate Services. The Integration Workplan includes specific activities for each of these five areas and the actual or estimated time frame by fiscal year for completion. Progress to date as well as remaining focus areas for the next six months is detailed in the narrative below.

Section 1. Major Strategic Initiatives:

Major strategic initiatives pertain to activities with a broad impact throughout the organization. YNHH is focusing on ten key areas:

1. *Physician Integration*
   Hospital-based services, including Diagnostic Radiology and Emergency Medicine were successfully integrated into the Yale School of Medicine full-time faculty. Additionally, all residencies, fellowships and medical education activities have been integrated. Remaining hospital-based services, Anesthesiology and Pathology/Laboratory, will be integrated in FY 2014.

2. *Epic Implementation*
   On February 1, 2013, YNHH successfully implemented the Epic system at the York Street campus and implementation at the Saint Raphael campus was completed on June 1, 2013. Implementation at both campuses went extremely well, without any patient incidents or business interruptions. The implementation of Epic provides the organization with a single inpatient/outpatient electronic medical record, including access to provider notes across the care continuum and medication barcoding, among others. The implementation of Epic also accelerated the cultural integration of both campuses as staff members were able to connect with their counterparts at the other campus and learn from their experiences.

   Epic was also implemented at Bridgeport Hospital in late September 2013, connecting all Yale New Haven Health System (YNHHS) hospitals and physician practices onto one common electronic platform and enhancing care continuity across greater New Haven. Activities in coming months will focus on optimizing the system (referred to as the "optimization phase") as well as further linking technology to facilitate care delivery (e.g. electronic ICU business plan).

3. *Patient Experience*
   The patient experience infrastructure, including service recovery, healing environment training and a new patient experience forum was implemented at the Saint Raphael campus in FY 2013. The focus in coming months will be on standardizing the content and structure of patient experience forums across campuses and clinical services. Additionally, a patient experience strategic plan was developed for FY 2014 and was themed "every patient, every time". This refers to the importance of providing an exceptional experience for patients, each and every time they are receiving care in an YNHH care setting (inpatient and outpatient). Physician engagement will also be an important focus area in coming months, and special

attention will be placed on fostering a nursing and medical leadership team for each patient unit.

4. *Regulatory / Safety and Quality*
In late September 2013, YNHH successfully completed its Department of Public Health licensure survey. Clean and Safe rounds (environment of care readiness) were implemented at the Saint Raphael campus and compliance with environment of care indicators (e.g. physical plant conditions) has increased significantly since implementation. Mock-audits and other regulatory readiness preparedness activities remain ongoing.

   As part of its commitment to exemplary patient safety and quality, YNHH is partnering with Healthcare Performance Improvement (HPI) in its journey to become a high reliability organization. To this end, senior executive rounds and safety and quality training for all employees and medical staff will be important focus areas in FY 2014. This initiative will be called "Getting To Zero Events of Harm" and is consistent with the approach endorsed by the Connecticut Hospital Association.

5. *Transforming Patient Care*
Transforming Patient Care refers to a review of nursing workflows and supporting systems/processes to remove unnecessary activities. Bedside electronic nursing documentation has been implemented at the Saint Raphael campus, and a comprehensive roll-out of best practices from the York Street campus will take place in FY 2014. Implementation of the Nursing Magnet readiness plan will also take place in FY 2014. Further improvement activities remain ongoing at the York Street campus.

6. *Safe Patient Flow*
Safe Patient Flow refers to throughput improvement activities and was instrumental in allowing YNHH to meet its patient care demand prior to the integration of the Hospital of Saint Raphael. The groundwork for the implementation of Safe Patient Flow at the Saint Raphael campus has been completed and the process was formally "kicked-off" in November 2013. Safe Patient Flow will help alleviate capacity challenges and ensure that patients are placed on the "right unit" for their care from the beginning of their hospitalization. Throughput improvements are expected to materialize in coming months.

7. *Cultural Integration*
To ensure that the Catholic heritage of the Sisters of Charity of Saint Elizabeth remains reflected in Saint Raphael campus operations, a Catholic Heritage Committee has been developed. Additionally, the YNHHS has developed singular vision and mission statements, and identified one set of core values, to provide all delivery networks with a common focus and clear, shared direction. Semi-annual open forums with employees and medical staff were implemented, as were monthly management meetings. YNHH activities and programs continue to be migrated to the Saint Raphael campus; these range from patient experience enhancement initiatives to employee recognition programs. Many committees—both clinical and non-clinical—have been integrated, including with front line staff. Finally, the integration of the YNHH and HSR auxiliaries will be completed at the end of FY 2014.

8. *Bed Management/Capacity*
   As part of its commitment to develop a leading musculoskeletal service line on the Saint Raphael campus, YNHH has decided to designate its newly renovated unit, Verdi 4 North, a 29- bed inpatient musculoskeletal unit. The first patients will be admitted to the unit in February 2014. Additionally, the complement of Medicine and Surgery beds is being reviewed with a number of Surgery beds being converted to Medicine to better match existing resources with patient care needs but maintaining the overall count of Medicine/Surgery beds. Bed allocation by service is outlined in Section B "Summary of Beds and Services by Campus" of this report. In addition, all bed management functions have been centralized on the York Street Campus.

9. *Infrastructure*
   A few years ago, the York Street campus implemented the Off Shift Executive model to provide executive level coverage during off-shifts (evenings, nights and weekends). The off-shift leaders engage in employee recognition, service recovery and other required general hospital operations. The model will be implemented on the Saint Raphael campus in early calendar 2014 and will allow for a common off-shift leadership structure to address emergencies across all practice sites.

10. *Care Management Across the Continuum*
    Transitional Care Rounds have been implemented in Medicine, Heart and Vascular, Surgery and Oncology at the York Street Campus, and have created an effective, unit-based process that focuses on high-quality transitions. These rounds have already had a positive impact on patient status updates, 11:00 am discharge rates, and hospital length of stay. Over the next few months, Transitional Care Rounds will be implemented in all remaining inpatient units at the York Street campus and Care Rounds will be aligned across both the York Street and Saint Raphael campuses.

Section 2. Service Lines

Vision, facility investments and integration activities for major clinical service lines comprise the second section of the Integration Workplan. It is important to note that the information provided below predominantly addresses inpatient services as ambulatory activities are currently being reviewed as part of a comprehensive ambulatory strategic planning exercise, discussed in Section 3.

The following service lines are included:

1. *Children's*
   The Pediatric Inpatient Unit at the Saint Raphael's Campus was closed on February 1, 2013. Neonatology services across the York Street and the Saint Raphael campuses were integrated as of July 1, 2013 with the newborn intensive care unit at the Saint Raphael campus converted from a Level 3 to a Level 1 unit. A 24/7 neonatal nurse practitioner service with on-call back up from neonatologists and daily rounding by pediatric hospitalists is in place. All infants requiring a higher level of care are transferred to the York Street campus.

2. *Heart and Vascular*
   All inpatient and outpatient Heart and Vascular programs were integrated in FY 2013, and an Aortic Center will open in February at the York Street campus. FY 2014 focus areas include the development of a vascular access center, a wound center and renovation of the cardiac catheterization laboratories at the Saint Raphael campus. Additionally, cardiac surgery will be consolidated at the York Street campus in summer 2014.

3. *Musculoskeletal*
   In collaboration with Yale School of Medicine physician leaders and leading community physicians, the vision for the Musculoskeletal Center was developed. The Musculoskeletal Center will be modeled after the Smilow Cancer Hospital and will focus on multidisciplinary patient-centered care and translational research. In addition, the Center will be the third clinical center of its kind within Yale University and the sixth service line for Yale-New Haven Hospital. A national search for a Musculoskeletal physician leader is underway and is expected to be completed by summer 2014.

   As was mentioned in the Bed Management section, Verdi 4 North at the Saint Raphael campus will be opening as a musculoskeletal unit. Elective joint replacement and spine cases from the York Street campus will be transferred to the Saint Raphael campus as the first phase in the musculoskeletal growth plan in spring 2014. Musculoskeletal Center components and phasing will be further refined in coming months.

4. *Neurosciences*
   Consistent with the initial workplan submission in March 2013, no additional service configurations have taken place in Neurosciences. Bed allocation for Neurology at the Saint Raphael campus will be reviewed in coming months.

5. *Oncology*
   Oncology services have been consolidated under common leadership and complex oncology cases have transitioned from the Saint Raphael campus to the Smilow Cancer Hospital at the York Street campus. Chemotherapy and radiation therapy services will continue to be provided on both campuses to support inpatient care needs.

6. *Transplant*
   The organ transplant donation committee has been consolidated and transplant activities will continue to remain solely at the York Street campus.

Section 3. Clinical Areas

Additional clinical integration beyond the service lines described in Section 2 are described and listed below:

1. *Diagnostic Radiology*
   The implementation of Epic has allowed the implementation of enterprise-wide scheduling across all YNHH radiology sites. Additionally, YNHH became the sole owner of the MRIs at the Saint Raphael campus in October 2013, following CON approval. Assessment of radiology equipment and master planning for radiology services remains ongoing.

Professional radiology readings by attending radiologists are now available 24/7 at the Saint Raphael Campus.

2. *Emergency Department*
   A common leadership structure and staffing pool of employees was established to float between YNHH's three Emergency Departments (York Street, Saint Raphael campus and Shoreline). Emergency transportation, including ground and other methods, will be reviewed in FY 2014.

3. *Laboratory/Pathology*
   During the summer of 2013, the SOFT laboratory information system was implemented at the Saint Raphael campus, in conjunction with Epic. Common information systems will facilitate the ordering, processing and test reporting for laboratory tests. In addition, components of microbiology will be consolidated at the York Street campus (specimen plating will take place at the Saint Raphael campus and analysis will be at the York Street campus). This will improve blood culture reading and turnaround time at the Saint Raphael campus.

4. *Medicine*
   Consistent with the inpatient clinical vision outlined in section I, a Geriatric Center of Excellence will be established at the Saint Raphael campus, and will include the relocation of the Acute Care for the Elderly (ACE) unit from the York Street campus to the Saint Raphael campus in late spring/early summer 2014. An evaluation of required ambulatory services to complement inpatient geriatric care is currently being completed.

   Additionally, a business case to implement electronic ICU (eICU) coverage capabilities at the Saint Raphael campus is currently being developed, with implementation to be completed in FY 2014/2015.

5. *Nursing*
   YNHH will be undergoing its Magnet re-designation in FY 2015 and will be ensuring adequate preparedness in coming months. This will be the first time the Saint Raphael campus will be included in the Magnet certification process. A Nursing Magnet gap analysis was completed and implementation of remediation plans remains ongoing to ensure that both campuses meet Magnet re-designation requirements.

   Additionally, a system-wide nursing standardization effort is underway across all delivery network hospitals, and a number of policies have been standardized to date. Nursing standardization will be an ongoing health system initiative.

6. *Pharmacy*
   A unified formulary was developed and implemented across both YNHH campuses and all Yale New Haven Health System network hospitals. This will facilitate standardization of clinical practice and yield important economies of scale for the Health System.

7. *Psychiatry*
   With the increasing demand for psychiatric services across the state, YNHH has appointed an executive leader to oversee all aspects of behavioral health (inpatient and outpatient). An

important focus area in FY 2014 will be the launch of Behavioral Intervention Teams, currently in place across inpatient medicine services at the York Street campus, at the Saint Raphael campus. The Behavioral Interventional Teams provide proactive consultations to Medicine patients with psychiatric conditions and have played an important role in decreasing length of stay for patients with psychiatric diagnoses on Medicine units. YNHH will also continue to participate in the statewide behavioral health collaborative.

8. *Surgical Services*
   Following the completion of a consulting engagement, YNHH has elected to make significant changes in its leadership structure as well as investments to improve operating efficiencies to optimize operating room resources across all practice sites in the coming year. A physician leader to co-lead the operating rooms will be recruited and a national search is currently underway. Detailed workplans are being developed to achieve targeted operational efficiencies.

   Additionally, a business case and model for the consolidation of bariatric surgery at the Saint Raphael campus is being developed, as is a business case for the creation of a Hernia Center, at the Saint Raphael campus. The business case continues to be refined for the establishment of a digestive diseases center of excellence at the Saint Raphael campus.

9. *Women's Services*
   One of the key focus areas in FY 2014 will be the development of a Center of Excellence for Low Risk/High Amenities Obstetrics at the Saint Raphael campus. Beginning January 15, 2014, the Yale School of Nursing Midwifery program will begin admitting its patients to the Saint Raphael campus. Main 6 (part of the Vidone Center), will re-open following a renovation to house the outpatient portion of the program.

10. *Ambulatory Services*
    In late summer 2013, YNHH completed its inventory of ambulatory operations. With the integration of the HSR, YNHH now has 111 ambulatory practices in 24 Connecticut towns. Programmatic recommendations and consolidations are currently being developed. An initial set of recommendations is expected in spring 2014.

Section 4. Non-Clinical Support Services

As it pertains to non-clinical support services, vendor consolidation opportunities were identified for Environmental Services, Food and Nutrition, Linen Services and Protective Services. Estimated savings can be found in Section C of this narrative.

Section 5. Corporate Services

Corporate services include seven key areas and integration activities for each are described below.

1. *Accounting & Finance*
   The financial close, reporting, and audit processes have been centralized within a single department. This consolidation has eliminated the need for dual audit, banking fees, and

invoicing processes. The savings associated with these activities is discussed in Section C (6).

2. *Compliance*
   Annual compliance training via Healthstream for all employees remains ongoing.

3. *Human Resources*
   Common employee career ladders and advancement criteria were developed in summer 2013. Employees eligible for the performance incentive program (PIP) will receive a one-time bonus based on the organization achieving required goals in early December 2013. Additionally, a common employee engagement survey was deployed across all YNHHS network hospitals in November 2013. Results are expected in winter/spring 2014. Merit based salary increases will be provided to all employees on or before December 1, 2013.

4. *Information Technology & Information Systems*
   While the immediate focus was on the implementation of Epic, additional focus areas/opportunities include streamlining of technology applications for Cardiology, Radiation Oncology, Neurosciences, Gastroenterology, Food and Nutrition and Sleep Study, among others.

   Help Desk operations and Telecom services were standardized across both campuses and are complete.

5. *Legal and Planning*
   Integration work with MCIC (malpractice insurance captive) remains ongoing.

6. *Marketing, Communications, Image & Community Wellness*
   The development of new employee and manager communication strategies employing new media (e.g. social media) remains ongoing. The organization will remain a strong advocate with State and Federal government agencies for continued access to high quality healthcare services for Connecticut residents.

7. *Supply Chain*
   Since summer 2013, the Service Response Center (a call center that triages calls pertaining to janitorial, maintenance and other similar requests) now includes requests from the Saint Raphael campus. Supply chain savings achieved through vendor contracts will be discussed in Section C (5).

B. SUMMARY OF SERVICES AND BEDS BY CAMPUS

As described in Section A above, integrating clinical services is still underway and specific campus locations and allocated beds continue to be adjusted. The two tables below summarize the current plan for the services and beds by location. This information is subject to change and any changes will be provided to OHCA in subsequent semi-annual reports.

Planned Services by Campus for 2015 (as of November 2013):

Services	YNHH Campus	SR Campus
Service Lines		
Children's	X	
Heart & Vascular	X (Tertiary/Quaternary)	X
Musculoskeletal		X
Neurosciences	X (Tertiary/Quaternary)	X
Oncology	X (Tertiary/Quaternary)	X
Transplant	X	
Clinical Areas		
Anesthesia	X	X
Diagnostic Radiology	X	X
Emergency Department	X	X
Laboratory/Pathology	X	X
Medicine	X	X **Geriatrics**
Psychiatry	Older Adolescents/Adult	Children's/ Younger Adolescents/Adult
Surgery	X	X
Women's	Low & High Risk Maternity	Low Risk Maternity/ Midwifery Program

FY 2014: (as of November 2013)

Beds:	YNHH Campus			SR Campus		
	General Care	***ICU***	***Total***	***General Care***	***ICU***	***Total***
Medicine	334	50	384	237	18	255
Surgery	211	53	264	112	31	143
Rehabilitation	0		0	18		18
Maternity	48		48	19		19
Pediatric*	88	17	105			
Pediatric Psych Only				20		20
Psych	73		73	25		25
Future Use				31		31
Total Beds	**754**	**120**	**874**	**462**	**49**	**511**
Bassinets	40	52	92	13	9	22

Note: Included in YNHH license is **another 22 pediatric beds and 20 bassinets** located at Bridgeport Hospital campus.

C. COST SAVINGS AND REVENUE ENHANCEMENT

Actual costs savings achieved in FY 2013 have been provided according to the categories outlined by OHCA and Report 175.

Cost Savings	Actual FY 2013	Updated Projected FY 2013
Salaries & Wages	$32.8M	$24.0M
Fringe Benefits	$9.7M	$6.7M
Contractual Labor Fees[1]	$0.5M	$1.0M
Medical Supplies & Pharmaceuticals	$6.3M	$8.1M
Malpractice	$0.5M	
Utilities	$0.9M	$1.3M
Business Expenses	$10.7M	$14.2M
Other Operating Expenses		
TOTAL	**$61.5M**	**$55.3M**

[1] *The projected 2013 cost savings figure for Contractual Labor Fees has been revised to reflect a shift of $2M from the Contractual Labor category to Business Expenses. This was done to coincide with OHCA's Report 175 categories.*

1. *Salaries and Wages / Fringe Benefits*

As anticipated the primary source of operating expense savings associated with the integration came from salaries, wages, and fringe benefits. The actual achieved saving in this category surpassed original estimates. This was due in large part to economies of scale identified in overhead departments, as well as a detailed review process that measured staffing levels against both industry and intercampus benchmarks.

The table below provides the breakdown of salary/wage and fringe benefit savings by major departments.

Department	Salary/Wage
Clinical Support	$4.5M
Finance/IT/Supply Chain	$5.2M
Non-Clinical Support	$3.7M
Nursing	$7.7M
Physician Practice/Office Staff	$4.9M
Administrative/Other	$6.8M
TOTAL	$32.8M

In the coming year, YNHH will continue to focus on staffing levels through the development and implementation of management tools that provide comparative staffing data and industry benchmarks.

2. *Contractual Labor Fees*

Please note that discussion of Contractual Labor and Legal Fees is now included under Business Expenses. This change was made in order to be consistent with OHCA Report 175.

Professional Services Agreements

The integration of physician services with Yale School of Medicine has yielded savings from contractual payments previously made for service coverage. For example, additional payments are no longer paid for Neurosurgery call coverage and Surgical ICU coverage. During FY 2013, YNHH will continue to identify opportunities where cross campus coverage will result in cost savings. In addition, during FY 2013 Saint Raphael's clinical departments were integrated within the Yale School of Medicine. It is expected that additional economies of scale and related cost savings will be identified as the clinical departments' integration matures.

3. *Malpractice Expense*

As part of the transition of all employed physicians from the HSR to New England Medical Group (NEMG), malpractice is now provided under YNHHS' malpractice plan. The rates provided by YNHHS' plan are less than those previously provided under the HSR captive.

4. *Utilities*

As part of the integration, YNHH has achieved lower electric rates. In addition to achieving lower rates, savings were also achieved through utilization management. In the coming year, the focus will be on realizing savings in telecommunications and other utilities.

5. *Medical/Surgical (Med/Surg) Supplies & Pharmaceuticals*

Several contracts for outside services have been renegotiated with lower rates. This is an ongoing effort and progress continues and will ultimately produce additional supply savings that will impact both New Haven campuses and the YNHHS overall.

System Contracting

In FY 2013, new contracts have been successfully negotiated in a number of areas including spine implants, blood products, exam gloves, and many others. As a result of these new contracts, YNHH has been able to reduce the cost of care significantly for the Saint Raphael campus. There were also cases where contracted rates for supplies that existed for HSR were extended to the rest of the health system lowering costs at YNHH, Greenwich, and Bridgeport Hospitals. YNHH is also reviewing opportunities for supply standardization to achieve cost savings.

Pharmaceuticals

Contractual pricing for specific high cost drugs that existed at YNHH prior to the merger was extended to the Saint Raphael's campus. This reduced pharmaceutical cost in many cases, but we did not achieve the projected savings anticipated in FY 2013 associated with the 340b program. A plan is in place for FY 2014 to further reduce pharmaceutical expense and achieve the 340b savings.

Additional information on high impact initiatives for this category:
Shared Supply Items: There are a large number of medical and non-medical supplies that were utilized by both hospitals prior to the transition. Dual contracts existed for each of these items. By reviewing pricing, YNHH was able to order items through the lower cost contract and generate large savings. As the individual contracts end, YNHH will consolidate items into a single contract.

Blood Products: HSR utilized a different blood supplier than YNHHS. During this past fiscal year, the YNHHS' contract expired and HSR's contract was extended to the entire YNHHS. Each hospital generated savings due to this renegotiation.

Heart & Vascular Implant: YNHH had lower pricing for a highly utilized cardiac implant used on the Saint Raphael campus. YNHH was able to standardize the utilization of this product during FY 2013 which reduced the expense per case for the involved patient population.

Spinal Implants: Spine surgeons worked closely with YNHH administrative personnel to identify preferred spinal implants and reduce the number of products purchased. By reducing the number of products, the contracting team was able to renegotiate the remaining contracts and generate savings.

Lupron: Saint Raphael's pricing for the drug Lupron was lower than YNHH. YNHH has been able to assume the Saint Raphael's pricing and the lower cost is now in place at both campuses.

6. *Business Expense*

Following the close of the transaction, business expense savings were quickly achieved. Savings included fees and memberships that existed on both campuses that could be consolidated. To date this has been one of the largest areas for savings. As YNHH continues to closely monitor business expense such as IT, it is anticipated that significant future savings will be achieved as this one of the largest expense categories (see the section "outside purchased services" J26 and J27 in Report 175). It should be noted that as a result of the assumed end dates of multiple contractual obligations, YNHH was only able to achieve partial year savings in FY 2013.

Contractual Management Services
During FY 2013, YNHH was able to terminate a number of management service contracts and insource the functions of Care Coordination, Pharmacy Management, and Environmental Services. Laboratory Medicine insourcing is expected to occur in the early fiscal year 2014.

Pharmacy: As a result of the integration of the ordering system and management structure for pharmaceutical services, YNHH was able to cancel its contract for outside managerial staff. The staff hired for these roles was the same staff that performed the function through the outside company and therefore facilitated the continuity of services.

The management fee and additional IT system cost associated with the outside contract were eliminated.

Care Coordination: Historically Saint Raphael's utilized an outside company to provide physician advisor resources to aid in determining appropriate admission criteria. Over the course of the past year, a team of physicians from both campuses was developed in order to provide this service internally. Outside care coordination had been gradually eliminated and now is no longer necessary because the internal team is fully operational.

Environmental Services: The Environmental Services Management contract was not renewed and the work associated with this contract was absorbed by current staff. Fees associated with onsite management staff and the service response center for both campuses have been eliminated.

Outside Legal Counsel
Integration of legal services into a single department was successfully completed. A significant portion of work previously done by outside legal counsel was able to be absorbed by in-house attorneys employed by YNHH. There are certain cases where outside legal assistance is and will be required; however YNHH has achieved savings from historical levels of outside legal fees.

Additional information on high impact initiatives for this category:
Audit and Bank Fee
As part of the corporate services integration corporate finance was able to generate savings associated with a consolidated single hospital audit process and the elimination of a large portion of the separate hospital banking fees.

Transcription Services
Two separate companies provided transcription services for each of the campuses of YNHH early in FY 2013. During this past year, one vendor was eliminated and the contract was renegotiated with the remaining vendor. This resulted in lower costs for the Saint Raphael campus.

Agency, Planning, and Membership Fees
As a result of the integration, YNHH was able to reduce the cost of fees associated with outside organizations that provide program certification, strategic planning management, and population/geographical analytics.

Food Service Integration
YNHH negotiated a contract in FY 2013 with the existing HSR food service management and supply vendor and eliminated the contract with YNHH's previous vendor. This resulted in overall savings to YNHH.

Microsoft Licensing Agreement
Previous YNHHS and HSR contracts for Microsoft licensing ended in FY 2013. As a result, YNHHS was able to execute a single licensing contract which provides better pricing for the Saint Raphael campus specifically and for the overall health system as well.

Tumor Registry Contract

An outside Tumor Registry contract held by Saint Raphael's was terminated. YNHH's internal Tumor Registry department absorbed the Saint Raphael campus functions and savings were achieved by eliminating the expenses paid to the outside company.

Revenue Enhancement

Over the past year Saint Raphael's has been incorporated into YNHH's existing Revenue Cycle Management (RCM) structure for the YNHHS. With this oversight, and the integration of fiscal departments, YNHH was able to execute some of the strategies identified in the Three Year Integration Plan. Specifically, areas of focus included denial reduction, combining the Clinical Documentation Management Program (CDMP) for both campuses into a single team, wage index and disproportionate share improvements due to the hospitals combining, and growth in point of service collections. These initiatives have been very successful and were critical in the first six (6) months of integration. While these processes continued to be improved, a major focus has been the implementation of the EPIC system and the benefits Epic has provided through Revenue Cycle Management. For example, an initial benefit of the implementation of EPIC was the conversion of billing forms and information into an electronic resource. The risk and potential waste associated with a paper billing process has been significantly reduced through these efforts. Some additional benefits of the EPIC implementation include:

1. Standardization of the Master Patient Index – This process reduced the duplicate patient identifiers between the campuses and resulted in both a clinical and financial benefit.

2. Shared Accounts Receivable: The system allowed YNHH to consolidate its inventory of accounts receivable into a single source managed by the Systems Business Office (SBO). Combined with the integration of the staff into one location this allowed for easier work flow associated with cash collections.

3. Bed Side Procedures and Recovery Room Documentation: Functionality has been added to bill for services previously performed but not captured prior to the implementation of EPIC.

4. Centralization of Service: EPIC's functionality has permitted the consolidation of some ancillary services that could not previously be easily combined due to IT constraints.

D. ONGOING REPORTING

The next semi-annual filing will be submitted by May 31, 2014 and will include the semi-annual reporting period of October 1 – March 31, 2014.

Attachment I

Three Year Integration Plan

Gantt Chart

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

Key Activities	PRE FY 2013	FY 2013	FY 2014	FY 2015
1. Major Strategic Initiatives				
1a. Physician & Midlevel Integration				
A1. Consolidate Hospital Based Services				
1. Anesthesiology				
2. Diagnostic Radiology				
3. Emergency Medicine				
4. Laboratory/Pathology				
A2. Integrated ACGME Residency and Fellowship Programs				
1b. EPIC Implementation				
A1. EPIC Go-Live at York Street Campus				
A2. EPIC Go-Live at Chapel Street Campus				
A3. Optimize Epic System			Ongoing	Ongoing
1c. Patient Experience				
A1. Implement Patient Experience Workplan and Supporting Infrastructure at SRC				
1. Patient and Family Advisor Program				
2. Reward and Recognition Structure				
3. Service Recovery Training/On-line Certificates				
A2. Implementation of the "Quiet Plan" Across Both Campuses				
1. Implement Leader Rounding				
2. Managers Train Staff				
A3. Launch Patient Experience Forum				
A4. FY 2014 Patient Experience Strategic Plan				
1. Emphasis on "Every Patient, Every Time"				
2. Physician and Nursing leadership training and engagement				
1d. Regulatory / Safety and Quality				
A1. Preparation for Department of Public Health and Joint Commission surveys				
1. Environmental of Care (EOC)			Ongoing	Ongoing
2. Life Safety			Ongoing	Ongoing
3. Provision of Care/Record of Care			Ongoing	Ongoing
4. Adherence to Licensure			Ongoing	Ongoing
5. Infection Prevention			Ongoing	Ongoing
A2. Consistent Regulatory Compliance and Practices				
1. Audit of Polices and Procedures to Ensure Adherence			Ongoing	Ongoing
A3. Ongoing Regulatory Education and Improvements				
1. Self-Review and Integrated Audits			Ongoing	Ongoing
2. Structure Implemented for Twice Monthly CMS/DPH Audits & Twice Yearly TJC Audits at SRC			Ongoing	Ongoing
A4. Clean and Safe Rounds			Ongoing	Ongoing
A5. Achieve HPI High Reliability Level 3				
1e. Transforming Patient Care				
A1. Implement Bedside Nursing Transformation at SRC to Ensure Consistent Staffing Models/Caregiver Hours Across Both Campuses			Ongoing	Ongoing
A2. Medication Barcoding Process Implemented				
A3. Implement Second Generation Bedside Nursing Transformation at the York Street Campus				
A4. Implement Magnet readiness plan				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
1f. Safe Patient Flow				
A1. Implement Common Safe Patient Flow Throughput Improvement				
A2. Identify Process Changes (Ongoing)			Ongoing	Ongoing
1g. Cultural Integration				
A1. Formation of Catholic Heritage Committee				
A2. Common Value System Defined				
A3. Auxiliaries of Two Campuses Integrated in Operations				
A4. Medical Staff "Healthier Together" Open Forums			Ongoing	Ongoing
A5. Employee Open Forums and Management Meetings			Ongoing	Ongoing
1h. Bed Management/Capacity				
A1. Common Bed Management System -Optimization of Beds Across Campuses				
A2. Open Verdi 4 North				
A3. Develop Strategies to Optimize Inpatient Bed Utilization Across Both Campuses			Ongoing	Ongoing
A4. Realignment of medicine and surgery beds				
1i. 24/7 Infrastructure				
A1. Common Administrator on Call and Off-Shift Executive Model Implemented				
A2. Off-shift Department Management				
1j. Care Management to Integrate Services Across the Continuum				
A1. Common Care Management Structure Implemented				
A2. Transitional Care Rounds in all York Street campus inpatient units				
A3. Transitional Care Rounds consistency across both campuses				
2. Service Lines				
2a. Children				
A1. Vision				
1. YNHCH is a destination of choice for pediatric care.			Ongoing	Ongoing
A2. Facilities & Capital				
1. Develop and Implement the Plan for NNICU Expansion and Fundraising				
A3. Integration Activities				
1. Integrate Pediatrics Services Across Both Campuses				
2. Align Child and Adolescent Psychiatry Across Campuses				
3. Combine Hospitalist Programs at YNHCH Campuses				
2b. Heart & Vascular				
A1. Vision				
1. Integrate Heart and Vascular Operations Across Both Campuses and Outpatient Centers				
A2. Facilities & Capital				
1. Renovate Catheterization Laboratories				
A3. Integration Activities				
1. Development of Vascular Access Center				
2. Development of Aortic Institute				
3. Expansion of the Interventional Radiology Program at SRC				
4. Consolidate cardiac surgery to York Street campus				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
5. Development of a Wound Center				
2c. Musculoskeletal				
A1. Vision				
1. Musculoskeletal Service Line Established and Recognized as leading program				
A2. Facilities & Capital				
1. Operational and Capital Plan in Place				
A3. Integration Activities				
1. Business plan definition and implementation				
2. Recruitment of physician leader				
3. Transition of elective joints and spine volume from York Street to Saint Raphael campus				
2d. Neurosciences				
A1. Vision				
Leading Neurosciences program in CT			Ongoing	Ongoing
A2. Facilities & Capital				
1. Allocated appropriate number of beds to Neurosciences				
A3. Integration Activities				
Telestroke at Saint Raphael Campus				
2e. Oncology				
A1. Vision				
1. Integrated Oncology Operations Across Both Campuses				
A3. Integration Activities				
Chemotherapy and radiation therapy on both campuses			Ongoing	Ongoing
2f. Transplant				
A1. Vision				
1. Provide leading solid organ transplantation services in CT (ongoing)			Ongoing	Ongoing
A3. Integration Activities				
2. Organ Donation Committee consolidation				
3. Clinical Areas				
3a. Diagnostic Radiology				
A1. Staffing/Coverage				
1. Enterprise-wide Scheduling (Consolidation of Scheduling/Registration Functions)				
A2. Facilities & Equipment				
1.CON for YNHH to acquire SRMRC Joint Venture				
2. Facilities Plan Completed				
A3. Integration Activities				
1. Assessment of all radiology services and equipment and implementation				
1. Professional readings available 24/7 at SRC				
3b. Emergency Department				
A1. Staffing/Coverage				
1. Realign ED Structure to Create an Integrated Model				
A3. Facilities & Equipment				
1. Review Emergency Transportation (Ambulance and Helicopter)				
2. Standardized Equipment (As Replacements Are Needed)				
A3. Integration Activities				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
1. Consolidation of Major Trauma at York Street				
2. Review Sponsor Hospital Program Offering, Infrastructure, Costs and Opportunities				
3c. Laboratory and Pathology				
A1. Integration Activities				
a. Evaluate consolidation of Laboratory Services System-Wide (Integrated Lab and Shared LIS)				
b. Install and Operate SOFTLaboratory IS system on Both Campuses				
3d. Medicine				
A1. Review Hospitalist Staffing Model and Admission Criteria to Hospitalist Service				
A2. Develop Business Case for eICU				
A3. Evaluate and implement Geriatrics Center of Excellence at the Saint Raphael campus				
3e. Nursing				
A1. Quality				
1. Implement Magnet Remediation Plans				
A2. Integration Activities				
1. Consistent Metrics and Standards and Creation of Unit/Service Line Dashboard				
2. Achieve Reduction in Caregiver Hours (see Transforming Patient Care)				
3f. Pharmacy				
A1. Staffing/Coverage				
1. Establish staffing with YNHH employees (eliminate Cardinal Health contract)				
A2. Facilities & Equipment				
1. Purchase and standardize Pyxis machines				
A3. Integration Activities				
1. Pharmacy Strategy Executed with Single Unified Product Formulary Cross Campuses				
3h. Psychiatry				
A1. Staffing/Coverage				
1. Develop a Standard Model of Care for Psychiatric Services at Both Campuses				
a. 12 Years Old and Under on Winchester One, YSC				
b. 13-15 Year Olds on Celaantano 5, SRC				
c. 16-17 Year Olds on LV2, YSC				
2. One Standard Model of Care with One Psych ED and BIT Team Implementation at SRC				
A2. Quality & Regulatory				
1. Participate in State Collaborative Regional Plan- Integrating Behav.Health Service Payment and Delivery				
A3. Integration Activities				
2. Conduct Crisis Intervention Unit Assessment & Develop/Implement an Improvement Plan (w/ED)				
3. Develop Strategies to Reduce Long LOS for Psychiatry Patients			Ongoing	Ongoing
3l. Surgical Services				
A1. Leadership				
1. Conduct an Assessment of Operating Room and Clinical Support Services				
2. Recruit physician leader to co-lead operating rooms				
3. Implement nursing clusters/specialty teams across all practice sites				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
A2. Consistent Operations				
1. Integrate OR Operations Across Both Campuses, Temple and Shoreline			Ongoing	
2. Optimize Utilization Across All Sites				Ongoing
3. GI Procedure Integration (YSC, SRC, and Temple)			Ongoing	Ongoing
4. Develop a Bariatric Center at the Saint Raphael Campus				
5. Develop Hernia Center at the Saint Raphael campus				
5. Establish Common Set of Metrics				
6. Implement operational recommendation from consulting engagement				
3m. Women				
A1. Integration Activities				
1. Integrate OB-GYN Services Across Both Campuses			Ongoing	
2. Expand OB Residency to Cover SRC				
3. Establish low risk delivery service at SR Campus utilizing midwifery program.				
3n. Ambulatory Services				
A1. Complete Ambulatory Strategic Plan				
1. Develop inventory of all ambulatory locations and services				
2. Develop and implement programmatic recommendations				
A1. Planning for new multidisciplinary satellites				
4. Non-Clinical Areas				
A1. Consolidation of Vendors for Environmental Svcs, Food/Nutrition, Linen and Protective Services				
5. Corporate Services				
5a. Accounting & Finance				
A1. Integrated Capital Budgeting Process Covering Both Campuses				
A2. Integrated Operating Budgeting Process Covering Both Campuses				
A3. Consolidation of Cost Accounting and Decision Support Systems				
A4. Combined Account Receivables for EPIC A/R with One Reserve Model				
A5. Maintain Individuals Accounts Receivable for Legacy SDK and Medipac Receivables				
A6. Replicate Financial Structure for Service Lines				
A7. Institute Flex Budgeting				
A8. Reduce Eliminate Fees Paid for Audit and Banking Operations at SRC				
A9. Review All Membership and Fees for Both Campuses and Remove/Renegotiate Duplicates				
5b. Compliance				
A1. Ensure All Staff Receive Compliance Education Annually (Ongoing Communications and In-services)			Ongoing	Ongoing
A2. Billing, Coding, and Documentation Audits of Both Hospital and Physician Activities				
A3. SRC Incorporated into YNHHS Conflict of Interest Process				
5c. Human Resources				
A1. Standardize Career Ladders				
A2. Standardize Performance Management System and Process				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of November 29, 2013

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
A3. Standardize Rewards, Recognition, and leveraging Performance Based Pay				
A5. Employee Engagement Survey			Ongoing	Ongoing
A6. Develop and Implement Saint Raphael Campus Manager Education Programs			Ongoing	Ongoing
5d. Information Technology and Information Systems				
A1. Consolidation of Approved Applications				
1. Reduce Application Portfolio for EPIC Implementation				
2. Application Consolidation for The Following Areas: Laboratory – Anatomic Pathology, Cardiology, Radiation Oncology & Neurosciences				
3. Application Consolidation for The Following Areas: Gastroenterology, Dietary Services, POS & Sleep Center				
A2. Service Desk Standardized				
A3. Consolidation of Telecom Operator Services				
A4. Review Service Contracts for Systems Used Prior to EPIC Integration				
5e. Legal & Planning				
A1. Identify vendor consolidation opportunities				
A2. Continue Integration Work with malpractice captive				
5f. Marketing, Communications, Image, and Community Wellness				
A1. Develop and Implement Community Revitalization Strategy			Ongoing	Ongoing
A2. Implement Communication Strategies for Managers and Employees			Ongoing	Ongoing
A3. Consolidate Advocacy Groups				
5g. Revenue Cycle				
A1. Transfers and Combined Accounts Seamless via EPIC				
A2. Identical CDMs and Charge Levels				
A3. Integrated Master Patient Indexes				
A4. Identical Billing Systems and Vendors to Support Revenue Cycle Functions				
A5. Revenue Cycle Functions Centralized Organizationally and Physically, Where Possible				
A6. Consistent Forms Throughout Entire Revenue Cycle				
A7. Revenue Cycle Opportunities Complete				
1. Pricing Strategies				
2. Denials				
3. Charge Capture				
5g. Reimbursement and Managed Care				
A1. Melded/Consistent Rates for All Payers Across Both Campuses				
5h. Supply Chain				
A1. Contract renegotiations				
A2. Inventory management				
A3. Service Response Center consolidation				

OHCA Reports

100, 150 and 175

	YALE-NEW HAVEN HOSPITAL				
	TWELVE MONTHS PRELIMINARY FILING				
	FISCAL YEAR 2013				
	REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2012 ACTUAL	FY 2013 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$64,557,000	$40,355,000	($24,202,000)	-37%
2	Short Term Investments	$613,360,000	$713,831,000	$100,471,000	16%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$202,909,000	$233,822,000	$30,913,000	15%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$28,060,000	$27,378,000	($682,000)	-2%
8	Prepaid Expenses	$19,334,000	$33,410,000	$14,076,000	73%
9	Other Current Assets	$70,999,000	$76,337,000	$5,338,000	8%
	Total Current Assets	**$999,219,000**	**$1,125,133,000**	**$125,914,000**	**13%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$12,127,000	$12,538,000	$411,000	3%
2	Board Designated for Capital Acquisition	$93,561,000	$69,450,000	($24,111,000)	-26%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$0	$0	$0	0%
	Total Noncurrent Assets Whose Use is Limited:	**$105,688,000**	**$81,988,000**	**($23,700,000)**	**-22%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$164,238,000	$208,342,000	$44,104,000	27%
7	Other Noncurrent Assets	$258,337,000	$296,238,000	$37,901,000	15%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$1,528,134,000	$1,596,042,000	$67,908,000	4%
2	Less: Accumulated Depreciation	$601,670,000	$677,907,000	$76,237,000	13%
	Property, Plant and Equipment, Net	**$926,464,000**	**$918,135,000**	**($8,329,000)**	**-1%**
3	Construction in Progress	$63,603,000	$22,942,000	($40,661,000)	-64%
	Total Net Fixed Assets	**$990,067,000**	**$941,077,000**	**($48,990,000)**	**-5%**
	Total Assets	**$2,517,549,000**	**$2,652,778,000**	**$135,229,000**	**5%**

	YALE-NEW HAVEN HOSPITAL				
	TWELVE MONTHS PRELIMINARY FILING				
	FISCAL YEAR 2013				
	REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2012 ACTUAL	FY 2013 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$213,511,000	$233,668,000	$20,157,000	9%
2	Salaries, Wages and Payroll Taxes	$89,048,000	$85,452,000	($3,596,000)	-4%
3	Due To Third Party Payers	$0	$0	$0	0%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$116,229,000	$33,767,000	($82,462,000)	-71%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$2,926,000	$14,079,000	$11,153,000	381%
	Total Current Liabilities	**$421,714,000**	**$366,966,000**	**($54,748,000)**	**-13%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$410,888,000	$675,937,000	$265,049,000	65%
2	Notes Payable (Net of Current Portion)	$316,318,000	$52,237,000	($264,081,000)	-83%
	Total Long Term Debt	**$727,206,000**	**$728,174,000**	**$968,000**	**0%**
3	Accrued Pension Liability	$280,718,000	$199,034,000	($81,684,000)	-29%
4	Other Long Term Liabilities	$339,133,000	$345,053,000	$5,920,000	2%
	Total Long Term Liabilities	**$1,347,057,000**	**$1,272,261,000**	**($74,796,000)**	**-6%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$676,008,000	$926,614,000	$250,606,000	37%
2	Temporarily Restricted Net Assets	$46,026,000	$59,782,000	$13,756,000	30%
3	Permanently Restricted Net Assets	$26,744,000	$27,155,000	$411,000	2%
	Total Net Assets	**$748,778,000**	**$1,013,551,000**	**$264,773,000**	**35%**
	Total Liabilities and Net Assets	**$2,517,549,000**	**$2,652,778,000**	**$135,229,000**	**5%**

	YALE-NEW HAVEN HOSPITAL				
	TWELVE MONTHS PRELIMINARY FILING				
	FISCAL YEAR 2013				
	REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2012 ACTUAL	FY 2013 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$5,740,304,000	$8,243,053,000	$2,502,749,000	44%
2	Less: Allowances	$3,948,050,000	$5,808,321,000	$1,860,271,000	47%
3	Less: Charity Care	$78,983,000	$87,167,000	$8,184,000	10%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$1,713,271,000**	**$2,347,565,000**	**$634,294,000**	**37%**
5	Other Operating Revenue	$31,029,000	$45,544,000	$14,515,000	47%
6	Net Assets Released from Restrictions	$16,655,000	$13,089,000	($3,566,000)	-21%
	Total Operating Revenue	**$1,760,955,000**	**$2,406,198,000**	**$645,243,000**	**37%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$585,247,000	$790,319,000	$205,072,000	35%
2	Fringe Benefits	$172,016,000	$235,370,000	$63,354,000	37%
3	Physicians Fees	$73,815,000	$80,364,000	$6,549,000	9%
4	Supplies and Drugs	$275,375,000	$377,459,000	$102,084,000	37%
5	Depreciation and Amortization	$73,101,000	$107,957,000	$34,856,000	48%
6	Bad Debts	$32,622,000	$64,649,000	$32,027,000	98%
7	Interest	$17,720,000	$23,920,000	$6,200,000	35%
8	Malpractice	$13,056,000	$13,713,000	$657,000	5%
9	Other Operating Expenses	$411,492,000	$607,571,000	$196,079,000	48%
	Total Operating Expenses	**$1,654,444,000**	**$2,301,322,000**	**$646,878,000**	**39%**
	Income/(Loss) From Operations	**$106,511,000**	**$104,876,000**	**($1,635,000)**	**-2%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$5,959,000	$7,300,000	$1,341,000	23%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	($29,793,000)	$16,263,000	$46,056,000	-155%
	Total Non-Operating Revenue	**($23,834,000)**	**$23,563,000**	**$47,397,000**	**-199%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$82,677,000**	**$128,439,000**	**$45,762,000**	**55%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$47,932,000	$47,059,000	($873,000)	-2%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$47,932,000**	**$47,059,000**	**($873,000)**	**-2%**
	Excess/(Deficiency) of Revenue Over Expenses	**$130,609,000**	**$175,498,000**	**$44,889,000**	**34%**
	Principal Payments	$10,185,000	$222,640,000	$212,455,000	2086%

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2013
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2012 ACTUAL	FY 2013 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
I.	OPERATING EXPENSE BY CATEGORY				
A.	Salaries & Wages:				
1	Nursing Salaries	$247,331,000	$332,110,000	$84,779,000	34%
2	Physician Salaries	$58,393,000	$72,059,000	$13,666,000	23%
3	Non-Nursing, Non-Physician Salaries	$279,523,000	$386,150,000	$106,627,000	38%
	Total Salaries & Wages	**$585,247,000**	**$790,319,000**	**$205,072,000**	**35%**
B.	Fringe Benefits:				
1	Nursing Fringe Benefits	$72,696,000	$98,908,000	$26,212,000	36%
2	Physician Fringe Benefits	$17,163,000	$21,460,000	$4,297,000	25%
3	Non-Nursing, Non-Physician Fringe Benefits	$82,157,000	$115,002,000	$32,845,000	40%
	Total Fringe Benefits	**$172,016,000**	**$235,370,000**	**$63,354,000**	**37%**
C.	Contractual Labor Fees:				
1	Nursing Fees	$2,295,000	$5,073,000	$2,778,000	121%
2	Physician Fees	$73,815,000	$80,364,000	$6,549,000	9%
3	Non-Nursing, Non-Physician Fees	$21,579,000	$37,083,000	$15,504,000	72%
	Total Contractual Labor Fees	**$97,689,000**	**$122,520,000**	**$24,831,000**	**25%**
D.	Medical Supplies and Pharmaceutical Cost:				
1	Medical Supplies	$162,187,000	$223,966,000	$61,779,000	38%
2	Pharmaceutical Costs	$113,188,000	$153,493,000	$40,305,000	36%
	Total Medical Supplies and Pharmaceutical Cost	**$275,375,000**	**$377,459,000**	**$102,084,000**	**37%**
E.	Depreciation and Amortization:				
1	Depreciation-Building	$28,290,000	$41,779,000	$13,489,000	48%
2	Depreciation-Equipment	$44,811,000	$66,178,000	$21,367,000	48%
3	Amortization	$0	$0	$0	0%
	Total Depreciation and Amortization	**$73,101,000**	**$107,957,000**	**$34,856,000**	**48%**
F.	Bad Debts:				
1	Bad Debts	$32,622,000	$64,649,000	$32,027,000	98%
G.	Interest Expense:				
1	Interest Expense	$17,720,000	$23,920,000	$6,200,000	35%
H.	Malpractice Insurance Cost:				
1	Malpractice Insurance Cost	$13,056,000	$13,789,000	$733,000	6%
I.	Utilities:				
1	Water	$1,078,000	$1,399,000	$321,000	30%
2	Natural Gas	$688,000	$1,685,000	$997,000	145%
3	Oil	$0	$0	$0	0%
4	Electricity	$15,830,000	$20,047,000	$4,217,000	27%
5	Telephone	$3,724,000	$4,681,000	$957,000	26%
6	Other Utilities	$1,015,000	$1,036,000	$21,000	2%
	Total Utilities	**$22,335,000**	**$28,848,000**	**$6,513,000**	**29%**
			$56,297,000		
J.	Business Expenses:				
1	Accounting Fees	$732,000	$1,358,000	$626,000	86%
2	Legal Fees	$2,639,000	$3,921,000	$1,282,000	49%
3	Consulting Fees	$397,000	$1,153,000	$756,000	190%
4	Dues and Membership	$1,356,000	$1,780,000	$424,000	31%
5	Equipment Leases	$3,417,000	$7,064,000	$3,647,000	107%
6	Building Leases	$10,952,000	$15,216,000	$4,264,000	39%
7	Repairs and Maintenance	$24,398,000	$31,831,000	$7,433,000	30%
8	Insurance	$2,272,000	$2,453,000	$181,000	8%
9	Travel	$26,000	$14,000	($12,000)	-46%
10	Conferences	$2,246,000	$3,329,000	$1,083,000	48%
11	Property Tax	$4,087,000	$4,474,000	$387,000	9%
12	General Supplies	$18,297,000	$16,658,000	($1,639,000)	-9%
13	Licenses and Subscriptions	$1,361,000	$1,798,000	$437,000	32%
14	Postage and Shipping	$671,000	$989,000	$318,000	47%
15	Advertising	$840,000	$87,000	($753,000)	-90%
16	Corporate parent/system fees	$20,398,000	$24,417,000	$4,019,000	20%
17	Computer Software	$251,000	$0	($251,000)	-100%
18	Computer hardware & small equipment	$20,000	$5,000	($15,000)	-75%
19	Dietary / Food Services	$2,777,000	$3,106,000	$329,000	12%
20	Lab Fees / Red Cross charges	$13,318,000	$16,189,000	$2,871,000	22%
21	Billing & Collection / Bank Fees	$639,000	$640,000	$1,000	0%
22	Recruiting / Employee Education & Recognition	$847,000	$664,000	($183,000)	-22%
23	Laundry / Linen	$4,325,000	$6,160,000	$1,835,000	42%
24	Professional / Physician Fees	$4,931,000	$5,626,000	$695,000	14%
25	Waste disposal	$969,000	$1,328,000	$359,000	37%
26	Purchased Services - Medical	$100,383,000	$121,768,000	$21,385,000	21%
27	Purchased Services - Non Medical	$107,027,000	$140,085,000	$33,058,000	31%
28	Other Business Expenses	$35,707,000	$59,729,000	$24,022,000	67%
	Total Business Expenses	**$365,283,000**	**$471,842,000**	**$106,559,000**	**29%**
K.	Other Operating Expense:				
1	Miscellaneous Other Operating Expenses	$0	$0	$0	0%
	Total Operating Expenses - All Expense Categories*	**$1,654,444,000**	**$2,236,673,000**	**$582,229,000**	**35%**
	*A.- K. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.				

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2013
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2012 ACTUAL	FY 2013 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
II.	OPERATING EXPENSE BY DEPARTMENT				
A.	General Services:				
1	General Administration	$51,268,562	62,721,269.66	$11,452,708	22%
2	General Accounting	$5,151,743	$5,395,950	$244,207	5%
3	Patient Billing & Collection	$18,650,594	$28,954,137	$10,303,543	55%
4	Admitting / Registration Office	$11,594,092	$15,328,578	$3,734,486	32%
5	Data Processing	$0	$0	$0	0%
6	Communications	$580,919	$5,615,681	$5,034,762	867%
7	Personnel	$4,062,882	3,940,429.97	($122,452)	-3%
8	Public Relations	$837,669	1,215,732.62	$378,064	45%
9	Purchasing	$1,843,983	3,578,303.09	$1,734,320	94%
10	Dietary and Cafeteria	$20,677,752	27,199,717.47	$6,521,965	32%
11	Housekeeping	$19,811,437	26,988,619.63	$7,177,183	36%
12	Laundry & Linen	$88,978	630,337.71	$541,360	608%
13	Operation of Plant	$18,410,937	32,606,161.19	$14,195,224	77%
14	Security	$7,348,400	10,285,731.01	$2,937,331	40%
15	Repairs and Maintenance	$13,982,256	23,216,911.95	$9,234,656	66%
16	Central Sterile Supply	$6,747,221	11,388,394.86	$4,641,174	69%
17	Pharmacy Department	$38,541,220	57,067,003.14	$18,525,783	48%
18	Other General Services	$451,252,538	487,629,322.35	$36,376,784	8%
	Total General Services	**$670,851,183**	**$803,762,281**	**$132,911,098**	**20%**
B.	Professional Services:				
1	Medical Care Administration	$30,459,343	52,151,124.96	$21,691,782	71%
2	Residency Program	$52,405,647	66,068,751.70	$13,663,105	26%
3	Nursing Services Administration	$13,490,986	18,299,375.26	$4,808,389	36%
4	Medical Records	$7,726,626	13,082,778.24	$5,356,152	69%
5	Social Service	$3,101,521	7,682,074.66	$4,580,554	148%
6	Other Professional Services	$0	$0	$0	0%
	Total Professional Services	**$107,184,123**	**$157,284,105**	**$50,099,982**	**47%**
C.	Special Services:				
1	Operating Room	$91,598,288	141,694,450.59	$50,096,163	55%
2	Recovery Room	$7,366,108	11,467,124.50	$4,101,017	56%
3	Anesthesiology	$21,132,075	20,001,438.28	($1,130,637)	-5%
4	Delivery Room	$10,322,141	12,467,328.88	$2,145,188	21%
5	Diagnostic Radiology	$31,566,753	36,698,323.65	$5,131,571	16%
6	Diagnostic Ultrasound	$4,744,733	6,467,464.40	$1,722,731	36%
7	Radiation Therapy	$11,595,265	18,576,882.72	$6,981,618	60%
8	Radioisotopes	$34,014,959	36,625,486.20	$2,610,527	8%
9	CT Scan	$4,640,187	5,699,028.59	$1,058,842	23%
10	Laboratory	$53,834,259	70,002,945.23	$16,168,686	30%
11	Blood Storing/Processing	$18,109,695	22,315,749.31	$4,206,054	23%
12	Cardiology	$0	$0	$0	0%
13	Electrocardiology	$13,797,493	19,416,864.22	$5,619,371	41%
14	Electroencephalography	$3,686,072	4,821,469.78	$1,135,398	31%
15	Occupational Therapy	$0	$0	$0	0%
16	Speech Pathology	$0	$0	$0	0%
17	Audiology	$0	$0	$0	0%
18	Respiratory Therapy	$13,614,078	15,635,790.09	$2,021,712	15%
19	Pulmonary Function	$0	3,896,608.14	$3,896,608	0%
20	Intravenous Therapy	$0	1,123,888.57	$1,123,689	0%
21	Shock Therapy	$0	$0	$0	0%
22	Psychiatry / Psychology Services	$3,417,954	6,301,283.44	$2,883,329	84%
23	Renal Dialysis	$3,232,129	3,895,167.81	$663,039	21%
24	Emergency Room	$49,029,560	67,237,087.40	$18,207,527	37%
25	MRI	$5,712,086	7,876,964.81	$2,164,879	38%
26	PET Scan	$0	$0	$0	0%
27	PET/CT Scan	$0	$0	$0	0%
28	Endoscopy	$2,453,083	2,775,833.80	$322,751	13%
29	Sleep Center	$0	$0	$0	0%
30	Lithotripsy	$67,808	(12,391.90)	($80,198)	-118%
31	Cardiac Catheterization/Rehabilitation	$3,922,227	5,105,156.41	$1,182,929	30%
32	Occupational Therapy / Physical Therapy	$5,581,844	8,863,643.53	$3,281,800	59%
33	Dental Clinic	$3,508,068	4,225,638.94	$717,571	20%
34	Other Special Services	$4,050,343	4,721,121.64	$670,779	17%
	Total Special Services	**$406,997,206**	**$537,900,149**	**$136,902,943**	**34%**
D.	Routine Services:				
1	Medical & Surgical Units	$153,542,875	220,229,179.55	$66,686,305	43%
2	Intensive Care Unit	$48,035,778	57,763,762.75	$9,727,985	20%
3	Coronary Care Unit	$5,541,502	10,858,604.20	$5,317,102	96%
4	Psychiatric Unit	$16,991,691	22,959,847.58	$5,968,157	35%
5	Pediatric Unit	$11,606,257	16,076,947.19	$4,470,690	39%
6	Maternity Unit	$5,343,379	$9,400,069	$3,056,690	48%
7	Newborn Nursery Unit	$3,843,514	$5,695,594	$1,852,080	48%
8	Neonatal ICU	$18,373,850	19,502,682.96	$1,128,833	6%
9	Rehabilitation Unit	$0	$0	$0	0%
10	Ambulatory Surgery	$11,990,705	10,253,988.98	($1,736,716)	-14%
11	Home Care	$0	$0	$0	0%
12	Outpatient Clinics	$143,497,726	199,679,008.77	$56,181,283	39%
13	Other Routine Services	$0	$0	$0	0%
	Total Routine Services	**$419,767,277**	**$572,419,685**	**$152,652,408**	**36%**
E.	Other Departments:				
1	Miscellaneous Other Departments	$55,644,211	$165,306,780	$109,662,569	197%
	Total Operating Expenses - All Departments*	**$1,654,444,000**	**$2,236,673,000**	**$582,229,000**	**35%**
	***A.- 0. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.**				

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

January 15, 2014

Ms. Nancy Rosenthal
Senior Vice President of Health Systems Development
Department of Planning & Business Development
Yale New Haven Health System
2 Howe Street
New Haven, CT 06510

RE: Compliance with Agreed-Upon Stipulations set forth in Docket Number: 12-31747-CON, as subsequently modified under Docket Number 12-31747-MDF
The Proposal of Yale-New Haven Hospital to Acquire the Hospital of Saint Raphael Healthcare System, Inc. including The Hospital Saint Raphael, Inc.

Dear Ms. Rosenthal:

On June 27, 2012, Yale-New Haven Hospital, the Hospital of Saint Raphael Healthcare System, Inc. including The Hospital of Saint Raphael, Inc., collectively hereinafter referred to as the "Applicants", entered into an Agreed Settlement with the Department of Public Health, Office of Health Care Access ("OHCA") under Docket Number ("DN"): 12-31747-CON, for Yale-New Haven Hospital to acquire the Hospital of Saint Raphael Healthcare System, Inc., including The Hospital of Saint Raphael, Inc. Subsequently on October 9, 2012, under DN: 12-31747-MDF, OHCA modified Stipulation 3 of the Order under DN: 12-31747-CON. A copy of the agreed-upon Stipulations under DN: 12-31747-CON is enclosed as Attachment 1 of this letter, while a copy of Stipulation 3 under DN: 12-31747-MDF is enclosed as Attachment 2 of this letter, each attachment for reference proposes.

On December 2, 2013, OHCA received the following information from Yale-New Haven Hospital ("YNHH"):

a. A report addressing the progress made to date against the implementation of the three-year integration plan;
b. Summary of beds and services by campus;
c. Cost savings and revenue enhancement; and
d. Ongoing reporting.

OHCA has reviewed the information contained in YNHH's December 2, 2013 submission and requires the Hospital to address the following questions.

1. With respect to Stipulation 3, which reads in part: "YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years."

   The first set of Reports 100, 150, 175 have not been provided on the required semi-annual basis, as was agreed-upon. These reports submitted on December 2, 2013 and all future reports are required to be filed in 6 month increments. Please provide Reports 100, 150 and 175 for the first two six month periods of the project as follows:
   a. The first set from October 1, 2012 to March 31, 2013; and
   b. The second set from April 1, 2013 to September 30, 2013.

2. With respect to Stipulation 3(b), which requires YNHH to report cost saving totals of the merger for the major Operating Expense Categories contained in Hospital Reporting System's ("HRS") Report 175. The table entitled "Cost Savings" on narrative page 11 of the submission provides "Actual Cost Savings achieved in FY 2013" which have "been provided according to the categories outlined by OHCA and HRS Report 175." The table on page 11 does not include operating expenses for the following categories:
   a. Depreciation and Amortization;
   b. Bad Debts; and
   c. Interest Expense.

   Please explain the omission of these categories from this Cost Savings table.

Kindly respond to this letter by the close of business on Friday, January 31, 2014. If you have any questions regarding the above, please feel to contact me at (860) 418-7069.

Sincerely,

Jack A. Huber

Jack A. Huber
Health Care Analyst

Attachment 1

ORDER

NOW, THEREFORE, the Department of Public Health, Office of Health Care Access, and Yale-New Haven Hospital ("YNHH"), the Saint Raphael Healthcare System ("SRHS") and Hospital of Saint Raphael, Inc. ("HSR") hereby stipulate and agree to the terms of settlement with respect to the acquisition of certain assets of SRHS, including HSR, as follows:

1. Within five (5) calendar days of the closing of YNHH's acquisition of certain assets of SRHS, including HSR, YNHH agrees to report to the Office of Health Care Access ("OHCA") the date of such and, upon surrender of HSR's acute care hospital license to the Department of Public Health, YNHH shall be authorized to increase its licensed bed capacity from the present 916 licensed hospital beds and 92 bassinets to 1,427 licensed hospital beds and 114 bassinets.

2. The Applicants agree that within sixty (60) calendar days of the closing date, YNHH shall provide OHCA with an unredacted copy of the Asset Purchase Agreement that was provided as Attachment III to the CON Application (Ex. A). The unredacted copy will be entered as part of the permanent record in this proceeding.

3. YNHH agrees to submit to OHCA, no later than January 31, 2013, a detailed and comprehensive document showing the three-year plan ("the plan") to integrate the operations of both hospitals and attain the cost savings stated within the CON Application. At a minimum, the submission shall address the planned location of services and beds, anticipated cost savings, staffing and quality improvements, and merger-related revenue enhancements. Subsequent to the submission of the plan, YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the 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. Due dates are May 31, 2013, November 30, 2013, May 31, 2014, November 30, 2014, May 31, 2015, and November 30, 2015. YNHH shall submit the following on a semi-annual basis:

    a. YNHH agrees to file narrative updates on the progress of the implementation of the plan. This would include integration of all affected clinical services including primary care initiatives in the community.

    b. YNHH agrees to report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, 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,F,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. YNHH will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. YNHH agrees to file a completed Balance Sheet and Statement of Operations for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. YNHH agrees to file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

4. Applicants agree to comply with all state and federal statutes and regulations applicable to all licenses and certificates issued by the Department of Public Health.

5. DPH and YNHH, SRHS, and HSR agree that this Agreed Settlement represents a final agreement between OHCA and YNHH, SRHS, and HSR with respect to this request. The signing of this Agreed Settlement resolves all objections, claims, and disputes, which may have been raised by the Applicants with regard to Docket Number 12-31747-CON.

6. This Agreed Settlement is an order of the Department of Public Health Office of Health Care Access with all the rights and obligations attendant thereto, and the Department of Public Health may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-642 and 19a-653 of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

Attachment 2

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

October 9, 2012

Gayle Capozzalo
Chief Exectuvie Officer
Yale-New Haven Hospital
20 York Street
New Haven, CT 06510-3220

Re: Docket Number 12-31747-MDF: A Request to Modify Docket Number 12-31747-CON
Yale-New Haven Hospital
Requet to Modify Condition 3 of the Order under Docket No.: 12-31747-CON

Dear Ms. Capozzalo:

On August 8, 2012, the Office of Health Care Access ("OHCA") received a request from Yale-New Haven Hospital ("Applicant") to modify the Certificate of Need ("CON") issued under Docket No.: 12-31747-CON, which authorized the Applicant to acquire the Saint Raphael Healthcare System, Inc. The Applicant requested a modification of Condition 3 of the Order under the Agreed Settlement due to the postponement of the final Closing Date in this matter.

In accordance with Connecticut General Statutes § 4-181a(b), OHCA hereby modifies Conditon 3 of the Order under Docket No.: 12-31747-CON as follows:

3. YNHH agrees to submit to OHCA, no later than March 31, 2013, a detailed and comprehensive document showing the three-year plan ("the plan") to integrate the operations of both hospitals and attain the cost savings stated within the CON Application. At a minimum, the submission shall address the planned location of services and beds, anticipated cost savings, staffing and quality improvements, and merger-related revenue enhancements. Subsequent to the submission of the plan, YNHH shall file additional information, as set forth below, on a semi-annual basis, for a period of three (3) years. For purposes of the 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. Due dates are November 30, 2013, May 31, 2014, November 30, 2014, May 31, 2015, November 30, 2015, and May 31, 2016. YNHH shall submit the following on a semi-annual basis:

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 34038
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

a. YNHH agrees to file narrative updates on the progress of the implementation of the plan. This would include integration of all affected clinical services including primary care initiatives in the community.

b. YNHH agrees to report cost saving totals of the merger for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, 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,F,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. YNHH will also file a narrative describing the specifics of the cost savings for each of these major expense categories.

c. YNHH agrees to file a completed Balance Sheet and Statement of Operations for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

d. YNHH agrees to file a completed Hospital Operating Expenses by Expense Category and Department for the consolidated Yale New Haven Hospital. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

If you have any questions regarding this action, please contact Steven W. Lazarus, Associate Health Care Analyst at (860) 418-7012.

Sincerely,

Lisa A Davis

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	3928
RECIPIENT ADDRESS	912038634736
DESTINATION ID	
ST. TIME	01/15 16:18
TIME USE	01'07
PAGES SENT	7
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: NANCY ROSENTHAL

FAX: (203) 863-4736

AGENCY: YALE NEW HAVEN HEALTH SYSTEM

FROM: JACK HUBER

DATE: 1/15/2014 Time: ~3:10 pm

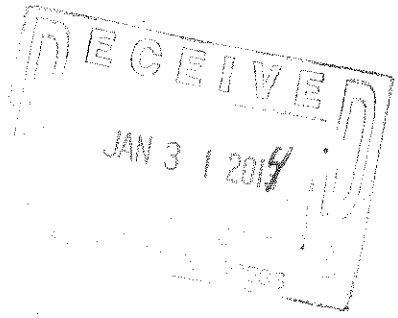
NUMBER OF PAGES: 6
(including transmittal sheet)

Transmitted: OHCA's letter responding to YNHH's narrative update addressing Compliance Reporting for the YNHH's Acquisition of the St. Raphael Healthcare System & The Hospital of St. Raphael

Docket Number 12-31747-CON, as subsequently modified under Docket Number 12-31747-MDF

YALE-NEW HAVEN HOSPITAL

January 31, 2014



Jack A. Huber
Health Care Analyst
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Compliance with agreed-upon stipulations set forth in Docket Number: 12-31747-CON as subsequently modified under Docket Number: 12-31747-MDF: The Proposal of Yale-New Haven Hospital to Acquire the Saint Raphael Healthcare System, Inc., including the Hospital of Saint Raphael

Dear Mr. Huber:

Please find attached responses to the questions posed by the Office of Health Care Access (OHCA) on January 15, 2014.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Nancy Rosenthal
Senior Vice President of Health System Development

Enclosures

20 York Street
New Haven, CT 06504

Yale-New Haven Hospital (YNHH)
Docket Number: 12-31747-CON as subsequently modified under
Docket Number: 12-31747-MDF
Responses to OHCA Questions

1. With respect to Stipulation 3 which reads in part: "YNHH shall file additional information, as set forth below on a semi-annual basis, for a period of three (3) years".

   The first set of Reports 100, 150, and 175 have not been provided on the required semi-annual basis, as was agreed-upon. These reports submitted on December 2, 2013 and all future reports are required to be filed in 6 month increments. Please provide Reports 100, 150 and 175 for the first two six month periods of the project as follows:

   a. The first set from October 1, 2012 to March 31, 2013; and
   b. The second from April 1, 2013 to September 30, 2013.

   Response

   Attachment I includes Reports 100, 150, and 175 in six month increments as requested above.

2. With respect to Stipulation 3(b), which requires YNHH to report cost saving totals of the merger for the major Operating Expense Categories contained in Hospital Report System's ("HRS") Report 175. The table entitled "Cost Savings" on narrative page 11 of the submission provides "Actual Cost Savings achieved in FY 2013" which have "been provided according to the categories outline by OHCA and HRS Report 175." The table on page 11 does not include operating expenses for the following categories:
   a. Depreciation and Amortization;
   b. Bad Debts; and
   c. Interest Expense.

   Please explain the omission of these categories from this Cost Savings table.

   Response

   The operating expense categories listed above were omitted in the Cost Savings table for the following reasons:

   a. Depreciation & Amortization: The integration plan for the Hospital of Saint Raphael included a significant capital investment as detailed

in the Certificate of Need Application. These investments were identified to both repair and improve the physical plant on the Saint Raphael Campus. Due to these capital improvements there were no savings realized for this category, and therefore it was omitted from the cost savings identified in the November 30, 3013 report.

b. Bad Debt: Yale-New Haven Hospital has historically provided a robust support program for uninsured patients. Following the acquisition and integration, a single Bad Debt and Free Care Policy was instituted across both campuses. As a result of the integration, both campuses operate on the same billing platform and YNHH no longer reports bad debt by campus. Therefore it was omitted from the cost savings identified in the November 30, 3013 report.

c. Interest Expense: In order to execute the Asset Purchase Agreement for the Hospital of Saint Raphael, YNHH secured financing in the amount of $160 million dollars. This action resulted in an increase to total interest expenses and therefore it was omitted from the cost savings identified in the November 30, 3013 report.

ATTACHMENT I

Reports 100, 150 & 175
6-Month Increments
2013

YALE-NEW HAVEN HOSPITAL
SIX MONTH INCREMENTS
FY 2013
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		3/31/13	9/30/13	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$34,952,000	$40,355,000	$5,403,000	15%
2	Short Term Investments	$614,251,000	$709,453,000	$95,202,000	15%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$272,835,000	$233,822,000	($39,013,000)	-14%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$28,963,000	$27,341,000	($1,622,000)	-6%
8	Prepaid Expenses	$14,256,000	$33,445,000	$19,189,000	135%
9	Other Current Assets	$58,328,000	$76,339,000	$18,011,000	31%
	Total Current Assets	**$1,023,585,000**	**$1,120,755,000**	**$97,170,000**	**9%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$12,481,000	$12,538,000	$57,000	0%
2	Board Designated for Capital Acquisition	$3,000	$71,557,000	$71,554,000	2385133%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$66,546,000	$0	($66,546,000)	-100%
	Total Noncurrent Assets Whose Use is Limited:	**$79,030,000**	**$84,095,000**	**$5,065,000**	**6%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$161,239,000	$214,382,000	$53,143,000	33%
7	Other Noncurrent Assets	$326,234,000	$297,238,000	($28,996,000)	-9%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$1,548,091,000	$1,596,042,000	$47,951,000	3%
2	Less: Accumulated Depreciation	$637,179,000	$677,907,000	$40,728,000	6%
	Property, Plant and Equipment, Net	**$910,912,000**	**$918,135,000**	**$7,223,000**	**1%**
3	Construction in Progress	$26,325,000	$22,942,000	($3,383,000)	-13%
	Total Net Fixed Assets	**$937,237,000**	**$941,077,000**	**$3,840,000**	**0%**
	Total Assets	**$2,527,325,000**	**$2,657,547,000**	**$130,222,000**	**5%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$254,748,000	$233,668,000	($21,080,000)	-8%
2	Salaries, Wages and Payroll Taxes	$73,643,000	$85,452,000	$11,809,000	16%
3	Due To Third Party Payers	$0	$0	$0	0%
4	Due To Affiliates	$0	$0	$0	0%

	YALE-NEW HAVEN HOSPITAL				
	SIX MONTH INCREMENTS				
	FY 2013				
	REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION				
					Page 5
5	Current Portion of Long Term Debt	$10,640,000	$12,625,000	$1,985,000	19%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$23,540,000	$36,221,000	$12,681,000	54%
	Total Current Liabilities	**$362,571,000**	**$367,966,000**	**$5,395,000**	**1%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$689,114,000	$675,937,000	($13,177,000)	-2%
2	Notes Payable (Net of Current Portion)	$51,471,000	$52,237,000	$766,000	1%
	Total Long Term Debt	**$740,585,000**	**$728,174,000**	**($12,411,000)**	**-2%**
3	Accrued Pension Liability	$289,270,000	$197,950,000	($91,320,000)	-32%
4	Other Long Term Liabilities	$314,004,000	$345,332,000	$31,328,000	10%
	Total Long Term Liabilities	**$1,343,859,000**	**$1,271,456,000**	**($72,403,000)**	**-5%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$738,967,000	$930,988,000	$192,021,000	26%
2	Temporarily Restricted Net Assets	$54,830,000	$59,982,000	$5,152,000	9%
3	Permanently Restricted Net Assets	$27,098,000	$27,155,000	$57,000	0%
	Total Net Assets	**$820,895,000**	**$1,018,125,000**	**$197,230,000**	**24%**
	Total Liabilities and Net Assets	**$2,527,325,000**	**$2,657,547,000**	**$130,222,000**	**5%**
	Note: Balance Sheet is a point in time so				
	used file previously submitted to OHCA				
	for September				

	YALE-NEW HAVEN HOSPITAL				
	SIX MONTH INCREMENTS				
	FY 2013				
	REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
		10/1/12-3/31/13	4/1/13-9/30/13	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$3,924,565,000	$4,318,488,000	$393,923,000	10%
2	Less: Allowances	$2,734,215,000	$3,074,106,000	$339,891,000	12%
3	Less: Charity Care	$41,391,000	$45,776,000	$4,385,000	11%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$1,148,959,000**	**$1,198,606,000**	**$49,647,000**	**4%**
5	Other Operating Revenue	$20,171,000	$25,363,000	$5,192,000	26%
6	Net Assets Released from Restrictions	$6,417,000	$6,682,000	$265,000	4%
	Total Operating Revenue*	**$1,175,547,000**	**$1,230,651,000**	**$55,104,000**	**5%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$391,752,000	$398,567,000	$6,815,000	2%
2	Fringe Benefits	$120,028,000	$115,342,000	($4,686,000)	-4%
3	Physicians Fees	$39,940,000	$41,264,000	$1,324,000	3%
4	Supplies and Drugs	$184,687,000	$192,772,000	$8,085,000	4%
5	Depreciation and Amortization	$52,707,000	$55,250,000	$2,543,000	5%
6	Bad Debts	$31,327,000	$33,322,000	$1,995,000	6%
7	Interest	$11,293,000	$12,627,000	$1,334,000	12%
8	Malpractice	$7,182,000	$6,568,000	($614,000)	-9%
9	Other Operating Expenses	$301,724,000	$304,970,000	$3,246,000	1%
	Total Operating Expenses**	**$1,140,640,000**	**$1,160,682,000**	**$20,042,000**	**2%**
	Income/(Loss) From Operations	**$34,907,000**	**$69,969,000**	**$35,062,000**	**100%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$7,994,000	($890,000)	($8,884,000)	-111%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$25,253,000	$38,610,000	$13,357,000	53%
	Total Non-Operating Revenue	**$33,247,000**	**$37,720,000**	**$4,473,000**	**13%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$68,154,000**	**$107,689,000**	**$39,535,000**	**58%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$4,252,000	($1,372,000)	($5,624,000)	-132%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$4,252,000**	**($1,372,000)**	**($5,624,000)**	**-132%**
	Excess/(Deficiency) of Revenue Over Expenses	**$72,406,000**	**$106,317,000**	**$33,911,000**	**47%**
	Principal Payments***	$0	$222,640,000	$222,640,000	0%

*Note: Bad debt reported as an expense

**includes bad debt expense

***principal payments made July 1st of every year

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2013
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	FY 2013 ACTUAL	Oct-Mar 2013 ACTUAL	Apr - Sep 2013 ACTUAL	% DIFFERENCE
L	OPERATING EXPENSE BY CATEGORY				
A.	Salaries & Wages:				
1	Nursing Salaries	332,110,467	166,055,234	166,413,756	32%
2	Physician Salaries	0	0	0	0%
3	Non-Nursing, Non-Physician Salaries	458,208,923	225,696,711	292,153,690	64%
	Total Salaries & Wages	**790,319,390**	**391,751,945**	**398,567,446**	**50%**
B.	Fringe Benefits:				
1	Nursing Fringe Benefits	98,907,729	70,573,796	28,333,933	29%
2	Physician Fringe Benefits	0	0	0	0%
3	Non-Nursing, Non-Physician Fringe Benefits	136,461,836	49,453,865	87,007,972	64%
	Total Fringe Benefits	**235,369,565**	**120,027,661**	**115,341,905**	**49%**
C.	Contractual Labor Fees:				
1	Nursing Fees	5,073,512	2,399,117	2,674,395	53%
2	Physician Fees	81,203,766	39,939,853	41,263,912	51%
3	Non-Nursing, Non-Physician Fees	37,082,812	17,907,048	19,175,764	52%
	Total Contractual Labor Fees	**123,360,090**	**60,246,018**	**63,114,071**	**51%**
D.	Medical Supplies and Pharmaceutical Cost:				
1	Medical Supplies	207,777,291	103,480,429	104,296,862	50%
2	Pharmaceutical Costs	153,492,545	71,948,114	81,544,431	53%
	Total Medical Supplies and Pharmaceutical Cost	**361,268,836**	**175,428,543**	**185,841,293**	**51%**
E.	Depreciation and Amortization:				
1	Depreciation-Building	41,725,249	19,591,150	22,134,100	53%
2	Depreciation-Equipment	66,231,411	33,115,706	33,115,706	50%
3	Amortization	0	0	0	0%
	Total Depreciation and Amortization	**107,956,660**	**52,706,856**	**55,249,806**	**51%**
F.	Bad Debts:				
1	Bad Debts	0	0	0	0%
G.	Interest Expense:				
1	Interest Expense	23,920,221	11,293,080	12,627,141	53%
H.	Malpractice Insurance Cost:				
1	Malpractice Insurance Cost	13,712,537	7,144,093	6,568,444	48%
I.	Utilities:				
1	Water	1,399,428	560,794	838,634	60%
2	Natural Gas	1,685,437	1,031,736	653,701	39%
3	Oil	0	0	0	0%
4	Electricity	20,046,640	9,730,911	10,315,729	51%
5	Telephone	4,680,740	2,167,499	2,513,240	54%
6	Other Utilities	1,035,578	624,248	411,330	40%
	Total Utilities	**28,847,823**	**14,115,188**	**14,732,634**	**51%**
		56,296,218	**27,669,582**	**28,626,634**	
J.	Business Expenses:				
1	Accounting Fees	1,357,791	641,181	716,610	53%
2	Legal Fees	3,920,714	1,694,432	2,226,282	57%
3	Consulting Fees	1,152,547	570,987	581,560	50%
4	Dues and Membership	1,780,207	1,047,216	732,991	41%
5	Equipment Leases	7,063,969	4,019,064	3,044,906	43%
6	Building Leases	15,215,564	7,073,101	8,142,463	54%
7	Repairs and Maintenance	31,830,805	15,285,403	16,545,402	52%
8	Insurance	2,452,530	1,356,561	1,095,969	45%
9	Travel	14,777	6,884	7,893	51%
10	Conferences	3,329,443	1,735,267	1,594,176	48%
11	Property Tax	4,474,111	1,846,164	2,627,948	59%
12	General Supplies	16,585,969	7,589,793	8,996,177	54%
13	Licenses and Subscriptions	1,798,013	946,296	851,717	47%
14	Postage and Shipping	1,061,517	929,556	131,960	12%
15	Advertising	88,900	73,919	12,980	15%
16	Corporate parent/system fees	24,416,549	11,872,348	12,544,201	51%
17	Computer Software	0	0	0	0%
18	Computer hardware & small equipment	984,083	396,193	587,890	60%
19	Dietary / Food Services	3,156,037	1,609,383	1,546,655	49%
20	Lab Fees / Red Cross charges	16,189,154	9,258,115	6,931,039	43%
21	Billing & Collection / Bank Fees	640,267	291,323	348,944	54%
22	Recruiting / Employee Education & Recognition	663,719	443,842	219,877	33%
23	Laundry / Linen	6,159,553	3,190,087	2,969,466	48%
24	Professional / Physician Fees	4,796,242	3,479,612	1,306,630	27%
25	Waste disposal	1,328,240	731,317	596,923	45%
26	Purchased Services - Medical	121,767,535	54,885,768	66,881,765	55%
27	Purchased Services - Non Medical	278,430,585	145,103,661	133,326,924	48%
28	Other Business Expenses	1,270,357	523,007	748,004	59%
	Total Business Expenses	**551,917,178**	**276,600,480**	**275,317,062**	**50%**
K.	Other Operating Expense:				
1	Miscellaneous Other Operating Expenses	0	0	0	0%
	Total Operating Expenses - All Expense Categories*	**2,236,673,300**	**1,109,313,863**	**1,127,359,792**	**50%**
	*A.- K. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.				

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2013
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

II.	OPERATING EXPENSE BY DEPARTMENT				
A.	General Services:				
1	General Administration	62,721,270	34,393,918	28,327,351	45%
2	General Accounting	5,395,950	2,696,205	2,699,745	50%
3	Patient Billing & Collection	28,954,137	14,514,211	14,439,927	50%
4	Admitting / Registration Office	15,328,578	7,317,639	8,010,939	52%
5	Data Processing	0	0	0	0%
6	Communications	5,668,103	2,232,310	3,435,793	61%
7	Personnel	3,940,430	1,930,547	2,009,882	51%
8	Public Relations	1,215,733	594,235	621,498	51%
9	Purchasing	3,578,303	2,088,974	1,489,330	42%
10	Dietary and Cafeteria	27,199,717	12,829,999	14,369,718	53%
11	Housekeeping	26,988,620	13,674,470	13,314,149	49%
12	Laundry & Linen	630,338	101,873	528,465	84%
13	Operation of Plant	32,606,161	16,919,744	15,686,417	48%
14	Security	10,285,731	4,779,907	5,505,824	54%
15	Repairs and Maintenance	23,216,912	10,438,723	12,778,189	55%
16	Central Sterile Supply	11,388,395	5,403,183	5,985,212	53%
17	Pharmacy Department	57,067,003	26,948,684	30,118,320	53%
18	Other General Services	487,232,237	240,265,285	246,966,952	51%
	Total General Services	**803,417,618**	**397,129,907**	**406,287,711**	**51%**
B.	Professional Services:				
1	Medical Care Administration	52,151,125	28,132,361	24,018,763	46%
2	Residency Program	66,068,752	37,489,921	28,578,831	43%
3	Nursing Services Administration	18,299,375	9,048,151	9,251,224	51%
4	Medical Records	13,082,776	6,006,981	7,075,797	54%
5	Social Service	7,682,075	4,323,915	3,358,159	44%
6	Other Professional Services	0	0	0	0%
	Total Professional Services	**157,284,105**	**85,001,329**	**72,282,774**	**46%**
C.	Special Services:				
1	Operating Room	142,606,686	70,211,276	72,395,391	51%
2	Recovery Room	11,467,125	6,461,273	5,005,851	44%
3	Anesthesiology	20,001,438	11,282,999	8,718,439	44%
4	Delivery Room	12,467,329	6,147,904	6,319,425	51%
5	Diagnostic Radiology	36,698,324	18,799,180	17,899,143	49%
6	Diagnostic Ultrasound	6,467,464	3,069,147	3,398,317	53%
7	Radiation Therapy	18,576,883	10,698,473	7,878,409	42%
8	Radioisotopes	36,625,486	16,953,410	19,672,076	54%
9	CT Scan	5,699,029	2,896,183	2,802,846	49%
10	Laboratory	70,002,945	34,760,477	35,242,468	50%
11	Blood Storing/Processing	22,315,749	12,221,555	10,094,194	45%
12	Cardiology	0	0	0	0%
13	Electrocardiology	19,416,864	7,450,659	11,966,205	62%
14	Electroencephalography	6,828,348	3,181,423	3,647,925	53%
15	Occupational Therapy	0	0	0	0%
16	Speech Pathology	0	0	0	0%
17	Audiology	0	0	0	0%
18	Respiratory Therapy	15,635,790	8,073,488	7,562,302	48%
19	Pulmonary Function	3,896,608	1,961,832	1,934,776	50%
20	Intravenous Therapy	1,123,689	623,151	500,537	45%
21	Shock Therapy	0		0	0%
22	Psychiatry / Psychology Services	6,301,283	3,428,943	2,872,340	46%
23	Renal Dialysis	3,895,168	1,975,136	1,920,032	49%
24	Emergency Room	67,237,087	32,569,626	34,667,461	52%
25	MRI	7,876,965	3,520,090	4,356,875	55%
26	PET Scan	0		0	0%
27	PET/CT Scan	0	0	0	0%
28	Endoscopy	2,775,834	2,270,188	505,645	18%
29	Sleep Center	0	0	0	0%
30	Lithotripsy	(12,392)	(12,396)	4	0%
31	Cardiac Catheterization/Rehabilitation	5,105,156	2,142,804	2,962,352	58%
32	Occupational Therapy / Physical Therapy	8,863,644	4,397,192	4,466,452	50%
33	Dental Clinic	4,225,639	2,268,513	1,957,126	46%
34	Other Special Services	4,721,122	2,281,016	2,440,105	52%
	Total Special Services	**540,820,243**	**269,533,542**	**271,186,696**	**50%**
D.	Routine Services:				
1	Medical & Surgical Units	220,229,180	108,397,860	111,831,320	51%
2	Intensive Care Unit	57,763,763	28,423,811	29,339,952	51%
3	Coronary Care Unit	10,858,604	5,310,908	5,547,696	51%
4	Psychiatric Unit	22,959,848	11,379,234	11,580,615	50%
5	Pediatric Unit	16,076,947	7,921,545	8,155,403	51%
6	Maternity Unit	11,252,149	4,830,580	6,421,569	57%
7	Newborn Nursery Unit	3,843,514	2,506,049	1,337,465	35%
8	Neonatal ICU	19,502,683	9,498,322	10,004,362	51%
9	Rehabilitation Unit	1,712,909	845,410	867,499	51%
10	Ambulatory Surgery	10,253,969	6,340,269	3,913,722	38%
11	Home Care	0	0	0	0%
12	Outpatient Clinics	199,679,009	91,367,249	108,311,760	54%
13	Other Routine Services	0	0	0	0%
	Total Routine Services	**574,132,594**	**276,821,235**	**297,311,366**	**52%**
E.	Other Departments:				
1	Miscellaneous Other Departments	161,018,441	80,727,850	80,290,590	50%
	Total Operating Expenses - All Departments*	**2,236,673,000**	**1,109,313,863**	**1,127,359,137**	**50%**

*A.- 0. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.

Roberts, Karen

From: Roberts, Karen
Sent: Tuesday, February 18, 2014 2:21 PM
To: Nancy.Rosenthal@greenwichhospital.org
Cc: Martone, Kim
Subject: CON Docket #12-31747-CON

Tracking:

Recipient	Delivery
Nancy.Rosenthal@greenwichhospital.org	
Martone, Kim	Delivered: 2/18/2014 2:23 PM

Hi Nancy
On March 28, 2013, the Hospital filed a three-year integration plan related to this approved CON project (acquisition of Saint Raphael Healthcare System, Inc.) and on November 29, 2013, the Hospital filed of an update in the progress of integration efforts. OHCA would like clarification of the status and location of the various Cardiac or Cardiology related services between the two hospital campuses. We see from November 29, 2013 filing that "*cardiac surgery will be consolidated at the York Street campus in summer 2014*". We are unclear as to the provision of each of the various cardiac services between the campuses. Could you send a clarification table which shows where all the cardiac services are or will be located in accordance with the Hospital's integration plans. We will place this email and your response in the CON record in this matter. The table should be similar to the following and should include the various services within the overall Cardiac service line (cardiac imaging, cardiac surgery, cardiac rehab, interventional cardiac procedures, etc.):

Cardiac Service	York Street Campus	St. Raphael Campus	Both Campuses	Check off if service was provided at time of CON but is no longer provided at either campus	Provide a note as to whether a change for the service is planned but hasn't yet occurred
CABG	X				
Angioplasty		X			
Cardiac Rehab			X		
Valve Replacement					
Etc.					

Thanks for this clarification. We'd appreciate it if the Hospital would be able to provide this clarification table by February 28, 2014.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Department of Public Health
Office of Health Care Access
(860) 418-7041
karen.roberts@ct.gov

Roberts, Karen

From: Roberts, Karen
Sent: Thursday, February 27, 2014 9:19 AM
To: 'Karen Banoff'
Cc: Nancy.Rosenthal@greenwichhospital.org; Martone, Kim
Subject: RE: CON Docket #12-31747-CON

Tracking:

Recipient	Delivery
'Karen Banoff'	
Nancy.Rosenthal@greenwichhospital.org	
Martone, Kim	Delivered: 2/27/2014 9:21 AM

Thank you Karen – this is very helpful. We will place it in the record for Docket #12-31747-CON and let you know if we have further questions.

Karen Roberts
Principal Health Care Analyst
Department of Public Health
Office of Health Care Access
(860) 418-7041
karen.roberts@ct.gov

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Thursday, February 27, 2014 7:10 AM
To: Roberts, Karen
Cc: Nancy Rosenthal (Nancy.Rosenthal@greenwichhospital.org)
Subject: FW: CON Docket #12-31747-CON

Hello Karen-
On behalf of YNHH, I have provided the attached table, as per OHCA's request, which clarifies where all the cardiac services are or will be located in accordance with the Hospital's integration plans. We hope this answers OHCA's questions. Please do not hesitate to let me know if you have any questions. Karen

Karen M. Banoff, DNP, RN
kmb consulting llc

91 Old Hollow Road
Trumbull, CT 06611
(203) 459-1601 (Phone/Fax)
kbanoff@kmbconsult.com

www.kmbconsultingllc.com

From: Rosenthal, Nancy [mailto:Nancy.Rosenthal@greenwichhospital.org]
Sent: Tuesday, February 18, 2014 3:13 PM
To: Karen Banoff
Subject: FW: CON Docket #12-31747-CON

Could you please follow up on this? Thanks.

Nancy Rosenthal
Senior Vice President-Health Systems Development

Greenwich Hospital
5 Perryridge Rd.
Greenwich, CT 06830
Phone:(203) 863-3908

Nancy.Rosenthal@greenwichhospital.org

www.greenwichhospital.org

Please consider the environment
before printing this email.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Tuesday, February 18, 2014 2:21 PM
To: Rosenthal, Nancy
Cc: Martone, Kim
Subject: CON Docket #12-31747-CON

Hi Nancy
On March 28, 2013, the Hospital filed a three-year integration plan related to this approved CON project (acquisition of Saint Raphael Healthcare System, Inc.) and on November 29, 2013, the Hospital filed of an update in the progress of integration efforts. OHCA would like clarification of the status and location of the various Cardiac or Cardiology related services between the two hospital campuses. We see from November 29, 2013 filing that "*cardiac surgery will be consolidated at the York Street campus in summer 2014*". We are unclear as to the provision of each of the various cardiac services between the campuses. Could you send a clarification table which shows where all the cardiac services are or will be located in accordance with the Hospital's integration plans. We will place this email and your response in the CON record in this matter. The table should be similar to the following and should include the various services within the overall Cardiac service line (cardiac imaging, cardiac surgery, cardiac rehab, interventional cardiac procedures, etc.):

Cardiac Service	York Street Campus	St. Raphael Campus	Both Campuses	Check off if service was provided at time of CON but is no longer provided at either campus	Provide a note as to whether a change for the service is planned but hasn't yet occurred
CABG	X				
Angioplasty		X			
Cardiac Rehab			X		
Valve Replacement					
Etc.					

Thanks for this clarification. We'd appreciate it if the Hospital would be able to provide this clarification table by February 28, 2014.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Department of Public Health
Office of Health Care Access
(860) 418-7041
karen.roberts@ct.gov

This message originates from the Yale New Haven Health System. The information contained in this message may be privileged and confidential. If you are the intended recipient you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you.

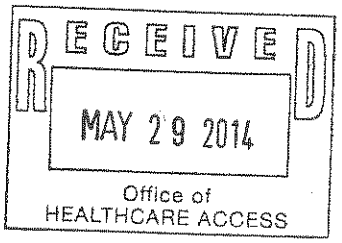
Yale-New Haven Hospital Cardiac Services
As of 2/24/14

	York Street Campus Only	Saint Raphael Campus Only	Both Campuses	Outpatient Satellites	Svc provided at time of CON but is no longer at either campus	Planned Change but Not Yet Occurred
CABG	X	Consolidated at York Street 2/1/14*		N/A	N/A	N/A
Valve Surgery (aortic , mitral, and/or tricuspid)	X	Consolidated at York Street 2/1/14*		N/A	N/A	N/A
Minimally Invasive Cardiac Surgery (OPCABG, Aortic & Mitral minimally invasive approaches)	X	Consolidated at York Street 2/1/14*		N/A	N/A	N/A
Ablative Operations for Atrial Fibrillation	X			N/A	N/A	N/A
Heart Failure Surgery (LVADS, RVADs, ECMO for Cardiac and/or Pulmonary Failure)	X			N/A	N/A	N/A
Aortic Surgery (Aneurysms, Dissections)	X			N/A	N/A	N/A
Pediatric Cardiac / Congenital Surgery	X			N/A	N/A	N/A
Heart Transplantation	X			N/A	N/A	N/A
Cardiac Catheterization Laboratories			X	N/A	N/A	N/A
Electrophysiology Laboratories			X	N/A	N/A	N/A

	York Street Campus Only	Saint Raphael Campus Only	Both Campuses	Outpatient Satellites	Svc provided at time of CON but is no longer at either campus	Planned Change but Not Yet Occurred
Interventional Radiology Laboratories			X	N/A	N/A	N/A
EKG			X	X	N/A	N/A
ECHO			X	X	N/A	N/A
Cardiac Nuclear Medicine / Imaging			X	X	N/A	N/A
Cardiac Rehab	N/A	N/A		X	N/A	N/A

*Consolidation occurred ahead of schedule

YALE-NEW HAVEN HOSPITAL



May 30, 2014

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 12-31747-CON and 12-31747-MDF: Yale-New Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc.

Dear Deputy Commissioner Davis:

Pursuant to Condition Number 3 of the Agreed Settlement signed on June 27, 2012 and subsequently modified by the Office of Health Care Access (OHCA) on October 9, 2012, I have enclosed Yale-New Haven Hospital's (YNHH) narrative update on the progress of implementation of the three year integration plan. Accompanying the narrative is a Gantt chart which displays updates to the integration activities and time frames for the three year integration plan. These activities are described in more detail in Section A of the narrative report. The narrative update includes cost saving totals per operating expense categories as identified by OHCA. In addition, completed OHCA Reports 100, 150 and 175 for the consolidated YNHH are also attached.

Please do not hesitate to contact me with any questions. Thank you for your time and attention.

Sincerely,

Richard D'Aquila
President

Enclosures

Copy to: Kimberly Martone, Director of Operations

Saint Raphael Campus
1450 Chapel Street
New Haven, CT 06511

Yale New-Haven Hospital's Acquisition of the Saint Raphael Healthcare System, Inc. Docket No: 12-31747-CON

Three Year Integration Plan Narrative

May 2014

Yale New-Haven Hospital's Acquisition
of the Saint Raphael Healthcare System, Inc.
Docket No: 12-31747-CON

Three Year Integration Plan
Narrative

INTRODUCTION

This narrative report has been prepared as part of the reporting requirements for Yale-New Haven Hospital (YNHH) in accordance with the Agreed Settlement for Docket Number: (DN) 12-31747-CON, subsequently modified as DN: 12-31757-MDF for the acquisition of the Saint Raphael Healthcare System, including the Hospital of Saint Raphael (HSR).

This report is structured into the following sections:

A. PROGRESS AGAINST THREE-YEAR INTEGRATION PLAN

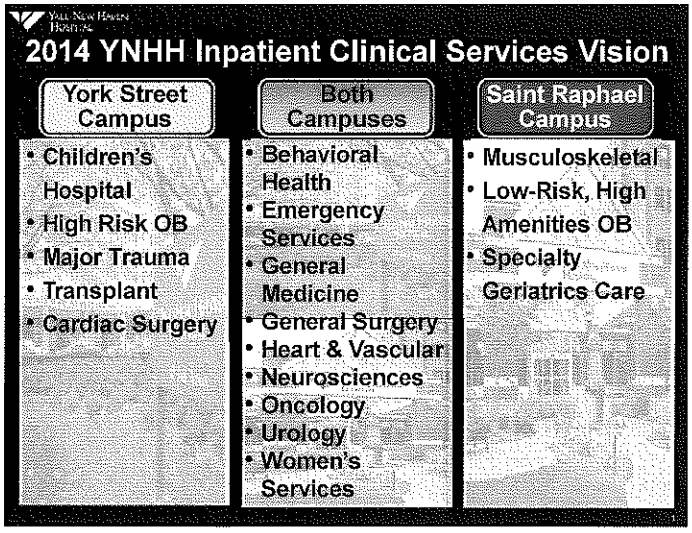
B. SUMMARY OF BEDS & SERVICES BY CAMPUS

C. COST SAVINGS AND REVENUE ENHANCEMENTS

D. ONGOING REPORTING

A. PROGRESS AGAINST THREE-YEAR INTEGRATION PLAN

Consistent with the three-year integration plan submitted on March 31, 2013, the focus of the last fiscal year has been on developing one standard of care across all inpatient campuses and ambulatory operations. YNHH has defined its clinical vision for its inpatient campuses and a summary can be found below.



As such, many of the activities described in this report were developed to support the successful implementation of the clinical vision.

Attachment I contains the updated Integration Workplan for FY 2013 through FY 2015 in Gantt chart format which is organized into five major sections including: (1) Major Strategic Initiatives; (2) Service Lines; (3) Clinical Areas; (4) Non-Clinical Areas; and (5) Corporate Services. The Integration Workplan includes specific activities for each of these five areas and the actual or estimated time frame by fiscal year for completion. Progress to date as well as remaining focus areas for the next six months is detailed in the narrative below.

Section 1. Major Strategic Initiatives:

Major strategic initiatives pertain to activities with a broad impact throughout the organization. YNHH is focusing on ten key areas:

1. *Physician Integration*
   Effective April 1, 2014, all hospital-based services have been integrated. Pathology / Laboratory and Anesthesiology were the last two remaining hospital-based departments to integrate, and the integrations went very smoothly without any business disruptions.

2. *Epic Implementation*
   Consistent with the November 30 submission, Epic was successfully implemented across all inpatient and outpatient Yale-New Haven sites as well as Yale School of Medicine (Yale Medical Group) practice sites. The focus has now shifted to system optimization and analytics, and a task force has been established to assess analytics requirements across the medical center and health system. Recommendations and associated organizational structure will be finalized in coming months.

3. *Regulatory / Safety and Quality*
   In January 2014, Yale-New Haven Hospital successfully completed its triennial Joint Commission accreditation survey. This was the first Joint Commission survey as an integrated organization and the Hospital received a number of positive comments from surveyors regarding the integration. Mock-audits and other regulatory readiness preparedness activities remain ongoing.

   Additionally, in recent months, we have been focusing on enhancing patient safety and quality. We launched our daily bi-campus Morning Safety Report on our first day as an integrated hospital on September 12, 2012. It has since become engrained in our culture and was the first step in developing an unwavering culture of safety. One of the goals we had set at the beginning of the fiscal year was to achieve level 3 High Reliability Organization (HRO) designation, which entails advanced leadership rounding and training all 14,236 staff members and physicians on the basic tenants of safety and quality reporting by the end of the fiscal year. Leadership training began in late November and staff training in February. To date, over 75% of leadership has been trained and 25% of staff members (representing a total of 3,422 members of the medical center). Over 200 Yale-New Haven employees, including a number of senior leaders, are leading the training sessions.

4. *Patient Experience*
As was reported in the November 30 submission, an integrated patient experience strategic plan was developed for FY 2014 and was themed "every patient, every time". Focus this fiscal year has been on two key items namely physician/nursing leadership collaboration and fostering an environment of care that promotes healing. To date, we have held four retreats with over 100 nursing and physician leaders, and the results have been outstanding. The sessions have helped us identify key strategies and requirements for success; including developing and conveying a shared vision, setting clear expectations and disseminating accurate data in a timely manner. As it pertains to the environment of care, we have launched a hospital-wide quiet campaign with unit-level plan development and accountability and are looking for improvement by the end of the fiscal year.

Recently, a number of YNHH service excellence recognition programs were implemented at the Saint Raphael campus including $2 bills for outstanding service. Additionally, Yale-New Haven recently inducted its latest class of "Service Excellence Heroes" (employees who live organizational values on a daily basis and exemplify outstanding customer service), which included employees from both inpatient campuses as well as outpatient satellites. Sixteen employees were selected for this honor and over 280 nominations were received this year throughout the medical center.

5. *Transforming Patient Care*
Transforming Patient Care refers to a review of nursing workflows and supporting systems/processes to remove unnecessary activities. As was discussed in the November submission, a comprehensive roll-out of best practices from the York Street campus will take place in FY 2014. The implementation plan is currently under development and will be rolled out in coming months. Further improvement activities remain ongoing at the York Street campus.

Additionally, a Nursing Magnet readiness improvement plan has been developed and will be implemented over the next 12 months, as the organization readies for its 2015 re-accreditation survey. This will be the first time the Saint Raphael campus is surveyed for Magnet, and we are optimistic that the improvement strategies being implemented will result in a successful survey.

6. *Safe Patient Flow*
Safe Patient Flow refers to throughput improvement activities and was instrumental in allowing YNHH to meet its patient care demand prior to the integration of the Hospital of Saint Raphael. The Safe Patient Flow process was recently kicked-off at the Saint Raphael campus and will help improve throughput throughout the medical center. The percentage of discharges by 11m is currently 15% for the Saint Raphael campus, while it is over 25% for the York Street campus. Diligent implementation of Safe Patient Flow processes at the Saint Raphael campus will create additional inpatient capacity.

7. *Cultural Integration*
A Management Advisory Group comprised of managers from both campuses was established this spring, with the objective of enhancing communications to the manager group. The group is actively focusing on redesigning the format of the on-line manager portal, as well as

identifying key topics for employee open forums/communications. Employee recognition and employee-generated efficiency enhancements (WorkSMART) were also aligned across both campuses in recent months. Finally, the integration of the Yale-New Haven Hospital and Hospital of Saint Raphael auxiliaries will be completed at the end of FY 2014.

8. *Bed Management/Capacity*
   As was mentioned in the November submission, Yale-New Haven Hospital opened a new musculoskeletal unit (Verdi 4 North) in February 2014. The state-of-the-art inpatient unit has the capacity for 29 beds. Preliminary patient, staff and physician feedback has been extremely positive. During this time, Yale-New Haven Hospital also realigned its medical and surgical beds at the Saint-Raphael campus. The new configuration allows to cohort medical and surgical patients, which has been demonstrated to lead to improved patient outcomes in the literature. Finally, construction is underway for a leading inpatient specialty geriatrics unit at the Saint Raphael campus (Verdi 4 West). The unit was designed to establish a prototype of advanced safety and acute care for the elderly. It was designed by renowned architect Michael Graves, and includes innovative features for fall prevention, cognitive support and a healing environment for the elderly. Bed allocation by service is outlined in Section B "Summary of Beds and Services by Campus" of this report.

9. *Infrastructure*
   The Off-Shift Executive and Off-Shift Nursing Leadership model was successfully implemented at the Saint Raphael campus in early winter 2014. Additionally, a single Administrator on Call for all campuses was also implemented, and schedules as well a contact information are now included in the on-line on-call system for the medical center (AMION).

10. *Care Management Across the Continuum*
    Transitional Care Rounds have been implemented throughout the entire institution (York Street and Saint Raphael campus) and have created an effective, unit-based process that continues to focus on high-quality care transitions out of the acute care setting. These rounds have demonstrated an improvement in multiple hospital operations metrics and greatly improved healthcare team communication. Care Management continues to work on improving our outreach to the highest-risk populations even after they have been discharged from the hospital. We have established a work group to assess how we can best support these patients including the use of patient navigators and other community-based resources. Since April 2014, Yale New Haven Health System is part of a CMS bundled payment project in Heart and Vascular and Musculoskeletal Services.

Section 2. Service Lines

Vision, facility investments and integration activities for major clinical service lines comprise the second section of the Integration Workplan. It is important to note that the information provided below predominantly addresses inpatient services as ambulatory activities are currently being reviewed as part of a comprehensive ambulatory strategic planning exercise, discussed in Section 3.

The following service lines are included:

1. *Children's*
   As was discussed in the November submission, inpatient Children's services were aligned in calendar 2013 with the closure of the pediatric inpatient unit at the Saint Raphael campus, the conversion of the newborn intensive care unit at the Saint Raphael campus from a Level 3 to a Level 1, and the conversion of the Child and Adolescent Psychiatry Unit to a Young Adolescent Unit. No additional changes are expected in the future for this service.

2. *Heart and Vascular*
   Cardiac surgery was consolidated in February 2014; ahead of schedule due to physician assistant shortages at the Saint Raphael campus (original target program closure date was summer 2014). The transition of cardiac surgery activities from the Saint Raphael campus to the York Street campus has gone extremely smoothly, thanks to the cooperation of all physicians and staff members involved in the transition. Additionally, an Aortic Center was opened at the York Street campus in spring 2014, focused on providing cutting-edge services. Renovation of cardiac catheterization / interventional laboratories is underway and will be completed in coming months.

3. *Musculoskeletal*
   As was referenced earlier, we successfully opened a new state-of-the-art inpatient musculoskeletal unit at the Saint Raphael campus three months ago (Verdi 4 North; the Dr. Robert J. and Lorraine D. Cronin Musculoskeletal Unit. Physician transitions from the York Street campus to the Saint Raphael campus are underway and the immediate focus has been on physicians specialized in total joints procedures. Operating room renovations are underway and are expected to be completed in early calendar 2015. Additionally, the recruitment of a physician leader to lead the musculoskeletal service line is underway and is expected to be completed by early summer 2014.

4. *Neurosciences*
   At this time, Yale-New Haven Hospital is currently exploring the creation of a neurovascular service at the Saint Raphael campus. The service would include inpatient beds and radiology services (including interventional radiology capabilities, consistent with the planned renovations of interventional laboratories referenced earlier), and would have synergies with the advanced elderly inpatient services discussed in Section 1. Program planning is in the early stages and will be refined in coming months.

5. *Oncology*
   Consistent with the November 2013 submission, no additional service configurations have taken place in Oncology.

6. *Transplant*
   Consistent with the November 2013 submission, no additional service configurations have taken place in Transplant.

Section 3. Clinical Areas

Additional clinical integration beyond the service lines described in Section 2 are described and listed below:

1. *Diagnostic Radiology*
   Assessment of radiology equipment and master planning for radiology services remains ongoing.

2. *Emergency Department*
   Consistent with the November submission, emergency transportation (ground and others) is currently being reviewed. An outside consultant will be retained to facilitate this process. Moreover, Emergency Department leadership has been focusing its effort on aligning clinical practice and patient experience across all Yale-New Haven ED locations.

3. *Laboratory/Pathology*
   As referenced in the November submission, most components of microbiology have been consolidated at the York St campus as of April 2014 (specimen plating takes place at the Saint Raphael campus and analysis is at the York Street campus). This consolidation has allowed for enhanced turnaround times for all microbiology cultures.

4. *Medicine*
   Consistent with the inpatient clinical vision outlined in section I, a Geriatric Center of Excellence will be established at the Saint Raphael campus, and will include the relocation of the Acute Care for the Elderly (ACE) unit from the York Street campus to the Saint Raphael campus in late summer 2014.

   An electronic ICU pilot comprised of 10 rooms at the Saint Raphael campus took place in February 2014 (February 5-28, 2014). Patients were monitored remotely 24/7 by a critical care physician (Intensivist). Over 25 inpatient admissions were completed during this time and the pilot yielded favorable results including reduced mortality, improved glucose management and lower cost per case, among others. An expansion plan to cover additional beds at the Saint Raphael campus and throughout delivery network hospitals (Greenwich and Bridgeport) is in the process of being developed.

5. *Nursing*
   As was referenced in section 1, YNHH will be undergoing its Magnet re-designation in FY 2015 and will be ensuring adequate preparedness in coming months. A Nursing Magnet gap analysis was completed and implementation of remediation plans remains ongoing to ensure that both campuses meet Magnet re-designation requirements. Additionally, a system-wide nursing standardization effort remains underway across all delivery network hospitals.

6. *Pharmacy*
   Consistent with the November 2013 submission, no additional changes have taken place in Pharmacy.

7. *Psychiatry*
   An important focus area in FY 2014 will be the launch of Behavioral Intervention Teams, currently in place across inpatient medicine services at the York Street campus, at the Saint Raphael campus. The Behavioral Interventional Teams provide proactive consultations to Medicine patients with psychiatric conditions and have played an important role in decreasing length of stay for patients with psychiatric diagnoses on Medicine units.

8. *Surgical Services*
   Consistent with the November submission, a physician leader to co-lead the operating rooms is in the process of being recruited. We are hopeful to have a new leader named by the end of the summer. Operational enhancements identified during the consulting engagement are also in the process of being implemented. To date, a number of enhancements have taken place with regards to time-outs, pre-admission testing (pilots in Urology and Orthopedics) reassignment of outpatient GYN and Ophthalmology services to our Temple Surgical facility as well as Epic reporting.

9. *Women's Services*
   On January 2, 2014, the Yale School of Nursing Midwifery program was relocated from the York Street Campus to the Saint Raphael campus, beginning with the relocation of all patient deliveries. This is an important first step in the development of a low risk, high amenities OB center of excellence at the Saint Raphael campus. Additionally, renovations on Main 6 (part of the Vidone Center) to house outpatient services began a few weeks ago and will be completed in coming months.

10. *Ambulatory Services*
    Programmatic recommendations are currently being developed and preliminary consolidation opportunities include outpatient psychiatric services and dental services, among others. A final set of recommendations is expected by the end of the fiscal year.

Section 4. Non-Clinical Support Services

As it pertains to non-clinical support services, vendor consolidation opportunities were identified for Environmental Services, Food and Nutrition, Linen Services and Protective Services. Estimated savings can be found in Section C of this narrative.

Section 5. Corporate Services

Corporate services include seven key areas and integration activities for each are described below.

1. *Accounting & Finance*
   Consistent with the November 2013 submission, no additional changes have taken place in Accounting and Finance.

2. *Compliance*
Annual compliance training via Healthstream for all employees remains ongoing.

3. *Human Resources*
In November 2013, Yale-New Haven Hospital completed its first employee engagement survey as an integrated organization. The survey results have yielded a number of improvement opportunities including scheduling, staffing and communication. Corrective action plans are currently under development and will be implemented in coming months. Additionally, Yale-New Haven will be launching its second "Know Your Numbers" campaign this spring/summer focused on empowering employees to take control of their health. Employees who complete the biometrics testing as well as other educational requirements will receive a $500 credit towards the cost of their health care benefits in calendar 2015.

4. *Information Technology & Information Systems*
While the immediate focus was on the implementation of Epic, focus has shifted to optimizing the Epic system (reporting, analytics, etc.) and additional areas/opportunities for standardization include streamlining of technology applications for clinical services.

5. *Legal and Planning*
Integration work with MCIC (malpractice insurance captive) remains ongoing.

6. *Marketing, Communications, Image & Community Wellness*
The development of new employee and manager communication strategies employing new media (e.g. social media) remains ongoing. The organization remains a strong advocate with State and Federal government agencies for continued access to high quality healthcare services for Connecticut residents.

7. *Supply Chain*
Consistent with the November 2013 submission, no additional changes have taken place in Supply Chain. Supply chain savings achieved through vendor contracts will be discussed in Section C (5).

B. SUMMARY OF SERVICES AND BEDS BY CAMPUS

As described in Section A above, integrating clinical services is still underway and specific campus locations and allocated beds continue to be adjusted. The two tables below summarize the current plan for the services and beds by location. This information is subject to change and any changes will be provided to OHCA in subsequent semi-annual reports.

Planned Services by Campus for 2015 (as of May 2014):

Services	YNHH Campus	SR Campus
Service Lines		
Children's	**X**	
Heart & Vascular	**X** (Tertiary/Quaternary)	**X**
Musculoskeletal		**X**
Neurosciences	**X** (Tertiary/Quaternary)	**X**
Oncology	**X** (Tertiary/Quaternary)	**X**
Transplant	**X**	
Clinical Areas		
Anesthesia	**X**	**X**
Diagnostic Radiology	**X**	**X**
Emergency Department	**X**	**X**
Laboratory/Pathology	**X**	**X**
Medicine	**X**	**X** **Geriatrics**
Psychiatry	Older Adolescents/Adult	Children's/ Younger Adolescents/Adult
Surgery	**X**	**X**
Women's	Low & High Risk Maternity	Low Risk Maternity/ Midwifery Program

FY 2014: (as of May 2014)

Beds:	**YNHH Campus**			**SR Campus**		
	General Care	***ICU***	***Total***	***General Care***	***ICU***	***Total***
Adult Med/Surg	570	109	679	300	56	356
Rehabilitation				18		18
Maternity	56		56	19		19
Pediatric*	73	17	90			
Pediatric Psych Only	16		16	20		20
Adult Psych	73		73	25		25
Future Use				17	16	33
Total Beds	**788**	**126**	**914**	**399**	**72**	**471**
Bassinets	40	52	92	13	9	22

Note: Included in YNHH license is **another 22 pediatric beds and 20 bassinets** located at Bridgeport Hospital campus.

C. COST SAVINGS AND REVENUE ENHANCEMENTS

Actual cost savings achieved in the first 6 months of FY 2014 have been provided according to the categories outlined by OHCA and Report 175.

Projected Cost Savings	Actual FY 2014 6 Months	Projected FY 2014 6 Months
Salaries & Wages	$18.7m	$13.4m
Fringe Benefits	$5.4M	$3.8m
Contractual Labor Fees	$0.6M	$0.6m
Medical Supplies & Pharmaceuticals	$4.6M	$5.4m
Malpractice	$0.3M	0
Utilities	$0.5M	$0.7m
Business Expenses	$6.1M	$8.5m
Other Operating Expenses	$0	$0
Depreciation/Interest/Bad Debt	$0	$0
TOTAL	**$36.0M**	**$32.4m**

1. *Salaries and Wages / Fringe Benefits*
   In the past six months, salary and benefit savings related to the Saint Raphael's integration have continued to improve. In May of FY 2014, the hospital plans to implement the PTR (payroll trend report) at the Saint Raphael Campus. As mentioned in the November submission, this tool will allow departmental management compare staffing levels with external industry benchmarks on a bi-weekly basis.

   In addition, a number of staffing initiatives mentioned in the November submission began at various points throughout Fiscal Year 2013 and have resulted in prorated savings figures. These activities were fully implemented by the start of FY 2014 and have therefore contributed to the increased six month savings figures shown in the table above. As the integration continues, and approaches a steady state of operation, these types of changes to expense will become less apparent.

   The table below provides the breakdown of salary/wage and fringe benefit savings by major departments.

Department	Salary/Wage
Clinical Support	$2.5M
Finance/IT/Supply Chain	$2.9M
Non-Clinical Support	$2.1M
Nursing	$4.5M
Physician Practice/Office Staff	$3.9M
Administrative/Other	$2.8M
TOTAL	**$18.7M**

2. *Contractual Labor Fees*
Please note that discussion of Contractual Labor and Legal Fees is included under Business expense constant with the submission in November 2013. This change was made in order to be consistent with OHCA Report 175.

Professional Service Agreements
As mentioned in section 1.1, the physician integration of the two campuses has gone smoothly, and resulted in the successful merging of a number of physicians into the Yale School of Medicine. As anticipated, the economies of scale gained through these activities decreased the need to contract with local community physician groups via Professional Service Agreements (PSA) to fill gaps in coverage. Some examples of these savings in the past six months include the Urology Clinic Coverage and CTICU attending coverage, detailed below.

Urology Clinic Coverage: A local group of Urologists have historically provided coverage for the community based Urology clinic at Saint Raphael Campus. This group has recently joined the faculty at Yale School of Medicine. As a result of this change, the clinics are now covered without the need to pay a PSA agreement.

CTICU Attending Coverage: As part of the integration of Cardiac Surgery, the two separate Cardiothoracic Intensive Care Units were consolidated into a single unit at the York Street Campus. In order to operate the Saint Raphael Campus based unit, the hospital paid a community Pulmonary Critical Care physician an annual stipend to provide physician support. With the consolidated unit at the York Street Campus, the existing physician resources at the York Street Campus were able to absorb that patient volume into their current workflow.

There are still a large number of PSAs that exist at Yale New Haven Hospital. Efforts will continue to identify areas of opportunity that leverage the efficiencies being gained in the combined physician workforce.

3. *Malpractice Expense*
As referenced in section 5.5, the hospital continues to work with the insurance captive MCIC and savings continue to be consistent with the November filing.

4. *Utilities*
Savings activities for electricity rate, electricity utilization, and other utilities remain consistent with the November submission.

5. *Medical/Surgical (Med/Surg) Supplies & Pharmaceuticals*
Yale New Haven Hospital continues to explore opportunities to further integrate contracts across the health system for Med/Surg Supplies and Pharmaceuticals. The ability to effectively achieve savings in this category is largely tied to the historical contract end dates at the Saint Raphael Campus that were assumed during the integration process. Year-to-date, the majority of these contracts have either been renegotiated under consolidated rates or renewed, but there are still a number of contracts being reviewed by supply chain staff that will provide additional savings opportunities.

Consistent with the salary savings being reported, initiatives in this category were started at different times throughout FY 2013 based on the contract end dates. All mid-year FY 2013 savings activities being fully implemented in FY 2014 has resulted in an increase to the savings activity reported.

System Contracting
The health system continues to standardize and jointly contract for a variety of Med/Surg supplies for all three campuses. The Saint Raphael Campus also gained the benefit of participation in the NPC (Northeast Purchasing Coalition), of which Yale New Haven Health System is a member. NPC allows for numerous health care organizations in the Northeast to develop join clinically focused supply chain initiatives designed at standardizing care, and driving down cost.

Pharmaceuticals
The hospital continues to achieve savings through the drug contracts for high cost pharmaceuticals referenced in the November submission. Additionally, YNHH is in the process of converting drug suppliers from Cardinal to McKesson. This change in suppliers is expected to result in additional expense reductions related to drug pricing and delivery.

Application for 340b status on the Saint Raphael Campus has been sent to HRSA and approval is expected in coming weeks. This designation will allow the hospital to increase savings in the Med/Surg & Pharmaceutical category. To date, the 340b status has been the primary driver for the gap between achieved and target savings for the Med/Surg Supply & Pharmaceutical category.

Additional information for high impact initiatives for this category started in FY 14
Hip & Knee Implants: Similar to the Spine Implant contract negotiations described in the November 2013 submission, a number of contracts related to hip & knee implants have been renegotiated in the early parts of FY 2014. By consolidating the contracts for these devices across the health system, savings were achieved for all six of the top utilized vendors. As clinical integration continues and product utilization becomes more standardized, it is expected that additional savings opportunities will be realized in the areas of hip, knee, and spine products.

CRM (Cardiac Rhythm Mechanism): CRM devices are another item where the hospital was able to achieve supply savings through work with the Northeast Purchasing Coalition. For this initiative, Supply Chain staff targeted the highest volume suppliers for the hospital (Medtronic, Boston Scientific, and St. Jude). The combined volume of the two inpatient campuses, along with physician standardization, allowed for additional savings to be achieved.

Rebates: By combining purchases at both campuses, the hospital has been able to see additional supply rebates from vendors at both campuses due to the integration. The rebates achieved on the high volume/high dollar items have been increasingly successful due in large part to the supply chain team organization structure across Yale New Haven Health System as well as our continued involvement with the Northeast Purchasing Coalition.

6. *Business Expenses*
   Initiatives in this category continue to provide the largest category of non-salary savings to date related to the Hospital of Saint Raphael integration. The achieved savings in areas such as Contracted Management Services, Outside Legal Counsel Utilization, Subscriptions & Fees and the other categories mentioned in the November submission have remained into FY 2014. The quantity and value of contracts renegotiated in FY 2013 accounted for the majority of potential opportunity, but there is still room for growth in a number of areas. An example of this would be IT service contracts. Due to the implementation of Epic and the lengthy terms on legacy IT agreements assumed from the Hospital of Saint Raphael, technology based service contracts remain one of the larger areas of opportunity for future savings. The hospital will also continue to review all service based contracts as they approach their term.

7. *Other Consolidation and Integration Savings*
   As the integration of Saint Raphael Campus continues to mature, other opportunities for savings have been realized due to economies of scale that resulted from the combined hospital entities. Below is an area of significant savings that falls within this category.

   TRCC (Temple Recovery Care Center)
   Historically, Yale-New Haven hospital operated a short term rehab facility for patients receiving outpatient surgery at the Temple Medical Facility. The hospital rented space at the hotel adjacent to the facility to meet the needs of the patients. With the integration of the Hospital of Saint Raphael, Yale New Haven Health System began operating the Grimes Center. Utilizing the space of the newly purchased facility and capitalizing on the rehab staff already in place at the Grimes Center, Yale-New Haven Hospital was able to close the Temple Facility. This resulted in salary, rent, and other non-salary expense savings previously spent at the Temple Medical Facility.

8. *Depreciation, Bad Debt, and Interest Expense*
   Consistent with the information provided to follow up questions in DN 12-31747-MDF, due to the financing needed to acquire the Hospital of Saint Raphael, required infrastructure investments at the Saint Raphael Campus and the unified Bad Debt and Charity Care policy, Yale New Haven Hospital continues to see no savings related to these categories.

Revenue Enhancements
The hospital continues to focus and improve upon the revenue enhancement capabilities of the Epic system. With the system going live 5 months prior to the start of FY 2014, both clinical and administrative staff have gained additional experience using the system through both training, and hand on experiences. The benefits of this system reported in the November submission, including standardization of the master patient index, shared accounts receivables, bedside procedures and recovery room documentation and centralization of services continue to be successful.

In addition, significant strides have been made with the hospital's Clinical Documentation and Management Program (CDMP). In the November submission, it was indicated that the two separate groups had been combined into a single department. To further benefit from the newly combined department, all employees were physically moved into a single contiguous space.

This allowed for cross education amongst the more senior staff and joint health system level training sessions. These changes have resulted in noticeable improvements in clinical documentation, including documentation accuracy and better understanding of patient acuity.

Attachment I

Three Year Integration Plan

Gantt Chart

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

Key Activities	PRE FY 2013	FY 2013	FY 2014	FY 2015
1. Major Strategic Initiatives				
1a. Physician & Midlevel Integration				
A1. Consolidate Hospital Based Services				
1. Anesthesiology				
2. Diagnostic Radiology				
3. Emergency Medicine				
4. Laboratory/Pathology				
A2. Integrated ACGME Residency and Fellowship Programs				
1b. EPIC Implementation				
A1. EPIC Go-Live at York Street Campus				
A2. EPIC Go-Live at Chapel Street Campus				
A3. Optimize Epic System			Ongoing	Ongoing
1c. Patient Experience				
A1. Implement Patient Experience Workplan and Supporting Infrastructure at SRC				
1. Patient and Family Advisor Program				
2. Reward and Recognition Structure				
3. Service Recovery Training/On-line Certificates				
A2. Implementation of the "Quiet Plan" Across Both Campuses				
1. Implement Leader Rounding				
2. Managers Train Staff				
A3. Launch Patient Experience Forum				
A4. FY 2014 Patient Experience Strategic Plan				
1. Emphasis on "Every Patient, Every Time"			Ongoing	
2. Physician and Nursing leadership training and engagement				
3. Developing a healing environment				
1d. Regulatory / Safety and Quality				
A1. Preparation for Department of Public Health and Joint Commission surveys				
1. Environmental of Care (EOC)				Ongoing
2. Life Safety				Ongoing
3. Provision of Care/Record of Care				Ongoing
4. Adherence to Licensure				Ongoing
5. Infection Prevention				Ongoing
A2. Consistent Regulatory Compliance and Practices				
1. Audit of Polices and Procedures to Ensure Adherence			Ongoing	Ongoing
A3. Ongoing Regulatory Education and Improvements				
1. Self-Review and Integrated Audits			Ongoing	Ongoing
2. Structure Implemented for Twice Monthly CMS/DPH Audits & Twice Yearly TJC Audits at SRC			Ongoing	Ongoing
A4. Clean and Safe Rounds			Ongoing	Ongoing
A5. Achieve HPI High Reliability Level 3				
1e. Transforming Patient Care				
A1. Implement Bedside Nursing Transformation at SRC to Ensure Consistent Staffing Models/Caregiver Hours Across Both Campuses			Ongoing	Ongoing
A2. Medication Barcoding Process Implemented				
A3. Implement Second Generation Bedside Nursing Transformation at the York Street Campus				
A4. Implement Magnet readiness plan				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

Key Activities	PRE FY 2013	FY 2013	FY 2014	FY 2015
1f. Safe Patient Flow				
A1. Implement Common Safe Patient Flow Throughput Improvement				
A2. Identify Process Changes (Ongoing)			Ongoing	Ongoing
1g. Cultural Integration				
A1. Formation of Catholic Heritage Committee				
A2. Common Value System Defined				
A3. Auxiliaries of Two Campuses Integrated in Operations				
A4. Medical Staff "Healthier Together" Open Forums			Ongoing	Ongoing
A5. Employee Open Forums and Management Meetings			Ongoing	Ongoing
1h. Bed Management/Capacity				
A1. Common Bed Management System -Optimization of Beds Across Campuses				
A2. Open Verdi 4 North				
A3. Develop Strategies to Optimize Inpatient Bed Utilization Across Both Campuses			Ongoing	Ongoing
A4. Realignment of Medicine and Surgery Beds at the Saint Raphael Campus				
A5. Open Verdi 4 West (new specialty Geriatrics unit)				
1i. 24/7 Infrastructure				
A1. Common Administrator on Call and Off-Shift Executive Model Implemented				
A2. Off-shift Department Management				
1j. Care Management to Integrate Services Across the Continuum				
A1. Common Care Management Structure Implemented				
A2. Transitional Care Rounds in all York Street campus inpatient units				
A3. Transitional Care Rounds consistency across both campuses				
2. Service Lines				
2a. Children				
A1. Vision				
1. YNHCH is a destination of choice for pediatric care.			Ongoing	Ongoing
A2. Facilities & Capital				
1. Develop and Implement the Plan for NNICU Expansion and Fundraising				
A3. Integration Activities				
1. Integrate Pediatrics Services Across Both Campuses				
2. Align Child and Adolescent Psychiatry Across Campuses				
3. Combine Hospitalist Programs at YNHCH Campuses				
2b. Heart & Vascular				
A1. Vision				
1. Integrate Heart and Vascular Operations Across Both Campuses and Outpatient Centers				
A2. Facilities & Capital				
1. Renovate Catheterization Laboratories				
A3. Integration Activities				
1. Development of Vascular Access Center				
2. Development of Aortic Institute				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
3. Expansion of the Interventional Radiology Program at SRC				
4. Consolidate cardiac surgery to York Street campus				
5. Development of a Wound Center				
2c. Musculoskeletal				
A1. Vision				
1. Musculoskeletal Service Line Established and Recognized as leading program				
A2. Facilities & Capital				
1. Operational and Capital Plan in Place				
A3. Integration Activities				
1. Business plan definition and implementation				
2. Recruitment of physician leader				
3. Transition of elective joints and spine volume from York Street to Saint Raphael campus				
2d. Neurosciences				
A1. Vision				
Leading Neurosciences program in CT			Ongoing	Ongoing
A2. Facilities & Capital				
1. Allocated appropriate number of beds to Neurosciences				
A3. Integration Activities				
Telestroke at Saint Raphael Campus				
2e. Oncology				
A1. Vision				
1. Integrated Oncology Operations Across Both Campuses				
A3. Integration Activities				
Chemotherapy and radiation therapy on both campuses			Ongoing	Ongoing
2f. Transplant				
A1. Vision				
1. Provide leading solid organ transplantation services in CT (ongoing)			Ongoing	Ongoing
A3. Integration Activities				
2. Organ Donation Committee consolidation				
3. Clinical Areas				
3a. Diagnostic Radiology				
A1. Staffing/Coverage				
1. Enterprise-wide Scheduling (Consolidation of Scheduling/Registration Functions)				
A2. Facilities & Equipment				
1.CON for YNHH to acquire SRMRC Joint Venture				
2. Facilities Plan Completed				
A3. Integration Activities				
1. Assessment of all radiology services and equipment and implementation				
1. Professional readings available 24/7 at SRC				
3b. Emergency Department				
A1. Staffing/Coverage				
1. Realign ED Structure to Create an Integrated Model				
A3. Facilities & Equipment				
1. Review Emergency Transportation (Ambulance and Helicopter)				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

Key Activities	PRE FY 2013	FY 2013	FY 2014	FY 2015
2. Standardized Equipment (As Replacements Are Needed)				
A3. Integration Activities				
1. Consolidation of Major Trauma at York Street				
2. Review Sponsor Hospital Program Offering, Infrastructure, Costs and Opportunities				
3c. Laboratory and Pathology				
A1. Integration Activities				
a. Evaluate consolidation of Laboratory Services System-Wide (Integrated Lab and Shared LIS)				
b. Install and Operate SOFTLaboratory IS system on Both Campuses				
3d. Medicine				
A1. Review Hospitalist Staffing Model and Admission Criteria to Hospitalist Service				
A2. Develop Business Case for eICU				
A3. Evaluate and implement Geriatrics Center of Excellence at the Saint Raphael campus				
3e. Nursing				
A1. Quality				
1. Implement Magnet Remediation Plans				
A2. Integration Activities				
1. Consistent Metrics and Standards and Creation of Unit/Service Line Dashboard				
2. Achieve Reduction in Caregiver Hours (see Transforming Patient Care)				
3f. Pharmacy				
A1. Staffing/Coverage				
1. Establish staffing with YNHH employees (eliminate Cardinal Health contract)				
A2. Facilities & Equipment				
1. Purchase and standardize Pyxis machines				
A3. Integration Activities				
1. Pharmacy Strategy Executed with Single Unified Product Formulary Cross Campuses				
3h. Psychiatry				
A1. Staffing/Coverage				
1. Develop a Standard Model of Care for Psychiatric Services at Both Campuses				
a. 12 Years Old and Under on Winchester One, YSC				
b. 13-15 Year Olds on Celaantano 5, SRC				
c. 16-17 Year Olds on LV2, YSC				
2. One Standard Model of Care with One Psych ED and BIT Team Implementation at SRC				
A2. Quality & Regulatory				
1. Participate in State Collaborative Regional Plan- Integrating Behav.Health Service Payment and Delivery				
A3. Integration Activities				
2. Conduct Crisis Intervention Unit Assessment & Develop/Implement an Improvement Plan (w/ED)				
3. Develop Strategies to Reduce Long LOS for Psychiatry Patients			Ongoing	Ongoing
3l. Surgical Services				
A1. Leadership				
1. Conduct an Assessment of Operating Room and Clinical Support Services				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

Key Activities	PRE FY 2013	FY 2013	FY 2014	FY 2015
2. Recruit physician leader to co-lead operating rooms				
3. Implement nursing clusters/specialty teams across all practice sites				
A2. Consistent Operations				
1. Integrate OR Operations Across Both Campuses, Temple and Shoreline			Ongoing	
2. Optimize Utilization Across All Sites			Ongoing	Ongoing
3. GI Procedure Integration (YSC, SRC, and Temple)			Ongoing	Ongoing
4. Develop a Bariatric Center at the Saint Raphael Campus				
5. Develop Hernia Center at the Saint Raphael campus				
5. Establish Common Set of Metrics				
6. Implement operational recommendations from consulting engagement				
3m. Women				
A1. Integration Activities				
1. Integrate OB-GYN Services Across Both Campuses			Ongoing	
2. Expand OB Residency to Cover SRC				
3. Establish low risk delivery service at SR Campus utilizing midwifery program.				
3n. Ambulatory Services				
A1. Complete Ambulatory Strategic Plan				
1. Develop inventory of all ambulatory locations and services				
2. Develop and implement programmatic recommendations				
A1. Planning for new multidisciplinary satellites				
4. Non-Clinical Areas				
A1. Consolidation of Vendors for Environmental Svcs, Food/Nutrition, Linen and Protective Services				
5. Corporate Services				
5a. Accounting & Finance				
A1. Integrated Capital Budgeting Process Covering Both Campuses				
A2. Integrated Operating Budgeting Process Covering Both Campuses				
A3. Consolidation of Cost Accounting and Decision Support Systems				
A4. Combined Account Receivables for EPIC A/R with One Reserve Model				
A5. Maintain Individuals Accounts Receivable for Legacy SDK and Medipac Receivables				
A6. Replicate Financial Structure for Service Lines				
A7. Institute Flex Budgeting				
A8. Reduce Eliminate Fees Paid for Audit and Banking Operations at SRC				
A9. Review All Membership and Fees for Both Campuses and Remove/Renegotiate Duplicates				
5b. Compliance				
A1. Ensure All Staff Receive Compliance Education Annually (Ongoing Communications and In-services)			Ongoing	Ongoing
A2. Billing, Coding, and Documentation Audits of Both Hospital and Physician Activities			Ongoing	Ongoing
A3. SRC Incorporated into YNHHS Conflict of Interest Process				
5c. Human Resources				

Yale-New Haven Hospital Acquisition of Saint Raphael Health Care System (HSR)
Integration Workplan
Certificate of Need Docket Number: 12-31747-CON
As of May 30, 2014

	PRE FY 2013	FY 2013	FY 2014	FY 2015
Key Activities				
A1. Standardize Career Ladders				
A2. Standardize Performance Management System and Process				
A3. Standardize Rewards, Recognition, and leveraging Performance Based Pay				
A5. Employee Engagement Survey				Ongoing
A6. Develop and Implement Saint Raphael Campus Manager Education Programs			Ongoing	Ongoing
5d. Information Technology and Information Systems				
A1. Consolidation of Approved Applications				
1. Reduce Application Portfolio for EPIC Implementation				
2. Application Consolidation for The Following Areas: Laboratory – Anatomic Pathology, Cardiology, Radiation Oncology & Neurosciences				
3. Application Consolidation for The Following Areas: Gastroenterology, Dietary Services, POS & Sleep Center				
A2. Service Desk Standardized				
A3. Consolidation of Telecom Operator Services				
A4. Review Service Contracts for Systems Used Prior to EPIC Integration				
5e. Legal & Planning				
A1. Identify vendor consolidation opportunities				
A2. Continue Integration Work with malpractice captive			Ongoing	Ongoing
5f. Marketing, Communications, Image, and Community Wellness				
A1. Develop and Implement Community Revitalization Strategy			Ongoing	Ongoing
A2. Implement Communication Strategies for Managers and Employees			Ongoing	Ongoing
A3. Consolidate Advocacy Groups				
5g. Revenue Cycle				
A1. Transfers and Combined Accounts Seamless via EPIC				
A2. Identical CDMs and Charge Levels				
A3. Integrated Master Patient Indexes				
A4. Identical Billing Systems and Vendors to Support Revenue Cycle Functions				
A5. Revenue Cycle Functions Centralized Organizationally and Physically, Where Possible				
A6. Consistent Forms Throughout Entire Revenue Cycle				
A7. Revenue Cycle Opportunities Complete				
1. Pricing Strategies				
2. Denials				
3. Charge Capture				
5g. Reimbursement and Managed Care				
A1. Melded/Consistent Rates for All Payers Across Both Campuses				
5h. Supply Chain				
A1. Contract renegotiations			Ongoing	Ongoing
A2. Inventory management				
A3. Service Response Center consolidation				

OHCA Reports

100, 150 and 175

	YALE-NEW HAVEN HOSPITAL				
	SIX MONTH INCREMENTS				
	FY 2014				
	REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
		3/31/13	3/31/14	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
I.	**ASSETS**				
A.	**Current Assets:**				
1	Cash and Cash Equivalents	$34,952,000	$21,903,000	($13,049,000)	-37%
2	Short Term Investments	$614,251,000	$761,926,000	$147,675,000	24%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$272,835,000	$252,822,000	($20,013,000)	-7%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0	$0	0%
5	Due From Affiliates	$0	$0	$0	0%
6	Due From Third Party Payers	$0	$0	$0	0%
7	Inventories of Supplies	$28,963,000	$27,718,000	($1,245,000)	-4%
8	Prepaid Expenses	$14,256,000	$21,651,000	$7,395,000	52%
9	Other Current Assets	$58,328,000	$75,114,000	$16,786,000	29%
	Total Current Assets	**$1,023,585,000**	**$1,161,134,000**	**$137,549,000**	**13%**
B.	**Noncurrent Assets Whose Use is Limited:**				
1	Held by Trustee	$12,481,000	$12,878,000	$397,000	3%
2	Board Designated for Capital Acquisition	$3,000	$0	($3,000)	-100%
3	Funds Held in Escrow	$0	$0	$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$66,546,000	$75,055,000	$8,509,000	13%
	Total Noncurrent Assets Whose Use is Limited:	**$79,030,000**	**$87,933,000**	**$8,903,000**	**11%**
5	Interest in Net Assets of Foundation	$0	$0	$0	0%
6	Long Term Investments	$161,239,000	$221,096,000	$59,857,000	37%
7	Other Noncurrent Assets	$326,234,000	$314,006,000	($12,228,000)	-4%
C.	**Net Fixed Assets:**				
1	Property, Plant and Equipment	$1,548,091,000	$1,621,225,000	$73,134,000	5%
2	Less: Accumulated Depreciation	$637,179,000	$713,261,000	$76,082,000	12%
	Property, Plant and Equipment, Net	**$910,912,000**	**$907,964,000**	**($2,948,000)**	**0%**
3	Construction in Progress	$26,325,000	$14,167,000	($12,158,000)	-46%
	Total Net Fixed Assets	**$937,237,000**	**$922,131,000**	**($15,106,000)**	**-2%**
	Total Assets	**$2,527,325,000**	**$2,706,300,000**	**$178,975,000**	**7%**
II.	**LIABILITIES AND NET ASSETS**				
A.	**Current Liabilities:**				
1	Accounts Payable and Accrued Expenses	$254,748,000	$234,682,000	($20,066,000)	-8%
2	Salaries, Wages and Payroll Taxes	$73,643,000	$82,409,000	$8,766,000	12%
3	Due To Third Party Payers	$0	$0	$0	0%
4	Due To Affiliates	$0	$0	$0	0%
5	Current Portion of Long Term Debt	$10,640,000	$11,070,000	$430,000	4%
6	Current Portion of Notes Payable	$0	$0	$0	0%
7	Other Current Liabilities	$23,540,000	$32,896,000	$9,356,000	40%
	Total Current Liabilities	**$362,571,000**	**$361,057,000**	**($1,514,000)**	**0%**
B.	**Long Term Debt:**				
1	Bonds Payable (Net of Current Portion)	$689,114,000	$676,983,000	($12,131,000)	-2%
2	Notes Payable (Net of Current Portion)	$51,471,000	$49,810,000	($1,661,000)	-3%
	Total Long Term Debt	**$740,585,000**	**$726,793,000**	**($13,792,000)**	**-2%**

YALE-NEW HAVEN HOSPITAL
SIX MONTH INCREMENTS
FY 2014
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	(5)	(6)
		3/31/13	3/31/14	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
3	Accrued Pension Liability	$289,270,000	$186,852,000	($102,418,000)	-35%
4	Other Long Term Liabilities	$314,004,000	$316,323,000	$2,319,000	1%
	Total Long Term Liabilities	**$1,343,859,000**	**$1,229,968,000**	**($113,891,000)**	**-8%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0	$0	0%
C.	**Net Assets:**				
1	Unrestricted Net Assets or Equity	$738,967,000	$1,022,710,000	$283,743,000	38%
2	Temporarily Restricted Net Assets	$54,830,000	$61,579,000	$6,749,000	12%
3	Permanently Restricted Net Assets	$27,098,000	$30,986,000	$3,888,000	14%
	Total Net Assets	**$820,895,000**	**$1,115,275,000**	**$294,380,000**	**36%**
	Total Liabilities and Net Assets	**$2,527,325,000**	**$2,706,300,000**	**$178,975,000**	**7%**

	YALE-NEW HAVEN HOSPITAL				
	SIX MONTH INCREMENTS				
	FY 2013				
	REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION				
(1)	(2)	(3)	(4)	(5)	(6)
		10/1/12-3/31/13	10/1/13-3/31/14	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$3,924,565,000	$4,142,077,000	$217,512,000	6%
2	Less: Allowances	$2,734,215,000	$2,936,664,000	$202,449,000	7%
3	Less: Charity Care	$41,391,000	$49,632,000	$8,241,000	20%
4	Less: Other Deductions	$0	$0	$0	0%
	Total Net Patient Revenue	**$1,148,959,000**	**$1,155,781,000**	**$6,822,000**	**1%**
5	Other Operating Revenue	$20,171,000	$23,635,000	$3,464,000	17%
6	Net Assets Released from Restrictions	$6,417,000	$4,328,000	($2,089,000)	-33%
	Total Operating Revenue	**$1,175,547,000**	**$1,183,744,000**	**$8,197,000**	**1%**
B.	**Operating Expenses:**				
1	Salaries and Wages	$391,752,000	$400,355,000	$8,603,000	2%
2	Fringe Benefits	$120,028,000	$118,017,000	($2,011,000)	-2%
3	Physicians Fees	$39,940,000	$38,744,000	($1,196,000)	-3%
4	Supplies and Drugs	$184,687,000	$194,841,000	$10,154,000	5%
5	Depreciation and Amortization	$52,707,000	$58,621,000	$5,914,000	11%
6	Bad Debts	$31,327,000	$27,566,000	($3,761,000)	-12%
7	Interest	$11,293,000	$12,666,000	$1,373,000	12%
8	Malpractice	$7,182,000	$535,000	($6,647,000)	-93%
9	Other Operating Expenses	$301,724,000	$273,405,000	($28,319,000)	-9%
	Total Operating Expenses	**$1,140,640,000**	**$1,124,750,000**	**($15,890,000)**	**-1%**
	Income/(Loss) From Operations	**$34,907,000**	**$58,994,000**	**$24,087,000**	**69%**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$7,994,000	$3,867,000	($4,127,000)	-52%
2	Gifts, Contributions and Donations	$0	$0	$0	0%
3	Other Non-Operating Gains/(Losses)	$25,253,000	$28,735,000	$3,482,000	14%
	Total Non-Operating Revenue	**$33,247,000**	**$32,602,000**	**($645,000)**	**-2%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$68,154,000**	**$91,596,000**	**$23,442,000**	**34%**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$4,252,000	$5,769,000	$1,517,000	36%
	All Other Adjustments	$0	$0	$0	0%
	Total Other Adjustments	**$4,252,000**	**$5,769,000**	**$1,517,000**	**36%**
	Excess/(Deficiency) of Revenue Over Expense	**$72,406,000**	**$97,365,000**	**$24,959,000**	**34%**
	Principal Payments	$0		$0	0%

$0

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2014
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	Oct-Mar 2013 ACTUAL	Oct-Mar 2014 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
I.	OPERATING EXPENSE BY CATEGORY				
A.	Salaries & Wages:				
1	Nursing Salaries	166,055,234	163,838,665	(2,216,569)	-1%
2	Physician Salaries	0	0	0	0%
3	Non-Nursing, Non-Physician Salaries	225,696,711	236,516,515	10,819,804	5%
	Total Salaries & Wages	**391,751,945**	**400,355,180**	**8,603,235**	**2%**
B.	Fringe Benefits:				
1	Nursing Fringe Benefits	70,573,796	69,720,682	(853,114)	-1%
2	Physician Fringe Benefits	0	0	0	0%
3	Non-Nursing, Non-Physician Fringe Benefits	49,453,865	48,296,599	(1,157,266)	-2%
	Total Fringe Benefits	**120,027,661**	**118,017,281**	(2,010,380)	**-2%**
C.	Contractual Labor Fees:				
1	Nursing Fees	2,399,117	2,471,091	71,974	3%
2	Physician Fees	39,939,853	38,722,596	(1,217,257)	-3%
3	Non-Nursing, Non-Physician Fees	17,907,048	18,265,189	358,141	2%
	Total Contractual Labor Fees	**60,246,018**	**59,458,876**	(787,143)	**-1%**
D.	Medical Supplies and Pharmaceutical Cost:				
1	Medical Supplies	103,480,429	106,703,959	3,223,530	3%
2	Pharmaceutical Costs	71,948,114	79,880,160	7,932,046	11%
	Total Medical Supplies and Pharmaceutical Cost	**175,428,543**	**186,584,119**	**11,155,576**	**6%**
E.	Depreciation and Amortization:				
1	Depreciation-Building	19,591,150	22,656,973	3,065,823	16%
2	Depreciation-Equipment	33,115,706	35,963,915	2,848,209	9%
3	Amortization	0	0	0	0%
	Total Depreciation and Amortization	**52,706,856**	**58,620,888**	**5,914,032**	**11%**
F.	Bad Debts:				
1	Bad Debts	0	0	0	**0%**
G.	Interest Expense:				
1	Interest Expense	11,293,080	12,665,748	1,372,668	**12%**
H.	Malpractice Insurance Cost:				
1	Malpractice Insurance Cost	7,144,093	714,855	(6,429,238)	**-90%**
I.	Utilities:				
1	Water	560,794	831,550	270,756	48%
2	Natural Gas	1,031,736	1,046,700	14,964	1%
3	Oil	0	0	0	0%
4	Electricity	9,730,911	9,159,138	(571,773)	-6%
5	Telephone	2,167,499	2,202,016	34,517	2%
6	Other Utilities	624,248	623,802	(446)	0%
	Total Utilities	**14,115,188**	**13,863,206**	(251,982)	**-2%**
J.	Business Expenses:				
1	Accounting Fees	641,181	515,641	(125,540)	-20%
2	Legal Fees	1,694,432	1,706,089	11,657	1%
3	Consulting Fees	570,987	37,762	(533,224)	-93%
4	Dues and Membership	1,047,216	1,068,160	20,944	2%
5	Equipment Leases	4,019,064	3,574,656	(444,408)	-11%
6	Building Leases	7,073,101	9,135,869	2,062,768	29%
7	Repairs and Maintenance	15,285,403	17,716,058	2,430,655	16%
8	Insurance	1,356,561	1,526,132	169,571	13%
9	Travel	6,884	775	(6,109)	-89%
10	Conferences	1,735,267	1,386,745	(348,522)	-20%
11	Property Tax	1,846,164	2,258,637	412,473	22%

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2014
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	Oct-Mar 2013 ACTUAL	Oct-Mar 2014 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
12	General Supplies	7,589,793	7,741,589	151,796	2%
13	Licenses and Subscriptions	946,296	752,480	(193,816)	-20%
14	Postage and Shipping	929,556	769,827	(159,729)	-17%
15	Advertising	73,919	55,383	(18,536)	-25%
16	Corporate parent/system fees	11,872,348	14,003,376	2,131,028	18%
17	Computer Software	0	0	0	0%
18	Computer hardware & small equipment	396,193	327,433	(68,760)	-17%
19	Dietary / Food Services	1,609,383	1,461,061	(148,322)	-9%
20	Lab Fees / Red Cross charges	9,258,115	8,256,484	(1,001,631)	-11%
21	Billing & Collection / Bank Fees	291,323	458,771	167,448	57%
22	Recruiting / Employee Education & Recognition	443,842	558,430	114,588	26%
23	Laundry / Linen	3,190,087	2,847,033	(343,054)	-11%
24	Professional / Physician Fees	3,479,612	1,935,988	(1,543,624)	-44%
25	Waste disposal	731,317	691,808	(39,509)	-5%
26	Purchased Services - Medical	54,885,768	55,434,626	548,858	1%
27	Purchased Services - Non Medical	145,103,661	139,848,478	(5,255,183)	-4%
28	Other Business Expenses	523,007	398,752	(124,255)	-24%
	Total Business Expenses	**276,600,480**	**274,468,042**	**(2,132,437)**	**-1%**
K.	**Other Operating Expense:**				
1	Miscellaneous Other Operating Expenses	0	0	0	0%
	Total Operating Expenses - All Expense Categories*	**1,109,313,863**	**1,124,748,195**	**15,434,332**	1%
	***A.- K. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.**				
II.	**OPERATING EXPENSE BY DEPARTMENT**				
A.	**General Services:**				
1	General Administration	34,393,918	38,057,838	3,663,920	11%
2	General Accounting	2,696,205	2,925,371	229,166	8%
3	Patient Billing & Collection	14,514,211	14,471,010	(43,201)	0%
4	Admitting / Registration Office	7,317,639	7,331,207	13,568	0%
5	Data Processing	0	0	0	0%
6	Communications	2,232,310	3,028,760	796,450	36%
7	Personnel	1,930,547	2,162,985	232,438	12%
8	Public Relations	594,235	559,083	(35,152)	-6%
9	Purchasing	2,088,974	1,891,384	(197,590)	-9%
10	Dietary and Cafeteria	12,829,999	15,159,492	2,329,493	18%
11	Housekeeping	13,674,470	13,464,845	(209,625)	-2%
12	Laundry & Linen	101,873	101,526	(347)	0%
13	Operation of Plant	16,919,744	15,508,765	(1,410,979)	-8%
14	Security	4,779,907	5,336,472	556,565	12%
15	Repairs and Maintenance	10,438,723	12,901,731	2,463,008	24%
16	Central Sterile Supply	5,403,183	5,181,552	(221,631)	-4%
17	Pharmacy Department	26,948,684	31,371,873	4,423,189	16%
18	Other General Services	240,265,285	224,186,619	(16,078,666)	-7%
	Total General Services	**397,129,907**	**393,640,513**	**(3,489,394)**	**-1%**
B.	**Professional Services:**				
1	Medical Care Administration	28,132,361	23,085,950	(5,046,411)	-18%
2	Residency Program	37,489,921	34,974,593	(2,515,328)	-7%
3	Nursing Services Administration	9,048,151	8,853,941	(194,210)	-2%
4	Medical Records	6,006,981	3,452,675	(2,554,306)	-43%
5	Social Service	4,323,915	3,046,004	(1,277,911)	-30%
6	Other Professional Services	0	0	0	0%
	Total Professional Services	**85,001,329**	**73,413,163**	**(11,588,166)**	**-14%**
C.	**Special Services:**				
1	Operating Room	70,211,276	72,450,721	2,239,445	3%

YALE-NEW HAVEN HOSPITAL
TWELVE MONTH PRELIMINARY FILING
FISCAL YEAR 2014
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	(5)	(6)
LINE	DESCRIPTION	Oct-Mar 2013 ACTUAL	Oct-Mar 2014 ACTUAL	AMOUNT DIFFERENCE	% DIFFERENCE
2	Recovery Room	6,461,273	5,494,048	(967,225)	-15%
3	Anesthesiology	11,282,999	10,033,530	(1,249,469)	-11%
4	Delivery Room	6,147,904	6,210,445	62,541	1%
5	Diagnostic Radiology	18,799,180	18,606,885	(192,295)	-1%
6	Diagnostic Ultrasound	3,069,147	3,411,259	342,112	11%
7	Radiation Therapy	10,698,473	7,749,588	(2,948,885)	-28%
8	Radioisotopes	16,953,410	18,397,466	1,444,056	9%
9	CT Scan	2,896,183	3,017,593	121,410	4%
10	Laboratory	34,760,477	34,531,372	(229,105)	-1%
11	Blood Storing/Processing	12,221,555	11,173,712	(1,047,843)	-9%
12	Cardiology	0	0	0	0%
13	Electrocardiology	7,450,659	10,784,930	3,334,271	45%
14	Electroencephalography	3,181,423	3,285,639	104,216	3%
15	Occupational Therapy	0	0	0	0%
16	Speech Pathology	0	0	0	0%
17	Audiology	0	0	0	0%
18	Respiratory Therapy	8,073,488	7,820,515	(252,973)	-3%
19	Pulmonary Function	1,961,832	1,520,652	(441,180)	-22%
20	Intravenous Therapy	623,151	536,189	(86,962)	-14%
21	Shock Therapy	0	0	0	0%
22	Psychiatry / Psychology Services	3,428,943	2,790,014	(638,929)	-19%
23	Renal Dialysis	1,975,136	1,957,467	(17,669)	-1%
24	Emergency Room	32,569,626	32,397,885	(171,741)	-1%
25	MRI	3,520,090	3,595,854	75,764	2%
26	PET Scan	0	0	0	0%
27	PET/CT Scan	0	0	0	0%
28	Endoscopy	2,270,188	1,617,510	(652,678)	-29%
29	Sleep Center	0	0	0	0%
30	Lithotripsy	(12,396)	0	12,396	-100%
31	Cardiac Catheterization/Rehabilitation	2,142,804	3,253,940	1,111,136	52%
32	Occupational Therapy / Physical Therapy	4,397,192	4,427,768	30,576	1%
33	Dental Clinic	2,268,513	2,014,448	(254,065)	-11%
34	Other Special Services	2,281,016	2,737,232	456,216	20%
	Total Special Services	**269,633,542**	**269,816,662**	**183,120**	**0%**
D.	**Routine Services:**				
1	Medical & Surgical Units	108,397,860	107,489,738	(908,122)	-1%
2	Intensive Care Unit	28,423,811	27,645,620	(778,191)	-3%
3	Coronary Care Unit	5,310,906	5,076,888	(234,018)	-4%
4	Psychiatric Unit	11,379,234	12,782,972	1,403,738	12%
5	Pediatric Unit	7,921,545	7,775,799	(145,746)	-2%
6	Maternity Unit	4,830,580	4,448,808	(381,772)	-8%
7	Newborn Nursery Unit	2,506,049	2,307,986	(198,063)	-8%
8	Neonatal ICU	9,498,322	9,602,946	104,624	1%
9	Rehabilitation Unit	845,410	725,431	(119,979)	-14%
10	Ambulatory Surgery	6,340,269	5,051,154	(1,289,115)	-20%
11	Home Care	0	0	0	0%
12	Outpatient Clinics	91,367,249	100,740,305	9,373,056	10%
13	Other Routine Services	0	0	0	0%
	Total Routine Services	**276,821,235**	**283,647,647**	**6,826,412**	**2%**
E.	**Other Departments:**				
1	Miscellaneous Other Departments	80,727,850	104,230,210	23,502,360	29%
	Total Operating Expenses - All Departments*	**1,109,313,863**	**1,124,748,195**	**15,434,332**	1%
	***A.- 0. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.**				